State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2019

DSH Version 6.00 2/21/2020

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2018	06/30/2019

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	07/01/2018	06/30/2019	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	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 (07/01/18 - 06/30/19)
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 07/01/2018 - 06/30/2019** — $ 842,763

   (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 07/01/2018 - 06/30/2019** — [blank]

   (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 Services07/01/2018 - 06/30/2019** — $ 842,763

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	11/2/20 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 3/31/2020

D. General Cost Report Year Information 7/1/2018 - 6/30/2019

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 c 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

	7/1/2018 through 6/30/2019		
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: 5/13/2020

	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	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	Yes	

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

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. 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: (07/01/2018 - 06/30/2019)

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)	$ 198,416	$ 834,187	$1,032,603
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,805,703	$ 12,850,769	$15,656,472
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)	$3,004,119	$13,684,956	$16,689,075
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.60%	6.10%	6.19%

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 thes 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 (07/01/2018 - 06/30/2019)

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)	64,318	(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	33,675,595
8. Outpatient Hospital Charity Care Charges	56,425,542
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	$ 90,101,137

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)			
11. Hospital	$95,928,206.00			$ 75,522,677	$ -	$ -	$ 20,405,529
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			$9,130,033.00			$ 7,187,923	
17. Nursing Facility			$0.00			$ -	
18. Other Long-Term Care			$0.00			$ -	
19. Ancillary Services	$306,393,374.00	$957,007,173.00		$ 241,218,393	$ 753,435,787	$ -	$ 268,746,367
20. Outpatient Services		$84,554,142.00			$ 66,568,066	$ -	$ 17,986,076
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	$22,433,926.00	$ -	$ -	$ 17,661,856	$ -
27. Total	$ 402,321,580	$ 1,041,561,315	$ 31,563,959	$ 316,741,070	$ 820,003,852	$ 24,849,779	$ 307,137,973

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,475,446,854	Total Contractual Adj. (G-3 Line 2)	1,160,403,735
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)			+	1,190,966
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
35. Adjusted Contractual Adjustments				1,161,594,701
36. Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) | 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	$ 32,616,594	$ -	$ -	$0.00	$ 32,616,594	53,010	$62,372,450.00		$ 615.29
2	03100	INTENSIVE CARE UNIT	$ 8,116,929	$ -	$ 2,658		$ 8,119,587	6,165	$23,378,988.00		$ 1,317.05
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	$ 3,259,617	$ -	$ -		$ 3,259,617	8,819	$10,176,768.00		$ 369.61
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 43,993,140	$ -	$ 2,658	$ -	$ 43,995,798	67,994	$ 95,928,206		
19		Weighted Average									$ 647.05

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)		3,676	-	-	$ 2,261,806	$68,637.00	$2,629,477.00	$ 2,698,114	0.838291

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	$24,633,933.00	$ -	$0.00		$ 24,633,933	$52,590,925.00	$155,680,478.00	$ 208,271,403	0.118278
22	5100	RECOVERY ROOM	$2,530,917.00	$ -	$0.00		$ 2,530,917	$10,876,929.00	$23,620,457.00	$ 34,497,386	0.073365
23	5200	DELIVERY ROOM & LABOR ROOM	$7,925,668.00	$ -	$0.00		$ 7,925,668	$17,184,552.00	$2,401,669.00	$ 19,586,221	0.404655
24	5300	ANESTHESIOLOGY	$1,168,991.00	$ -	$0.00		$ 1,168,991	$14,948,184.00	$32,449,681.00	$ 47,397,865	0.024663
25	5400	RADIOLOGY-DIAGNOSTIC	$13,843,127.00	$ -	$14,263.00		$ 13,857,390	$17,653,293.00	$83,935,770.00	$ 101,589,063	0.136406
26	5500	RADIOLOGY-THERAPEUTIC	$24,649,004.00	$ -	$3,487.00		$ 24,652,491	$8,865,279.00	$135,932,496.00	$ 144,797,775	0.170255
27	5700	CT SCAN	$2,108,815.00	$ -	$0.00		$ 2,108,815	$20,048,673.00	$74,534,189.00	$ 94,582,862	0.022296
28	5800	MRI	$1,157,078.00	$ -	$0.00		$ 1,157,078	$4,515,564.00	$17,606,089.00	$ 22,121,653	0.052305
29	6000	LABORATORY	$14,946,138.00	$ -	$19,990.00		$ 14,966,128	$44,469,523.00	$82,659,906.00	$ 127,129,429	0.117724

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) 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	$3,508,234.00	$ -	$0.00	$ 3,508,234	$15,167,826.00	$1,482,561.00	$ 16,650,387	0.210700
31	6600	PHYSICAL THERAPY	$2,815,919.00	$ -	$0.00	$ 2,815,919	$8,854,709.00	$7,534,513.00	$ 16,389,222	0.171815
32	6700	OCCUPATIONAL THERAPY	$941,662.00	$ -	$0.00	$ 941,662	$4,995,772.00	$1,565,455.00	$ 6,561,227	0.143519
33	6800	SPEECH PATHOLOGY	$387,422.00	$ -	$0.00	$ 387,422	$1,475,740.00	$529,678.00	$ 2,005,418	0.193188
34	6900	ELECTROCARDIOLOGY	$2,466,594.00	$ -	$5,192.00	$ 2,471,786	$3,774,066.00	$8,833,669.00	$ 12,607,735	0.196053
35	7000	ELECTROENCEPHALOGRAPHY	$259,215.00	$ -	$290.00	$ 259,505	$408,728.00	$595,096.00	$ 1,003,824	0.258516
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$18,770,009.00	$ -	$0.00	$ 18,770,009	$11,212,939.00	$19,387,171.00	$ 30,600,110	0.613397
37	7200	IMPL. DEV. CHARGED TO PATIENTS	$7,848,151.00	$ -	$0.00	$ 7,848,151	$4,835,359.00	$22,126,209.00	$ 26,961,568	0.291087
38	7300	DRUGS CHARGED TO PATIENTS	$67,582,614.00	$ -	$3,518.00	$ 67,586,132	$65,394,791.00	$305,476,289.00	$ 370,871,080	0.182236
39	7400	RENAL DIALYSIS	$1,063,620.00	$ -	$0.00	$ 1,063,620	$4,696,056.00	$419,338.00	$ 5,115,394	0.207925
40	9100	EMERGENCY	$10,887,432.00	$ -	$0.00	$ 10,887,432	$10,824,416.00	$48,693,592.00	$ 59,518,008	0.182927
41	9300	WOUND CARE	$4,863,393.00	$ -	$8,069.00	$ 4,871,462	$1,234,058.00	$23,802,076.00	$ 25,036,134	0.194577
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 (07/01/2018-06/30/2019) 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**	$ 214,357,936	$ -	$ 54,809		$ 214,412,745	$ 324,096,019	$ 1,051,895,859	$ 1,375,991,878	
127		**Weighted Average**									0.157468
128		**Sub Totals**	$ 258,351,076	$ -	$ 57,467		$ 258,408,543	$ 420,024,225	$ 1,051,895,859	$ 1,471,920,084	
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)*					$341,522.00				
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**					$ 258,067,021				
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 (07/01/2018-06/30/2019) 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	$ 615.29		2,956		3,890		3,463		4,307		3,360		14,616		36.65%
2	03100	INTENSIVE CARE UNIT	$ 1,317.05		733		123		625		638		423		2,119		41.28%
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	$ 369.61		214		4,672		-		237		386		5,123		62.69%
11			$ -												-		
12			$ -												-		
13			$ -												-		
14			$ -												-		
15			$ -												-		
16			$ -												-		
17			$ -												-		
18				**Total Days**	3,903		8,685		4,088		5,182		4,169		21,858		38.47%
19		Total Days per PS&R or Exhibit Detail			3,903		8,685		4,088		5,182		4,169				
20		Unreconciled Days (Explain Variance)			-		-		-		-		-				
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21		Routine Charges			$ 5,764,242		$ 10,444,696		$ 6,552,178		$ 7,853,450		$ 6,161,762		$ 30,614,566		38.52%
21.01		Calculated Routine Charge Per Diem			$ 1,476.87		$ 1,202.61		$ 1,602.78		$ 1,515.52		$ 1,478.00		$ 1,400.61		
		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)		0.838291	52,895	436,892	24,233	594,811	4,825	101,244	10,158	412,087	-	233,217	$ 92,111	$ 1,545,034	70.57%
23	5000	OPERATING ROOM		0.118278	2,726,463	3,989,684	1,656,117	15,528,606	3,459,954	3,151,519	3,157,450	4,885,185	3,888,595	8,535,921	$ 10,999,984	$ 27,554,994	24.62%
24	5100	RECOVERY ROOM		0.073365	312,850	567,036	2,209,125	3,639,410	314,321	369,575	963,904	796,046	633,062	1,023,309	$ 3,800,200	$ 5,372,067	31.54%
25	5200	DELIVERY ROOM & LABOR ROOM		0.404655	262,567	-	7,163,041	146,990	14,916	-	1,731,982	44,030	469,310	8,697	$ 9,172,506	$ 191,020	50.35%
26	5300	ANESTHESIOLOGY		0.024663	432,483	726,812	2,120,605	3,746,664	558,285	488,588	1,165,977	1,052,655	876,539	1,497,826	$ 4,277,350	$ 6,014,719	26.87%
27	5400	RADIOLOGY-DIAGNOSTIC		0.136406	963,123	1,788,464	658,662	4,221,735	1,608,028	2,159,603	1,346,040	3,347,217	1,370,519	8,349,441	$ 4,575,853	$ 11,517,019	25.71%
28	5500	RADIOLOGY-THERAPEUTIC		0.170255	149,435	2,631,579	277,532	5,027,919	678,750	4,792,882	744,594	5,652,772	939,648	8,779,668	$ 1,850,311	$ 18,105,152	20.85%
29	5700	CT SCAN		0.022296	1,264,197	2,490,290	511,806	2,954,059	1,506,173	2,431,705	1,557,279	3,418,426	2,065,763	9,924,962	$ 4,839,455	$ 11,294,480	30.19%
30	5800	MRI		0.052305	365,451	517,766	166,996	529,707	218,797	480,940	297,598	646,817	452,714	1,020,703	$ 1,048,842	$ 2,175,230	21.37%
31	6000	LABORATORY		0.117724	3,216,806	2,599,820	3,845,315	5,687,612	3,586,087	2,489,598	3,737,947	3,480,003	3,733,833	12,446,664	$ 14,386,155	$ 14,257,033	35.53%
32	6500	RESPIRATORY THERAPY		0.210700	1,153,451	149,702	236,374	215,808	1,607,930	67,917	1,770,958	147,137	802,161	260,102	$ 4,768,713	$ 580,564	38.75%
33	6600	PHYSICAL THERAPY		0.171815	279,544	82,110	59,324	562,243	348,100	145,940	453,838	752,821	262,326	264,832	$ 1,140,806	$ 1,543,114	19.62%
34	6700	OCCUPATIONAL THERAPY		0.143519	82,778	13,567	9,765	81,642	86,096	36,422	130,358	178,470	67,327	31,774	$ 308,997	$ 310,101	10.96%
35	6800	SPEECH PATHOLOGY		0.193188	66,031	3,234	47,979	10,758	94,525	7,376	112,347	37,318	58,294	27,266	$ 320,882	$ 58,686	23.25%
36	6900	ELECTROCARDIOLOGY		0.196053	302,981	179,043	130,287	213,002	341,611	288,825	404,926	485,372	435,648	763,003	$ 1,179,805	$ 1,166,242	28.49%
37	7000	ELECTROENCEPHALOGRAPHY		0.258516	12,769	79,513	4,452	49,754	26,935	-	25,252	38,367	19,625	95,493	$ 69,408	$ 167,634	35.19%
38	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.613397	412,619	350,695	336,413	850,979	652,245	358,496	677,532	600,408	766,472	1,023,351	$ 2,078,809	$ 2,160,578	19.78%
39	7200	IMPL. DEV. CHARGED TO PATIENTS		0.291087	176,478	165,771	168,283	760,249	352,939	387,691	354,574	681,291	414,571	366,415	$ 1,052,274	$ 1,995,002	14.53%
40	7300	DRUGS CHARGED TO PATIENTS		0.182236	4,320,358	10,323,895	3,519,812	6,070,216	4,669,643	9,995,527	4,944,064	11,926,975	4,122,943	5,662,690	$ 17,453,877	$ 38,316,613	17.97%
41	7400	RENAL DIALYSIS		0.207925	99,441	-	61,710	4,688	803,319	140,176	281,336	44,584	361,498	11,305	$ 1,245,806	$ 189,448	35.40%
42	9100	EMERGENCY		0.182927	838,405	2,920,867	274,233	7,603,610	966,828	1,723,555	921,268	2,597,443	1,227,922	10,547,186	$ 3,000,734	$ 14,845,475	50.46%
43	9300	WOUND CARE		0.194577	-	-	222,687	754,607	628,498	1,138,642	564,288	1,507,313	407,282	821,949	$ 1,415,473	$ 3,400,562	24.36%
44				-											$ -	$ -	
45				-											$ -	$ -	
46				-											$ -	$ -	
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59				-											$ -	$ -	
60				-											$ -	$ -	

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

Cost Report Year (07/01/2018-06/30/2019) 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				-											$ -	$ -	
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67				-											$ -	$ -	
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126				-											$ -	$ -	
127				-											$ -	$ -	
					$ 17,491,125	$ 30,016,740	$ 23,704,751	$ 59,255,069	$ 22,528,805	$ 30,756,221	$ 25,353,670	$ 42,732,737	$ 23,376,052	$ 71,695,774			

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

Cost Report Year (07/01/2018-06/30/2019) CANDLER HOSPITAL

Line	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 23,255,367	$ 30,016,740	$ 34,149,447	$ 59,255,069	$ 29,080,983	$ 30,756,221	$ 33,207,120	$ 42,732,737	$ 29,537,814 **(Agrees to Exhibit A)**	$ 71,695,774 **(Agrees to Exhibit A)**	$ 119,692,917	$ 162,760,767	26.34%
129	Total Charges per PS&R or Exhibit Detail	$ 23,255,367	$ 30,016,740	$ 34,149,447	$ 59,255,069	$ 29,080,983	$ 30,756,221	$ 33,207,120	$ 42,732,737	$ 29,537,814	$ 71,695,774			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 5,597,033	$ 4,761,262	$ 9,321,814	$ 8,547,941	$ 6,535,284	$ 4,802,788	$ 7,895,000	$ 6,780,238	$ 6,387,992	$ 9,836,675	$ 29,349,131	$ 24,892,229	27.57%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 6,069,365	$ 4,535,881			$ 892,200	$ 386,246	$ 296,491	$ 478,402			$ 7,258,056	$ 5,400,529	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 9,104,599	$ 8,460,779			$ 304,432	$ 140,199			$ 9,409,031	$ 8,600,978	
134	Private Insurance (including primary and third party liability)	$ 98,688	$ 15,620	$ 641	$ 10,616		$ 2,087	$ 2,271,453	$ 1,666,335			$ 2,370,782	$ 1,694,658	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 12,409	$ 377	$ 11,134	$ 25	$ 13,026	$ 3,388	$ 23,562			$ 3,790	$ 60,131	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 6,168,053	$ 4,563,910	$ 9,105,617	$ 8,482,529									
137	Medicaid Cost Settlement Payments (See Note B)		$ (336,973)									$ -	$ (336,973)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 5,766,078	$ 3,909,964	$ 494,575	$ 508,682			$ 6,260,653	$ 4,418,646	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 4,746,618	$ 4,101,842			$ 4,746,618	$ 4,101,842	
141	Medicare Cross-Over Bad Debt Payments					$ 86,415	$ 163,289					$ 86,415	$ 163,289	
142	Other Medicare Cross-Over Payments (See Note D)					$ 207,058	$ 20,141			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 207,058	$ 20,141	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 198,416	$ 834,187			
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)**	$ (571,020)	$ 534,325	$ 216,197	$ 65,412	$ (416,492)	$ 308,035	$ (221,957)	$ (138,784)	$ 6,189,576	$ 9,002,488	$ (993,272)	$ 768,988	
146	**Calculated Payments as a Percentage of Cost**	110%	89%	98%	99%	106%	94%	103%	102%	3%	8%	103%	97%	
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)**					29,705								
148	**Percent of cross-over days to total Medicare days from the cost report**					14%								

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 (07/01/2018-06/30/2019) 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	$ 615.29		104								104	
2	03100 INTENSIVE CARE UNIT	$ 1,317.05		3								3	
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	$ 369.61		20								20	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	127		-		-		-		127	
19	Total Days per PS&R or Exhibit Detail			127		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 177,165								$ 177,165	
21.01	Calculated Routine Charge Per Diem			$ 1,395.00		$ -		$ -		$ -		$ 1,395.00	
	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)		0.838291	-	33,580							$ -	$ 33,580
23	5000 OPERATING ROOM		0.118278	46,369	248,718							$ 46,369	$ 248,718
24	5100 RECOVERY ROOM		0.073365	11,276	39,536							$ 11,276	$ 39,536
25	5200 DELIVERY ROOM & LABOR ROOM		0.404655	19,888	-							$ 19,888	$ -
26	5300 ANESTHESIOLOGY		0.024663	15,182	52,716							$ 15,182	$ 52,716
27	5400 RADIOLOGY-DIAGNOSTIC		0.136406	94,225	211,964							$ 94,225	$ 211,964
28	5500 RADIOLOGY-THERAPEUTIC		0.170255	36,748	484,640							$ 36,748	$ 484,640
29	5700 CT SCAN		0.022296	70,951	361,857							$ 70,951	$ 361,857
30	5800 MRI		0.052305	19,548	9,797							$ 19,548	$ 9,797
31	6000 LABORATORY		0.117724	110,314	233,414							$ 110,314	$ 233,414
32	6500 RESPIRATORY THERAPY		0.210700	19,928	20,475							$ 19,928	$ 20,475
33	6600 PHYSICAL THERAPY		0.171815	3,552	1,070							$ 3,552	$ 1,070
34	6700 OCCUPATIONAL THERAPY		0.143519	-	1,008							$ -	$ 1,008
35	6800 SPEECH PATHOLOGY		0.193188	-	1,191							$ -	$ 1,191
36	6900 ELECTROCARDIOLOGY		0.196053	25,213	21,717							$ 25,213	$ 21,717
37	7000 ELECTROENCEPHALOGRAPHY		0.258516	1,134	-							$ 1,134	$ -
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.613397	8,389	13,980							$ 8,389	$ 13,980
39	7200 IMPL. DEV. CHARGED TO PATIENTS		0.291087	3,661	86,413							$ 3,661	$ 86,413
40	7300 DRUGS CHARGED TO PATIENTS		0.182236	91,242	1,002,207							$ 91,242	$ 1,002,207
41	7400 RENAL DIALYSIS		0.207925	-	2,631							$ -	$ 2,631
42	9100 EMERGENCY		0.182927	42,248	372,082							$ 42,248	$ 372,082
43	9300 WOUND CARE		0.194577	12,089	41,468							$ 12,089	$ 41,468
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) CANDLER HOSPITAL

Line					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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107				-									$ -	$ -
108				-									$ -	$ -
109				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) CANDLER HOSPITAL

Line					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				-									$ -	$ -
					$ 631,957	$ 3,240,464	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

Line	Description	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
128	**Total Charges (includes organ acquisition from Section K)**	$ 809,122	$ 3,240,464	$ -	$ -	$ -	$ -	$ -	$ -	$ 809,122	$ 3,240,464
129	Total Charges per PS&R or Exhibit Detail	$ 809,122	$ 3,240,464	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 167,733	$ 511,430	$ -	$ -	$ -	$ -	$ -	$ -	$ 167,733	$ 511,430
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 130,910	$ 264,530							$ 130,910	$ 264,530
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)		$ 3,254							$ -	$ 3,254
135	Self-Pay (including Co-Pay and Spend-Down)	$ 1,314	$ 18,470							$ 1,314	$ 18,470
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 132,224	$ 286,254	$ -	$ -						
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)**	$ 35,509	$ 225,176	$ -	$ -	$ -	$ -	$ -	$ -	$ 35,509	$ 225,176
144	**Calculated Payments as a Percentage of Cost**	79%	56%	0%	0%	0%	0%	0%	0%	79%	56%

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.