

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2024	06/30/2025

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

CANDLER HOSPITAL

Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1
4. Cost Report Year 2 (if applicable)
5. Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
07/01/2022	06/30/2023

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

6. Medicaid Provider Number:
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
9. Medicare Provider Number:

Data
000000327A
0
0
110024

B. DSH Qualifying Information

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

During the DSH Examination Year:

1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

DSH Examination
Year (07/01/24 -
06/30/25)
Yes

No

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 07/01/2024 - 06/30/2025 \$ 2,475,910
(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 07/01/2024 - 06/30/2025 \$ 5,599,343
(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 Services 07/01/2024 - 06/30/2025 \$ 8,075,253

Certification:

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.

Answer

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


Date

Allen Butcher
Hospital CEO or CFO Printed Name

912-819-6162
Hospital CEO or CFO Telephone Number

butcher@sjchs.org
Hospital CEO or CFO E-Mail

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

Hospital Contact:
Name: Allen Butcher
Title: CFO
Telephone Number: 912-819-6162
E-Mail Address: butcher@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 9.00

9/11/2024

D. General Cost Report Year Information 7/1/2022 - 6/30/2023

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

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:

5/9/2024

4. Hospital Name:

CANDLER HOSPITAL

5. Medicaid Provider Number:

000000327A

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

0

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

0

8. Medicare Provider Number:

110024

Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):

Private

Correct?

Yes

Yes

Yes

Yes

Yes

Yes

If Incorrect, Proper Information

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

9. State Name & Number

10. State Name & Number

11. State Name & Number

12. State Name & Number

13. State Name & Number

14. State Name & Number

15. State Name & Number

(List additional states on a separate attachment)

State Name

Provider No.

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2022 - 06/30/2023)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)

2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**

5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)

6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**8. **Out-of-State DSH Payments (See Note 2)**

9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)

10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)

11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)

12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

\$-
\$-

Inpatient	Outpatient	Total
\$ 174,061	\$ 959,025	\$1,133,086
\$ 3,007,202	\$ 15,233,263	\$18,240,465
\$3,181,263	\$16,192,288	\$19,373,551
5.47%	5.92%	5.85%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?**

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

Yes
\$ 5,599,343
\$5,599,343

←These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.

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 (07/01/2022 - 06/30/2023)

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)

67,039

(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
8. Outpatient Hospital Charity Care Charges
9. Non-Hospital Charity Care Charges
10. Total Charity Care Charges

22,674,746
49,706,602
\$ 72,381,348

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

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

Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$111,715,472.00		\$ 85,932,096	\$ -	\$ -	\$ 25,783,376
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		\$9,077,932.00			\$ 6,982,790	
17. Nursing Facility		\$0.00			\$ -	
18. Other Long-Term Care		\$0.00			\$ -	
19. Ancillary Services	\$354,575,100.00	\$1,315,311,647.00	\$ 272,740,928	\$ 1,011,744,253	\$ -	\$ 385,401,566
20. Outpatient Services		\$135,283,832.00		\$ 104,060,996	\$ -	\$ 31,222,836
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	\$ -	\$ -	\$ -	\$ -
27. Total	\$ 466,290,572	\$ 1,450,595,479	\$ 358,673,024	\$ 1,115,805,248	\$ 6,982,790	\$ 442,407,778
28. Total Hospital and Non Hospital		Total from Above		Total from Above	\$ 1,481,461,063	

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

Unreconciled Difference (Should be \$0)

\$ -

Total Contractual Adj. (G-3 Line 2)

1,485,119,215

Unreconciled Difference (Should be \$0)

\$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) 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
32	6700 OCCUPATIONAL THERAPY	\$1,272,336.00	\$ -	\$ -	\$ 1,272,336	\$8,496,472.00	\$1,383,707.00	\$ 9,880,179	0.128777
33	6800 SPEECH PATHOLOGY	\$445,063.00	\$ -	\$ -	\$ 445,063	\$2,864,050.00	\$433,481.00	\$ 3,297,531	0.134969
34	6900 ELECTROCARDIOLOGY	\$3,873,691.00	\$ -	\$ 6,110	\$ 3,879,801	\$6,432,641.00	\$15,785,899.00	\$ 22,218,540	0.174620
35	7000 ELECTROENCEPHALOGRAPHY	\$304,746.00	\$ -	\$ -	\$ 304,746	\$383,473.00	\$444,538.00	\$ 828,011	0.368046
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$24,916,274.00	\$ -	\$ -	\$ 24,916,274	\$11,889,640.00	\$25,645,867.00	\$ 37,535,507	0.663805
37	7200 IMPL. DEV. CHARGED TO PATIENTS	\$12,714,655.00	\$ -	\$ -	\$ 12,714,655	\$4,378,091.00	\$34,993,422.00	\$ 39,371,513	0.322940
38	7300 DRUGS CHARGED TO PATIENTS	\$125,567,850.00	\$ -	\$ 3,794	\$ 125,571,644	\$65,099,675.00	\$533,079,719.00	\$ 598,179,394	0.209923
39	7400 RENAL DIALYSIS	\$1,623,614.00	\$ -	\$ -	\$ 1,623,614	\$6,403,306.00	\$1,476,020.00	\$ 7,879,326	0.206060
40	9100 EMERGENCY	\$16,788,915.00	\$ -	\$ -	\$ 16,788,915	\$14,267,855.00	\$52,873,777.00	\$ 67,141,632	0.250052
41	9300 WOUND CARE	\$5,761,295.00	\$ -	\$ 5,085	\$ 5,766,380	\$1,037,417.00	\$14,948,201.00	\$ 15,985,618	0.360723
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) 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
92		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 334,867,348	\$ -	\$ 34,508	\$ 334,901,856	\$ 375,303,194	\$ 1,430,753,408	\$ 1,806,056,602	
127	Weighted Average								0.187575
128	Sub Totals	\$ 401,319,276	\$ -	\$ 34,508	\$ 401,353,784	\$ 486,132,643	\$ 1,430,753,408	\$ 1,916,886,051	
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)				\$464,934.00				
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				\$ 400,888,850				
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 (07/01/2022-06/30/2023)

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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)																			Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)																			Uninsured																			Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)																			% Survey to Cost Report Totals (Includes all 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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data

Cost Report Year (07/01/2022-06/30/2023)

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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)			% Survey to Cost Report										
74				-														\$	-	\$	-									
75				-														\$	-	\$	-									
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					\$	23,599,638	\$	25,109,289	\$	22,743,018	\$	66,775,797	\$	12,979,366	\$	22,686,039	\$	37,728,834	\$	85,825,027	\$	-	\$	-	\$	-	\$	-	\$	-

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

Cost Report Year (07/01/2022-06/30/2023)

CANDLER HOSPITAL

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report	
Totals / Payments															
128	Total Charges (includes organ acquisition from Section J)				\$ 32,009,303	\$ 25,109,289	\$ 32,663,768	\$ 66,775,797	\$ 16,369,024	\$ 22,686,039	\$ 49,332,819	\$ 85,825,027	\$ -	\$ -	23.16%
129	Total Charges per PS&R or Exhibit Detail				\$ 32,009,303	\$ 25,109,289	\$ 32,663,768	\$ 66,775,797	\$ 16,369,024	\$ 22,686,039	\$ 49,332,819	\$ 85,825,027	\$ -	\$ -	
130	Unreconciled Charges (Explain Variance)				-	-	-	-	-	-	-	-	-	-	
131	Total Calculated Cost (includes organ acquisition from Section J)				\$ 9,600,334	\$ 4,872,043	\$ 10,405,992	\$ 11,344,506	\$ 4,243,925	\$ 4,413,947	\$ 14,066,476	\$ 17,229,102	\$ -	\$ -	24.86%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				\$ 5,818,367	\$ 4,613,899	\$ -	\$ 132	\$ 535,418	\$ 434,931	\$ 261,990	\$ 1,129,907			
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)						\$ 8,360,564	\$ 8,967,083	\$ -	\$ -	\$ 239,013	\$ 419,998			
134	Private Insurance (including primary and third party liability)				\$ 106,536	\$ 4,069	\$ -	\$ -	\$ -	\$ 14,370	\$ 3,520,946	\$ 3,389,092			
135	Self-Pay (including Co-Pay and Spend-Down)						\$ 58	\$ 21,729	\$ 3,280	\$ 6,533	\$ 10,435	\$ 27,100			
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)				\$ 5,924,903	\$ 4,617,988	\$ 8,360,622	\$ 8,988,944							
137	Medicaid Cost Settlement Payments (See Note B)					\$ 585,595									
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)														
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)								\$ 3,094,131	\$ 3,518,216	\$ 408,458	\$ 409,177			
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)										\$ 6,350,789	\$ 9,328,746			
141	Medicare Cross-Over Bad Debt Payments								\$ 91,478	\$ 71,999					
142	Other Medicare Cross-Over Payments (See Note D)								\$ 464,538	\$ 142,734		\$ 118,445	\$ 75,072		
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)												(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)												\$ 174,061	\$ 959,025	
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)				\$ 3,675,431	\$ (331,520)	\$ 2,045,370	\$ 2,355,562	\$ 55,080	\$ 225,164	\$ 3,156,400	\$ 2,450,010	\$ -	\$ -	
146	Calculated Payments as a Percentage of Cost				62%	107%	80%	79%	99%	95%	78%	86%	0%	0%	
147	Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6								31,463						
148	Percent of cross-over days to total Medicare days from the cost report								6%						

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 payment
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) CANDLER HOSPITAL

			Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		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	\$ 858.36	126						324		450	
2	03100 INTENSIVE CARE UNIT	\$ 2,242.22	7						81		88	
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	\$ 508.31	35						2		37	
11		\$ -									-	
12		\$ -									-	
13		\$ -									-	
14		\$ -									-	
15		\$ -									-	
16		\$ -									-	
17		\$ -									-	
18			Total Days	168	-	-	-	-	407		575	
19	Total Days per PS&R or Exhibit Detail		168	-	-	-	-	-	407			
20	Unreconciled Days (Explain Variance)		-	-	-	-	-	-	-			
21	Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21.01	Calculated Routine Charge Per Diem		\$ 274,049		\$ -		\$ -		\$ 795,206		\$ 1,069,255	
			\$ 1,631.24		\$ -		\$ -		\$ 1,953.82		\$ 1,859.57	
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)	2.103899	-	7,439					-	25,023		32,462
23	5000 OPERATING ROOM	0.129901	220,491	131,833					348,957	361,136	\$ 569,448	\$ 492,969
24	5100 RECOVERY ROOM	0.096486	51,790	20,115					16,735	37,974	\$ 68,525	\$ 58,089
25	5200 DELIVERY ROOM & LABOR ROOM	0.504800	47,738	2,130					8,953	448	\$ 56,691	\$ 2,578
26	5300 ANESTHESIOLOGY	0.023511	57,359	28,299					51,558	36,520	\$ 108,917	\$ 64,819
27	5400 RADIOLOGY-DIAGNOSTIC	0.169663	47,270	168,872					158,870	282,376	\$ 206,140	\$ 451,248
28	5500 RADIOLOGY-THERAPEUTIC	0.221577	35,058	155,124					49,649	556,861	\$ 84,707	\$ 711,985
29	5700 CT SCAN	0.030760	82,639	317,775					153,003	302,287	\$ 235,642	\$ 620,062
30	5800 MRI	0.051683	13,737	19,174					78,699	70,961	\$ 92,436	\$ 90,135
31	6000 LABORATORY	0.125919	172,369	180,022					413,241	187,257	\$ 585,610	\$ 367,279
32	6500 RESPIRATORY THERAPY	0.211281	61,405	15,847					237,571	12,457	\$ 298,976	\$ 28,304
33	6600 PHYSICAL THERAPY	0.185392	9,641	-					40,687	1,884	\$ 50,328	\$ 1,884
34	6700 OCCUPATIONAL THERAPY	0.128777	929	-					12,079	-	\$ 13,008	\$ -
35	6800 SPEECH PATHOLOGY	0.134969	518	-					13,042	-	\$ 13,560	\$ -
36	6900 ELECTROCARDIOLOGY	0.174620	20,131	18,545					53,269	37,483	\$ 73,400	\$ 56,028
37	7000 ELECTROENCEPHALOGRAPHY	0.368046	-	-					-	-	\$ -	\$ -
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.663805	36,344	21,446					53,578	17,690	\$ 89,922	\$ 39,136
39	7200 IMPL. DEV. CHARGED TO PATIENTS	0.322940	7,068	27,298					15,456	8,000	\$ 22,524	\$ 35,298
40	7300 DRUGS CHARGED TO PATIENTS	0.209923	170,091	88,459					478,265	4,916,422	\$ 648,356	\$ 5,004,881
41	7400 RENAL DIALYSIS	0.206060	6,171	-					115,221	3,868	\$ 121,392	\$ 3,868
42	9100 EMERGENCY	0.250052	53,525	365,652					88,996	137,900	\$ 142,521	\$ 503,552
43	9300 WOUND CARE	0.360723	435	15,421					15,910	70,089	\$ 16,345	\$ 85,510
44		-									\$ -	\$ -
45		-									\$ -	\$ -
46		-									\$ -	\$ -
47		-									\$ -	\$ -
48		-									\$ -	\$ -
49		-									\$ -	\$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) 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 & with Medicaid Secondary)	Total Out-Of-State Medicaid		
50				-					\$ -	\$ -	
51				-					\$ -	\$ -	
52				-					\$ -	\$ -	
53				-					\$ -	\$ -	
54				-					\$ -	\$ -	
55				-					\$ -	\$ -	
56				-					\$ -	\$ -	
57				-					\$ -	\$ -	
58				-					\$ -	\$ -	
59				-					\$ -	\$ -	
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61				-					\$ -	\$ -	
62				-					\$ -	\$ -	
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66				-					\$ -	\$ -	
67				-					\$ -	\$ -	
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70				-					\$ -	\$ -	
71				-					\$ -	\$ -	
72				-					\$ -	\$ -	
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74				-					\$ -	\$ -	
75				-					\$ -	\$ -	
76				-					\$ -	\$ -	
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78				-					\$ -	\$ -	
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110				-					\$ -	\$ -	
111				-					\$ -	\$ -	

Cost Report Year (07/01/2022-06/30/2023)	CANDLER HOSPITAL
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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 (07/01/2022-06/30/2023) 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)*	\$ 4,667,963	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Contractual Adjustment	015.5515.4000 (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 ----->)	\$ 4,667,963	
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	\$ 5.00 (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	\$ 4,667,963	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:	
18 Medicaid Eligible*** Charges Sec. G	343,988,855
19 Uninsured Hospital Charges Sec. G	99,869,911
20 Total Hospital Charges Sec. G	1,916,886,051
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	17.95%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	5.21%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	159,510,366
27 Uninsured Hospital Charges Sec. G	99,869,911
28 Total Hospital Charges Sec. G	1,916,886,051
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	8.32%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	5.21%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ -
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
33 Medicaid Primary 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.

***For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.