# State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part I For State DSH Year 2025

DSH Version 6.02 2/10/2023 A. General DSH Year Information 1. DSH Year: 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: Cost Report Begin Date(s) Cost Report End Date(s) 3. Cost Report Year 1 07/01/2022 Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES 06/30/2023 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): 8. Medicaid Subprovider Number 2 (Psychiatric or Rehab): 0 9. Medicare Provider Number: 110024 B. DSH Qualifying Information Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act. **DSH Examination** Year (07/01/24 -During the DSH Examination Year: 06/30/25) 1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to Yes 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 No 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 nonemergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

3a. Was the hospital open as of December 22, 1987?

3b. What date did the hospital open?

Yes

7/26/1934

# State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part 1 For State DSH Year 2025

Disclosure of Other Medicaid Payments Received:		
Medicald Supplemental Payments for Heavital Services DSU V 07/04/000	4 00/00/0005	
Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/202     Should include USI and are also as a fine and the second services.		\$ 2,475,910
(Should include UPL and non-claim specific payments paid based on the state fish	al year. However, DSH payments should NOT be included.)	
<ol><li>Medicald Managed Care Supplemental Payments for hospital services for D</li></ol>	SH 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	er incentive payments.	
NOTE: Hospital portion of supplemental payments reported on DSH Survey Part	I, Section E, Question 14 should be reported here if paid on a S	FY basis.
	A SECTION OF THE CONTROL OF THE SECTION OF THE SECT	
3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospi	tal Services07/01/2024 - 06/30/2025	\$ 8,075,253
The second secon	tal 001710030170172024 - 00/30/2023	\$ 0,075,255
W.C W		
tification:		
		Answer
. Was your hospital allowed to retain 100% of the DSH payment it received for	this DSH year?	Yes
Matching the federal share with an IGT/CPE is not a basis for answering this	question "no" If your	165
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.	1010	
Explanation for "No" answers:		
The following certification is to be completed by the hospital's CEO or CFO:		
I harshy and it, that the information in Continue to D. O. D. E. E. C. v. v. v.		
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 pri	vate insurance coverage, have been reported on the DSH surve	by 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 Disproportionat	te Share Hospital (DSH) eligibility and payments
provisions. Detailed support exists for all amounts reported in the survey. These re available for inspection when requested.	scords will be retained for a period of not less than 5 years follow	ving the due date of the survey, and will be made
Transport in inspection mon requestion.		
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411. 11. 1511		
Jun " ware	CFO	11131205
Hospital CEO or CFO Signature	Title	Date
Allen Butcher	912-819-6162	butcheral@sjchs.org
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Contact Information for Individuals with other dis-		
Contact Information for individuals authorized to respond to inquiries relate	d to this survey:	
Hospital Contact:		Outside Preparer:
Name Allen Butche	r	Name Bert Bennett
Title CFO		Title Partner
Telephone Number 912-819-616		Firm Name Draffin & Tucker, LLP
E-Mail Address butcheral@s		Telephone Number 229-883-7878
Mailing Street Address 5353 Reynol		E-Mail Address bbennett@draffin-tucker.com
Mailing City, State, Zip Savannah, C	iA 31405	

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 CANDLER HOSPITAL 1. Select Your Facility from the Drop-Down Menu Provided: 7/1/2022 through 6/30/2023 2. Select Cost Report Year Covered by this Survey (enter "X"): 3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted 5/9/2024 3a. Date CMS processed the HCRIS file into the HCRIS database: 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): Yes 7. Medicaid Subprovider Number 2 (Psychiatric or Rehab): Yes 8. Medicare Provider Number: 110024 Yes Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal): Private Yes Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year: 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: (07/01/2022 - 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) Inpatient Outpatient Total \$1,133,086 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B) 174,061 959.025 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B) 3,007,202 15,233,263 \$18.240.465 \$3,181,263 \$16,192,288 \$19,373,551 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: 5 47% 5 02% 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, containing payments received by theospital (not by the MCO), or other incentive payments. <--These payments do NOT flow to Section H, and therefore do not impact 14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services the UCC. If these payments are not already considered in the UCC and

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.

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

\$5,599,343

should be, include the amount reported here on line 133 of Section H.

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)

34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an

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)"

67,039 (See Note in Section F-3, below)

4 667 963

1.481.461.063

Unreconciled Difference (Should be \$0)

22,674,746

### 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
- 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

increase in net patient revenue)

36. Adjusted Contractual Adjustments

37. Unreconciled Difference

8. Outpatient Hospital Charity Care Charges 49,706,602 9. Non-Hospital Charity Care Charges 72.381.348 10. Total Charity Care Charges 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 Contractual Adjustments (formulas below can be overwritten if amounts report data. If the hospital has a more recent version of the cost report, Total Patient Revenues (Charges) are known) the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data. Inpatient Hospital **Outpatient Hospital** Non-Hospital Inpatient Hospital **Outpatient Hospital** Non-Hospital Net Hospital Revenue \$111,715,472.00 85.932.096 11. Hospital 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 \$9.077.932.00 16. Skilled Nursing Facility 6.982.790 17. Nursing Facility \$0.00 18. Other Long-Term Care \$0.00 19. Ancillary Services \$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 \$0.00 21. Home Health Agency 22. Ambulance 23. Outpatient Rehab Providers \$0.00 24. ASC \$0.00 \$0.00 25. Hospice \$0.00 26. Other \$0.00 \$0.00 \$0.00 466.290.572 1.450.595.479 9.077.932 358.673.024 442,407,778 27 Total \$ \$ 1 115 805 248 \$ 6 982 790 28 Total Hospital and Non Hospital Total from Above 1.925.963.983 Total from Above 1,481,461,063 29. Total Per Cost Report Total Patient Revenues (G-3 Line 1) 1,925,963,983 Total Contractual Adj. (G-3 Line 2) 1,485,119,215 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 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) 1.009.811 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)

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
hosp comple has a n be u	oital. If o eted usin more rec updated	data in this section must be verified by the data is already present in this section, it was ng CMS HCRIS cost report data. If the hospital cent version of the cost report, the data should to the hospital's version of the cost report. In be overwritten as needed with actual data.	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
	Routin	ne Cost Centers (list below):									
1		ADULTS & PEDIATRICS	\$ 49,969,272	\$ -	\$ -	\$0.00	\$ 49,969,272	58,215	\$74,198,927.00		\$ 858.36
2					\$ -	,	\$ 12,551,933	5,598	\$24,009,968.00		\$ 2,242.22
3		CORONARY CARE UNIT		•	\$ -		\$ -	-	\$0.00		\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -		\$ -		\$ -	_	\$0.00		\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	T	\$ -		\$ -	-	\$0.00		\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ -	7	\$ -		\$ -	_	\$0.00		\$ -
7	04000	SUBPROVIDER I	\$ -		\$ -		\$ -	_	\$0.00		\$ -
8	04100	SUBPROVIDER II	\$ -	•	\$ -		\$ -	_	\$0.00		\$ -
9		OTHER SUBPROVIDER	\$ -		\$ -		\$ -	_	\$0.00		\$ -
10		NURSERY	7	\$ -	T		\$ 3,930,723	7,733	\$12,620,554.00		\$ 508.31
11	04300		\$ 3,930,723		\$ -		\$ 3,930,723	1,133	\$0.00		\$ -
			•	•	•			-			
12			\$ -		\$ -		\$ -	-	\$0.00		\$ -
13			\$ -	•	\$ -		\$ -	-	\$0.00		\$ -
14			\$ -	\$ -			\$ -	-	\$0.00		\$ -
15			\$ -		\$ -		\$ -	-	\$0.00		\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00		\$ -
17			\$ -	\$ -	\$		\$ -	-	\$0.00		\$ -
18		Total Routine	\$ 66,451,928	\$ -	\$ -	\$ -	\$ 66,451,928	71,546	\$ 110,829,449		_
19		Weighted Average									\$ 928.80
10		Weighted / Weilage									Ψ 020.00
	Observ	vation 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)		4,507	-	_	\$ 3,868,629	\$137,182.00	\$1,701,608.00	\$ 1,838,790	2.103899
		,	!	,,,,			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Ap-1//	one Coat Contage (from W/S Coarded) - Other	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
04		ary Cost Centers (from W/S C excluding Observ		Φ.	Φ.		A 00.005.011	#E0 500 000 00	#040 040 <b>7</b> 40 00	ф 070 470 570	0.400004
21		OPERATING ROOM	\$36,265,614.00		\$ -		\$ 36,265,614	\$59,530,863.00	\$219,648,710.00	\$ 279,179,573	0.129901
22		RECOVERY ROOM	Ţ .,		\$ -		\$ 4,065,875	\$11,918,856.00	\$30,220,511.00	\$ 42,139,367	0.096486
23		DELIVERY ROOM & LABOR ROOM	\$11,273,513.00		\$ -		\$ 11,273,513	\$19,687,413.00	\$2,645,204.00	\$ 22,332,617	0.504800
24		ANESTHESIOLOGY	\$1,335,342.00				\$ 1,335,342	\$15,372,521.00	\$41,422,750.00	\$ 56,795,271	0.023511
25		RADIOLOGY-DIAGNOSTIC	\$19,761,723.00				\$ 19,763,844	\$20,519,894.00	\$95,968,862.00	\$ 116,488,756	0.169663
26		RADIOLOGY-THERAPEUTIC	\$39,045,528.00		\$ 883		\$ 39,046,411	\$7,910,877.00	\$168,309,867.00	\$ 176,220,744	0.221577
27	5700	CT SCAN	\$3,254,693.00	\$ -	\$ -		\$ 3,254,693	\$23,135,525.00	\$82,673,805.00	\$ 105,809,330	0.030760
28	5800	MRI	\$1,566,275.00	\$ -	\$ -		\$ 1,566,275	\$4,387,798.00	\$25,917,680.00	\$ 30,305,478	0.051683
29	6000	LABORATORY	\$16,006,709.00	\$ -	\$ 16,515		\$ 16,023,224	\$55,465,102.00	\$71,784,815.00	\$ 127,249,917	0.125919
30		RESPIRATORY THERAPY	\$4,983,302.00		\$ -		\$ 4,983,302	\$22,207,336.00	\$1,378,744.00	\$ 23,586,080	0.211281
31		PHYSICAL THERAPY	\$4,040,335.00		\$ -		\$ 4,040,335	\$13,777,207.00	\$8,016,221.00	\$ 21,793,428	0.185392

### G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	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
6700	OCCUPATIONAL THERAPY	\$1,272,336.00		\$ -	\$ 1,272,336	\$8,496,472.00		\$ 9,880,179	0.128777
	SPEECH PATHOLOGY	\$445,063.00		\$ -	\$ 445,063	\$2,864,050.00		\$ 3,297,531	0.134969
	ELECTROCARDIOLOGY	\$3,873,691.00		\$ 6,110	\$ 3,879,801	\$6,432,641.00		\$ 22,218,540	0.174620
	ELECTROENCEPHALOGRAPHY	\$304,746.00		\$ -	\$ 304,746	\$383,473.00		\$ 828,011	0.368046
	MEDICAL SUPPLIES CHARGED TO PATIENT	\$24,916,274.00		\$ -	\$ 24,916,274	\$11,889,640.00		\$ 37,535,507	0.663805
	IMPL. DEV. CHARGED TO PATIENTS	\$12,714,655.00	T	\$ -	\$ 12,714,655	\$4,378,091.00		\$ 39,371,513	0.322940
	DRUGS CHARGED TO PATIENTS	\$125,567,850.00		\$ 3,794	\$ 125,571,644	\$65,099,675.00		\$ 598,179,394	0.209923
	RENAL DIALYSIS	\$1,623,614.00		\$ -	\$ 1,623,614	\$6,403,306.00		\$ 7,879,326	0.206060
9100	EMERGENCY	\$16,788,915.00	\$ -	\$ -	\$ 16,788,915	\$14,267,855.00	\$52,873,777.00	\$ 67,141,632	0.250052
	WOUND CARE	\$5,761,295.00		\$ 5,085	\$ 5,766,380	\$1,037,417.00		\$ 15,985,618	0.360723
		\$0.00		\$ -	\$ -	\$0.00		\$ -	
		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	
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		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
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		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$ -	\$ -	\$0.00	70.00	\$ -	
		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$ -	\$ -	\$0.00	70.00	\$ -	
		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	
		\$0.00	\$ -	\$ -	\$ -	\$0.00	70.00	\$ -	•
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		\$0.00	\$ -	\$ -	\$ -	\$0.00	70.00	\$ -	•
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		\$0.00	\$ -	\$ -	-	\$0.00	\$0.00	\$ -	•
		\$0.00	\$ -	\$ -	\$ -	\$0.00	70.00	\$ -	-
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		\$0.00		\$ -	\$ -	\$0.00	70.00	\$ -	-
		\$0.00		•	\$ -	\$0.00	Ψ0.00	\$ <u>-</u>	-
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		\$0.00		\$ -	\$ -	\$0.00		\$ - \$ -	-
		\$0.00			\$ -	\$0.00		\$ -	-

### G. Cost Report - Cost / Days / Charges

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

	ine # Cost C	enter Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	-	E 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
2			\$0.00	\$ -	\$	-	\$ -	\$0.00	\$0.00	\$ -	-
3			\$0.00	\$ -	\$	-	\$ -	\$0.00	\$0.00	\$ -	-
4			\$0.00	\$ -	\$	-	\$ -	\$0.00	\$0.00	\$ -	-
5			\$0.00	\$ -	\$	-	\$ -	\$0.00	\$0.00	\$ -	-
6			\$0.00		\$	-	\$	\$0.00	\$0.00	\$ -	-
17			\$0.00	•	\$	-	\$	\$0.00	\$0.00	\$ -	-
8			\$0.00		\$	-	\$	\$0.00	1 1 1 1 1	\$ -	-
9			\$0.00		\$	-	\$	\$0.00	\$0.00	\$ -	-
00			\$0.00		\$	-	\$	\$0.00		\$ -	-
01			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
02			\$0.00		\$	-	\$	\$0.00	\$0.00	\$ -	-
03			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
04			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
05			\$0.00	•	\$	-	\$ -	\$0.00	\$0.00	\$ -	-
06			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
07			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
08			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
09			\$0.00	•	\$	-	\$ -	\$0.00	\$0.00	\$ -	-
10			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
11			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
12			\$0.00	•	\$	-	\$ -	\$0.00	\$0.00	\$ -	-
13			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
14			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
15			\$0.00	•	\$	-	\$ -	\$0.00	\$0.00	\$ -	-
16			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
17 18			\$0.00 \$0.00		\$	-	\$ - \$ -	\$0.00 \$0.00	\$0.00 \$0.00	\$ -	-
19			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	
20			\$0.00	•	\$	-	\$ -	\$0.00		\$ -	-
21			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
22			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
23			\$0.00	•	\$	-	\$ -	\$0.00	\$0.00	\$ -	-
24			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
25			\$0.00		\$	-	\$ -	\$0.00	\$0.00	\$ -	-
26	T	otal Ancillary	\$ 334,867,348		\$	34.508	\$ 334,901,856			7	
27		ghted Average	Ψ 004,007,040	Ψ -	Ψ	34,300	Ψ 334,301,030	Ψ 070,000,104	ψ 1,400,700,400	Ψ 1,000,030,002	0.187575
28		Sub Totals	\$ 401,319,276	\$ -	\$	34.508	\$ 401,353,784	\$ 486,132,643	\$ 1,430,753,408	\$ 1,916,886,051	
29		ng Bed Cost for Medicaid (Sum ov. Title 19, Column 5-7, Line 20	of applicable Cost Re		Title 1	9, Column 3, Line 200 and	\$0.00		, , , , , , , , , , , , , , , , , , , ,	, ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
30	NF, SNF, and Swir	ng Bed Cost for Medicare (Sum V, Title 18, Column 5-7, Line 20	of applicable Cost Re	eport Worksheet D-3,	Title 1	8, Column 3, Line 200 and	\$464,934.00				
31	,	ng Bed Cost for Other Payers (H	,	e. Submit support for o	calcui	ation of cost.)					
31.01	Other Cost Adjustn	nents (support must be submitte	ed)								
32	•	Grand Total	•				\$ 400,888,850	<b>_</b>			
33		ent Cost as a Percent of Other A	Mowahle Cost				0.00%				

<sup>\*</sup> 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 (07/01/2022-06/30/2)	(CANDLER HOSPITAL

				In-State Medic	aid FFS Primary	In-State Medicaid M	lanaged Care Primary		FS Cross-Overs (with Secondary)	Included Elsewhole Secondary - Exclud	edicaid Eligibles (Not ere & with Medicaid e Medicaid Exhausted n-Covered)	Medicaid FFS & MC Covered (Not to be	O Exhausted and Non- Included Elsewhere)	Unir	nsured	Total In-State Med Medicaid FFS & MCC Cow	dicaid (Days Include D Exhausted and No ered)	n- % Survey to Cost Report
Line#	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	Totals (Includes all payers)
		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 PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal	From Hospital's Own Internal			
	Centers (from Section G): TS & PEDIATRICS	\$ 858.36		Days 3 275		Days 3.368		Days 1.580		Days 6.127	1	Days		Days 3.745		Days 14 350		34 53%
03100 INTEN	ISIVE CARE UNIT	\$ 2,242.22		979		81		286		612				399		1,958		43.68%
03300 BURN	INTENSIVE CARE UNIT	\$ - \$ -														-		
04000 SUBP		\$ - \$ -														-		
4100 SUBP 4200 OTHE	R SUBPROVIDER	\$ - \$ -														-		
4300 NURS	ERY	\$ 508.31 \$ -		414		3,103				457				249		3,974		55.09%
		\$ - \$ -														-		
		\$ - \$ -														-		
		\$ -	Total Days	4,668		6,552		1,866		7,196				4,393		20,282		35.29%
Total Days per	PS&R or Exhibit Detail		Total Days	4,668		6,552		1,866		7,196	2			4,393		20,202		30.29%
Total Days por	Unreconciled Days	(Explain Variance)		- 4,000		-		1,000			:			- 4,000				
Routin	e Charges	_		Routine Charges \$ 8,409,665		Routine Charges \$ 9,920,750 \$ 1,514.16		Routine Charges \$ 3,389,658 \$ 1,816.54		Routine Charges \$ 11,603,985		Routine Charges		Routine Charges \$ 7,156,557		Routine Charges \$ 33,324,058		37.49%
Calcu	ated Routine Charge Per Diem			\$ 1,801.56						\$ 1,612.56		\$ -		\$ 1,629.08		\$ 1,643.04		
09200 Obser	Centers (from W/S C) (from Secti vation (Non-Distinct) ATING ROOM	on G):	2.103899 0.129901	118,502 3,497,047	295,309 4,658,168	3,555 1,820,322	Ancillary Charges 159,993 18,711,919	Ancillary Charges - 1,930,657	55,100 2,377,267	Ancillary Charges 12,833 5.531,716	735,950 12,346,996	Ancillary Charges	Ancillary Charges	3,111 3,714,464	Ancillary Charges 147,317 10.043.696	Ancillary Charges \$ 134,890 \$ 12,779,742	\$ 1,246,35 \$ 38.094,35	2 85.06%
5100 RECC	VERY ROOM ERY ROOM & LABOR ROOM		0.096486 0.504800	374,260 334,214	728,754	2,204,945 6,844,916	4,120,519 352,505	1,930,657 161,653 4,972	227,946	1,231,070 2,054,733	1,619,410			497,756 456,995	1,095,499	\$ 3,971,928 \$ 9,238,835	\$ 6,696,62 \$ 489.59	9
5300 ANES	THESIOLOGY DLOGY-DIAGNOSTIC		0.023511 0.169663	540,970 1,255,170	904,340 1,361,663	2,165,447 585,941	4,421,826 4,115,170	235,103 924,705	326,180 1.303,774	1,497,618 2,175,397	2,126,538 5,534,129			710,385 1.666,957	1,621,749 8,086,601	\$ 9,236,635 \$ 4,439,138 \$ 4,941,213	\$ 7,778,88 \$ 12,314,73	4 5.27%
5500 RADIO 5700 CT SO	DLOGY-THERAPEUTIC		0.221577 0.030760	237,506 1,738,453	2,875,991 2,074,699	367,368 708,563	5,127,244 3,903,162	387,433 1,010,294	3,200,053 1,290,269	1,216,397 2,418,293	13,523,359 6,010,752			697,570 2,138,776	6,973,730 10,024,754	\$ 2,208,704 \$ 5,875,603	\$ 24,726,64 \$ 13,278,88	7 158.53%
5800 MRI 6000 LABO			0.051683 0.125919	332,318 4,498,694	346,454 2,269,768	95,197 3,572,521	650,027 3,935,404	172,241 2,240,237	212,224 1,281,424	421,663 6,375,665	1,437,660 4,615,844			514,288 3,779,965	1,005,428 11,495,859	\$ 1,021,419 \$ 16,687,116	\$ 2,646,36 \$ 12,102,44	5 4.61%
6600 PHYS	IRATORY THERAPY ICAL THERAPY		0.211281 0.185392	2,342,570 372,503	562,233 26,291	197,288 37,492	132,983 261,166	1,171,216 217,357	46,557 47,476	2,763,122 685,010	206,611 835,214			871,299 219,355	273,423 230,430	\$ 6,474,196 \$ 1,312,362	\$ 948,38 \$ 1,170,14	7 9.85%
6800 SPEE	PATIONAL THERAPY CH PATHOLOGY		0.128777 0.134969	120,075 154,514	8,370	7,692 55,932	33,775 3,242	66,154 143,619	13,307 7,041	192,946 203,547	147,420 37,753			56,669 101,558	57,949 54,741	\$ 386,867 \$ 557,612	\$ 202,87 \$ 48,03	6 3.29%
7000 ELEC	TROCARDIOLOGY TROENCEPHALOGRAPHY		0.174620 0.368046	443,997 31,615	169,167	143,261 8,810	351,526 122,619	384,895 23,577	221,679	736,325 74,213	1,076,816 33,253			624,618 26,813	847,710 44,265	\$ 1,708,478 \$ 138,215	\$ 1,819,18 \$ 155,87	2 3.70%
7200 IMPL.	CAL SUPPLIES CHARGED TO PATIE DEV. CHARGED TO PATIENTS IS CHARGED TO PATIENTS	NT	0.663805 0.322940	657,975 151,769	392,068 290,530	384,148 228,657	1,065,386 845,106	332,004 82,162	250,511 202,754	1,212,161 483,880				789,494 288,143	895,559 558,244	\$ 2,586,288 \$ 946,468 \$ 16,633,271	\$ 3,083,27 \$ 3,001,00	21.84%
7400 RENA 9100 EMER	L DIALYSIS		0.209923 0.206060 0.250052	5,227,183 122,845 1,047,459	5,654,230 - 2,491,254	2,786,653 37,026 423,060	11,095,967 7,651 6,677,315	2,420,691 253,861 779,460	10,080,842 109,305 1,174,924	6,198,744 615,835 1,507,464	26,469,603 300,100 4 362 434			4,231,801 179,285 1,291,828	5,805,913 51,174 9,761,372	\$ 16,633,271 \$ 1,029,567 \$ 3,757,443	\$ 53,300,64 \$ 417,05 \$ 14,705,92	6 4.80%
9300 WOU			0.360723	- 1,047,438	-	64,224	681,292	37,075	256,510	120,202	1,231,067			30,863	681,006	\$ 221,501	\$ 2,168,86	
			-													\$ - \$ -	\$	- 0.00%
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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 Medicare F	FS Cross-Overs (with	In-State Other Med Included Elsewher Secondary - Exclude	re & with Medicaid Medicaid Exhausted	Medicaid FFS & MCC	Exhausted and Non-			Total In-State Med Medicaid FFS & MCO	icaid (Days Include Exhausted and Non- rred) Survey to Cost Repor
	In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	Medicaid S	Secondary)	and Non-	Covered)	Covered (Not to be	Included Elsewhere)	Unin	sured	Cove	(ed) Cost Repor
74											\$ -	\$ -
75 -											\$ -	\$ -
76 -											\$ -	\$ -
77											\$ -	
												\$ -
79											S -	3 -
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126												\$ -
127		0.740.040	10.070.77	00.000.000	07.700.07	0.005.555	_		0.004	00.004.777	\$ -	5 -
	\$ 23,599,638 \$ 25,109,289	\$ 22,743,018 \$ 66,775,797	\$ 12,979,366	\$ 22,686,039	\$ 37,728,834	\$ 85,825,027	\$ -	\$ -	\$ 22,891,992	\$ 69,821,362		

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

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

		ı	In-State Medic	aid FFS Primary	In-	State Medicaid Ma	anaged Ca	re Primary	In-State	e Medicare FFS Medicaid Se			Included Elsev Secondary - Excl	vhere &	dicaid Exhausted			Exhausted and Non- icluded Elsewhere)		Unins	ured			caid (Days Include Exhausted and Nor ed)	- % Survey to Cost Report
	Totals / Payments																								
128	Total Charges (includes organ acquisition from Section J)	\$	32,009,303	\$ 25,109,289	\$	32,663,768	\$ 6	66,775,797	\$	16,369,024	\$	22,686,039	\$ 49,332,81	9 \$	85,825,027	\$	-	\$ -	\$ (Ag	30,048,549 rees to Exhibit A)	\$ 69,821,362 (Agrees to Exhibit A)	\$ 1	30,374,913	\$ 200,396,152	23.16%
129 130	Total Charges per PS&R or Exhibit Detail Unreconciled Charges (Explain Variance)	\$	32,009,303	\$ 25,109,289	\$	32,663,768	\$ 6	66,775,797	\$	16,369,024	\$	22,686,039	\$ 49,332,81	9 \$	85,825,027	S	- 1	\$ - -	S	30,048,549	\$ 69,821,362				
131	Total Calculated Cost (includes organ acquisition from Section J)	\$	9,600,334	\$ 4,872,043	\$	10,405,992	\$ 1	11,344,506	\$	4,243,925	\$	4,413,947	\$ 14,066,47	6 \$	17,229,102	\$	-	\$ -	\$	8,267,250	\$ 11,486,585	\$ :	38,316,727	\$ 37,859,598	24.66%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$	5,818,367	\$ 4,613,899	\$	-	\$	132	\$	535,418	\$	434,931	\$ 261,99	0 S	1,129,907							\$	6,615,775	\$ 6,178,869	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				\$	8,360,564	\$	8,967,083	\$	-	\$	-	\$ 239,01	3 \$	419,998							\$	8,599,577	\$ 9,387,081	
134	Private Insurance (including primary and third party liability)	\$	106,536	\$ 4,069	\$	-	\$	-	\$	-	\$	14,370	\$ 3,520,94	6 \$	3,389,092							\$	3,627,482	\$ 3,407,531	
135	Self-Pay (including Co-Pay and Spend-Down)				\$	58	\$	21,729	\$	3,280	\$	6,533	\$ 10,43	5 \$	27,100							\$	13,773	\$ 55,362	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$	5,924,903	\$ 4,617,968	\$	8,360,622	\$	8,988,944																	
137	Medicaid Cost Settlement Payments (See Note B)			\$ 585,595																		\$	-	\$ 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	\$ 408,45		409,177								3,502,589	\$ 3,927,393	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)										_		\$ 6,350,78	9 \$	9,328,746							\$	6,350,789	\$ 9,328,746	
141	Medicare Cross-Over Bad Debt Payments								\$	91,478 464 538	\$	71,999 142,734	S 118.44	_   _	75.070				(Agre	ees to Exhibit B and R <sub>2</sub> 1)	(Agrees to Exhibit B and B-1)	\$	91,478	\$ 71,999	
142	Other Medicare Cross-Over Payments (See Note D)								\$	464,538	\$	142,734	\$ 118,44	5 5	75,072					174.061		3	582,983	\$ 217,806	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	0																	\$	174,061	\$ 959,025				
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from	Section E	:)																5		\$ -				
145 146	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH) Calculated Payments as a Percentage of Cost	\$	3,675,431 62%	\$ (331,520) 107%	\$	2,045,370 80%	\$	2,355,562 79%	\$	55,080 99%	\$	225,164 95%	\$ 3,156,40 78	0 S	2,450,010 86%	S	- 0%	\$ - 0%	\$	8,093,189 2%	\$ 10,527,560 8%	\$	8,932,281 77%	\$ 4,699,216 88%	
147 148	Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Percent of cross-over days to total Medicare days from the cost report	Col. 6, Su	um of Lns. 2, 3	i, 4, 14, 16, 17, 18 less	lines 5	& 6				31,463 6%															

Note A - These amounts must agree to your impatient 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 surve Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not refected on the claims paid summary (R4 summary or PS&R). Note C - Other Medicaid Payments on Non-Claim Specific payments. Sold NOT be included. UP to be included. UP to be included in the sale facility are based as should be reported in Section C of the survey. Note D - Should include other Medicaire cross-over payments included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare databate Medicaid Calculation payment Note E - Medicaid Managed Care payments should included if Medicaid Med

### I. Out-of-State Medicaid Data:

			Out-of-State Med	dicaid FFS Primary		icaid Managed Care mary		are FFS Cross-Overs id Secondary)	Included Elsewhe	Medicaid Eligibles (Not ere & with Medicaid ndary)	Total Out-Of-	State Medicaid
Line # Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	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)		
toutine Cost Centers (list below):			Days		Days		Days		Days		Days	
3000 ADULTS & PEDIATRICS	\$ 858.36		126						324		450	
3100 INTENSIVE CARE UNIT 3200 CORONARY CARE UNIT	\$ 2,242.22 \$ -		7						81		88	
03300 BURN INTENSIVE CARE UNIT	\$ -										-	
03400 SURGICAL INTENSIVE CARE UNIT	\$ -										-	
03500 OTHER SPECIAL CARE UNIT	\$ -										-	
4000 SUBPROVIDER I	\$ -										-	
04100 SUBPROVIDER II 04200 OTHER SUBPROVIDER	\$ - \$ -										-	
4300 NURSERY	\$ 508.31		35						2		37	
	\$ -								_		-	
	\$ -										-	
	\$ -										-	
	\$ - \$ -										-	
	\$ -										-	
	\$ -										-	
		Total Days	168		-		-		407		575	
Unreconciled Days	s (Explain Variance)		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
	s (Explain Variance)		-		-				- Routine Charges		Routine Charges \$ 1,069,255 \$ 1,859.57	
Unreconciled Days  Routine Charges  Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below		2 402000	Routine Charges \$ 274,049	Ancillary Charges	-	Ancillary Charges		Ancillary Charges	Routine Charges \$ 795,206	Ancillary Charges	\$ 1,069,255	
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below) 9200 [Observation (Non-Distinct)]		2.103899 0.129901	Routine Charges \$ 274,049 \$ 1,631.24  Ancillary Charges	7,439	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953.82  Ancillary Charges -	25,023	\$ 1,069,255 \$ 1,859.57 Ancillary Charges \$ -	\$ 3
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below		2.103899 0.129901 0.096486	Routine Charges \$ 274,049 \$ 1,631.24		Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953.82		\$ 1,069,255 \$ 1,859.57	\$ 3: \$ 49
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 19200   Observation (Non-Distinct) 1900   OPERATING ROOM 1900   PERATING ROOM		0.129901 0.096486 0.504800	Routine Charges \$ 274,049 \$ 1,631.24 Ancillary Charges - 220,491 51,790 47,738	7,439 131,833 20,115 2,130	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953,82 Ancillary Charges 	25,023 361,136 37,974 448	\$ 1,069,255 \$ 1,859.57 Ancillary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691	\$ 3 \$ 49 \$ 5
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dient  Ancillary Cost Centers (from W/S C) (list below 19200   Observation (Non-Distinct) 5000   OPERATING ROOM 5100   RECOVERY ROOM 5200   DELINERY ROOM & LABOR ROOM 5300   ANESTHESIOLOGY		0.129901 0.096486 0.504800 0.023511	Routine Charges \$ 274,049 \$ 1,631.24  Ancillary Charges - 220,491 51,790 47,738 57,359	7,439 131,833 20,115 2,130 28,299	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953.82 Ancillary Charges 	25,023 361,136 37,974 448 36,520	\$ 1,069,255 \$ 1,859.57 Ancillary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917	\$ 3 \$ 49 \$ 5 \$
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 19200 Observation (Non-Distinct) 5000 OPERATING ROOM 5000 DELIVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY 5400 RADIOLOGY-DIAGNOSTIC		0.129901 0.096486 0.504800 0.023511 0.169663	Routine Charges \$ 274,049 \$ 1,631,24 Ancillary Charges 220,491 51,790 47,738 57,059 47,270	7,439 131,833 20,115 2,130 28,299 168,872	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953.82 Ancillary Charges 346,957 16,735 8,953 51,558 158,870	25,023 361,136 37,974 448 36,520 282,376	\$ 1,069,255 \$ 1,859.57 <b>Ancillary Charges</b> \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 206,140	\$ 3 \$ 49 \$ 5 \$ \$ 6 \$ 45
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 19200   Observation (Non-Distinct) 5000   OPERATING ROOM 5100   RECOVERY ROOM 5200   DELIVERY ROOM & LABOR ROOM 5300   ANESTHESIOLOGY		0.129901 0.096486 0.504800 0.023511	Routine Charges \$ 274,049 \$ 1,631.24  Ancillary Charges - 220,491 51,790 47,738 57,359	7,439 131,833 20,115 2,130 28,299	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953.82 Ancillary Charges 	25,023 361,136 37,974 448 36,520	\$ 1,069,255 \$ 1,859.57 Ancillary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917	\$ 3 \$ 49 \$ 5 \$ \$ 6 \$ 45 \$ 71
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 19200 Observation (Non-Distinct) 5000 OPERATING ROOM 5100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY 5400 RADIOLOGY-DIAGNOSTIC 5500 RADIOLOGY-THERAPEUTIC 5700 CT SCAN		0.129901 0.096486 0.504800 0.023511 0.169663 0.221577	Routine Charges \$ 274,049 \$ 1,631.24  Ancillary Charges - 220,491 51,790 47,738 57,359 47,270 35,058	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953.82 Ancillary Charges - 348,957 16,735 8,953 51,558 158,870 49,649	25,023 361,136 37,974 448 36,520 282,376 556,861 302,287 70,961	\$ 1,069,255 \$ 1,859,57 Anciliary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 206,140 \$ 84,707 \$ 235,642 \$ 92,436	\$ 3 \$ 49 \$ 5 \$ \$ 6 \$ 45 \$ 71 \$ 62 \$ 9
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 9200   Observation (Non-Distinct) 5000   OPERATING ROOM 5100 RECOVERY ROOM 5200 DELIVERY ROOM 5200 DELIVERY ROOM 5300 ANESTHESIOLOGY 5400   RADIOLOGY-DIAGNOSTIC 5500   RADIOLOGY-THERAPEUTIC 5700 CT SCAN 5800 MRI 69000 LABORATORY		0.129901 0.096486 0.504800 0.023511 0.169663 0.221577 0.030760 0.051683 0.125919	Routine Charges \$ 274,049 \$ 1,631.24 Ancillary Charges - 220,491 51,790 47,736 47,270 35,058 82,639 13,737 172,369	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953.82  Ancillary Charges  16,735 8,953 51,558 158,870 49,649 153,003 78,699 413,241	25,023 361,136 37,974 448 36,520 282,376 556,861 302,287 70,961 187,257	\$ 1,069,255 \$ 1,859,57 Ancillary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 206,140 \$ 44,707 \$ 235,642 \$ 92,432 \$ 92,432 \$ 92,5610	\$ 3. \$ 49 \$ 5. \$ 6. \$ 45 \$ 71 \$ 62 \$ 9 \$ 36
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below) 19200 (Deservation (Non-Distinct) 5000 (DPERATING ROOM 5000 (DPERATING ROOM 5200 (DELIVERY ROOM & LABOR ROOM 5300 (ANESTHESIOLOGY 5400 (RADIOLOGY-DIAGNOSTIC 5500 (RADIOLOGY-THERAPEUTIC 5700 (CT SCA) 5800 (MRI 6000 (LABORATORY 6500 (RESPIRATORY THERAPY		0.129901 0.096486 0.504800 0.023511 0.169663 0.221577 0.030760 0.051683 0.125919	Routine Charges \$ 274,049 \$ 1,631,24 Ancillary Charges 	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953,82 Ancillary Charges 	25,023 361,136 37,974 448 36,520 282,376 556,861 302,287 70,961 187,257 12,457	\$ 1,069.255 \$ 1,859.57 Ancillary Charges \$ . \$ 569,448 \$ 68,525 \$ 56,891 \$ 108,917 \$ 206,140 \$ 84,707 \$ 235,642 \$ 92,436 \$ 585,610 \$ 29,976	\$ 3. \$ 49 \$ 5 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 22
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 19200 Observation (Non-Distinct) 19000 OPERATING ROOM 190		0.129011 0.096486 0.504800 0.023511 0.169663 0.221577 0.030760 0.051683 0.125919 0.211281	Routine Charges \$ 274,049 \$ 1,631,24 Ancillary Charges - - 220,491 51,790 47,738 57,359 47,270 35,058 82,639 13,737 172,389 61,405 9,641	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953.82 Ancillary Charges  348,957 16,735 8,953 51,558 158,870 49,649 153,003 76,699 413,241 237,571 40,687	25,023 361,136 37,974 448 36,520 282,376 556,861 302,287 70,961 187,257 12,457	\$ 1,069,255 \$ 1,859,57 Ancillary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 206,140 \$ 84,707 \$ 235,642 \$ 92,436 \$ 98,581 \$ 58,610 \$ 98,976 \$ 50,328	\$ 3 \$ 49 \$ 5 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below) 9200   Observation (Non-Distinct) 5000   OPERATING ROOM 5000   DELWERY ROOM 5200   DELWERY ROOM & LABOR ROOM 5300   ANESTHESIOLOGY 5400   RADIOLOGY-DIAGNOSTIC 5500   RADIOLOGY-THERAPEUTIC 5500   RADIOLOGY-THERAPEUTIC 5500   CT SCAN 5800   MRI 6000   LABORATORY 6500   RESPIRATORY THERAPY		0.129901 0.096486 0.504800 0.023511 0.169663 0.221577 0.030760 0.051683 0.125919	Routine Charges \$ 274,049 \$ 1,631,24 Ancillary Charges 	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953,82 Ancillary Charges 	25,023 361,136 37,974 448 36,520 282,376 556,861 302,287 70,961 187,257 12,457	\$ 1,069.255 \$ 1,859.57 Ancillary Charges \$ . \$ 569,448 \$ 68,525 \$ 56,891 \$ 108,917 \$ 206,140 \$ 84,707 \$ 235,642 \$ 92,436 \$ 585,610 \$ 29,976	\$ 3 \$ 49 \$ 5 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 19200   Observation (Non-Distinct) 5000   OPERATING ROOM 5100   RECOVERY ROOM 5200   DELIVERY ROOM & LABOR ROOM 5300   ANESTHESIOLOGY 5400   RADIOLOGY-DIAGNOSTIC 5500   RADIOLOGY-HERAPEUTIC 5700   CT SCAN 5800   MRI 6000   LABORATORY 6500   RESPIRATORY THERAPY 6600   PHYSICAL THERAPY 6600   PHYSICAL THERAPY		0.129901 0.096486 0.504800 0.023511 0.169663 0.221577 0.030760 0.051683 0.125919 0.211281 0.185392 0.128779	Routine Charges \$ 274,049 \$ 1,631.24 Ancillary Charges	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,208 \$ 1,953.82  Ancillary Charges	25,023 361,136 37,974 448 36,520 282,376 556,861 302,287 70,961 187,257 12,457	\$ 1,069,255 \$ 1,859,57 Ancillary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 206,140 \$ 44,707 \$ 235,642 \$ 92,436 \$ 585,610 \$ 585,610 \$ 585,610 \$ 13,008	\$ 33 \$ 49 \$ 5 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2 \$ 3
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below) 19200 (Doservation (Non-Distinct) 1900 (DECOVERY ROOM 1900 (DELIVERY ROOM & LABOR ROOM 1900 (DELIVERY ROOM & LABOR ROOM 1900 (ADDITION OF THE TOWN OF TOWN OF THE TOWN OF THE TOWN OF TOWN OF THE TOWN OF TOWN OF THE TOWN OF THE TOWN OF THE TOWN OF TOWN OF THE TOWN OF THE TOWN OF TOWN OF THE TOW	d):	0.129901 0.096486 0.504800 0.023511 0.169963 0.221577 0.030760 0.051683 0.125919 0.2112811 0.185392 0.128777 0.134969 0.174620 0.368046	Routine Charges \$ 274,049 \$ 1,631,24  Ancillary Charges	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,647	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953,82  Ancillary Charges	25,023 361,136 37,974 448 36,520 282,376 556,861 187,257 70,961 187,257 12,457	\$ 1,069.255 \$ 1,859.57 Ancillary Charges \$ \$ 569,448 \$ 68,525 \$ 56,891 \$ 108,917 \$ 206,140 \$ 84,707 \$ 235,642 \$ 92,436 \$ 585,610 \$ 299,976 \$ 13,008 \$ 13,008 \$ 13,560 \$ 73,400	\$ 33 \$ 49 \$ 5 \$ 5 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2 \$ 5 \$ 5
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below) 9200 (Deservation (Non-Distinct) 5000 (DeFATING ROOM) 5100 (RECOVERY ROOM) 5200 (DELIVERY ROOM) 5300 (ANESTHESIOLOGY) 5400 (RADIOLOGY-DIAGNOSTIC) 5500 (RADIOLOGY-THERAPEUTIC) 5700 (CT SCAN) 5800 (MRI) 6000 (LABORATORY) 6500 (RESPIRATORY THERAPY) 6500 (RESPIRATORY THERAPY) 6500 (RESPIRATORY THERAPY) 6500 (DEVISIOLA THERAPY) 6500 (SECOLA THERAPY) 6900 (SELECTROCANCIER)	d):	0.129011 0.096486 0.504800 0.0235111 0.169663 0.221577 0.030760 0.051683 0.125919 0.211281 0.185392 0.128777 0.134969 0.174620 0.368046 0.663805	Routine Charges \$ 274,049 \$ 1,631,24  Ancillary Charges - 220,491 51,790 47,738 57,359 47,270 35,058 82,639 13,737 172,369 61,405 9,641 929 518 20,131	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953.82  Ancillary Charges	25,023 361,136 37,974 448 36,520 282,376 556,861 302,287 70,961 187,257 1,884 - - 37,483 17,690	\$ 1,069,255 \$ 1,859,57 Ancillary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 206,140 \$ 235,642 \$ 92,436 \$ 585,610 \$ 298,976 \$ 50,328 \$ 13,008 \$ 13,560 \$ 73,400 \$ -	\$ 33 \$ 49 \$ 5 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2 \$ 5 \$ 5
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below) 9200 (Deservation (Non-Distinct) 5000 (DERATING ROOM) 5100 (RECOVERY ROOM) 5100 (RECOVERY ROOM) 5200 (DELIVERY ROOM) 5300 (ANESTHESIOLOGY) 5400 (RADIOLOGY-DIAGNOSTIC) 5500 (RADIOLOGY-THERAPEUTIC) 5700 (CT SCAN) 5800 (MRI 6500 (RESPIRATORY THERAPY) 6500 (RESPIRATORY THERAPY) 6600 (PHYSICAL THERAPY) 6700 (OCCUPATIONAL THERAPY) 6800 (SPEECH PATHOLOGY) 6900 (ELECTROCARDIOLOGY) 7000 (ELECTROCARDIOLOGY) 7100 (MEDICAL SUPPLIES CHARGED TO PATIET	d):	0.129901 0.096486 0.504800 0.023511 0.169663 0.221577 0.030760 0.051683 0.125919 0.211281 0.185392 0.128777 0.134969 0.174620 0.368046 0.663805 0.322940	Routine Charges \$ 274,049 \$ 1,631.24 Ancillary Charges	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847 18,545 21,446 27,298	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,208 \$ 1,953.82  Ancillary Charges	25,023 361,136 37,974 448 36,520 282,376 556,861 302,287 70,961 187,257 12,457 1,884 - - 37,483	\$ 1,069,255 \$ 1,859,57 Ancillary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 206,140 \$ 84,707 \$ 235,642 \$ 92,436 \$ 585,610 \$ 598,976 \$ 13,560 \$ 73,400 \$ 8,992 \$ 99,922 \$ 22,524	\$ 33 \$ 49 \$ 5 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2 \$ 5 \$ 5 \$ 36 \$ 36 \$ 36 \$ 36 \$ 36 \$ 36 \$ 36 \$ 36
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below) 9200   Observation (Non-Distinct) 5000   OPERATING ROOM 5100   RECOVERY ROOM 5300   ANESTHESIOLOGY 5400   RADIOLOGY-DIAGNOSTIC 5500   RADIOLOGY-THERAPEUTIC 5700   CT SCAN 5800   MRI 6000   LABORATORY 6500   RESPIRATORY THERAPY 6500   RESPIRATORY THERAPY 6500   RESPIRATORY HERAPY 6700   OCCUPATIONAL THERAPY 6700   OCCUPATIONAL THERAPY 6800   SPEEGH PATHOLOGY 6900   ELECTROENCEPHALOGRAPHY 7100   MEDICAL SUPPLIES CHARGED TO PATIE	d):	0.129011 0.096486 0.504800 0.0235111 0.169663 0.221577 0.030760 0.051683 0.125919 0.211281 0.185392 0.128777 0.134969 0.174620 0.368046 0.663805	Routine Charges \$ 274,049 \$ 1,631,24  Ancillary Charges - 220,491 51,790 47,738 57,359 47,270 35,058 82,639 13,737 172,369 61,405 9,641 929 518 20,131	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953.82  Ancillary Charges	25,023 361,136 37,974 448 36,520 282,376 556,861 302,287 70,961 187,257 1,884 - - 37,483 17,690	\$ 1,069,255 \$ 1,859,57 Ancillary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 206,140 \$ 235,642 \$ 92,436 \$ 585,610 \$ 298,976 \$ 50,328 \$ 13,008 \$ 13,560 \$ 73,400 \$ -	\$ 49 \$ 49 \$ 5 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2 \$ 36 \$ 2 \$ 36 \$ 36 \$ 5 \$ 36 \$ 5 \$ 36 \$ 5 \$ 36 \$ 5 \$ 36 \$ 5 \$ 36 \$ 36
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 19200 (Doservation (Non-Distinct) 5000 (DERATING ROOM 5100 (RECOVERY ROOM 5200 (DELIVERY ROOM & LABOR ROOM 5300 (ANESTHESIOLOGY 5400 (RADIOLOGY-DIAGNOSTIC 5500 (RADIOLOGY-DIAGNOSTIC 5500 (RADIOLOGY-THERAPEUTIC 5700 (CT SCAN 5600 (RESPIRATORY THERAPY 6500 (RESPIRATORY THERAPY 6700 (CCLUPATIONAL THERAPY 6800 (SPEECH PATHOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (REDICAL SUPPLIES CHARGED TO PATIENTS 7300 (DRUGS CHARGED TO PATIENTS 7300 (RENAL DIALYSIS 9100 (ENARCED TO PATIENTS	d):	0.129901 0.096486 0.504800 0.023511 0.169863 0.221577 0.030760 0.051683 0.125919 0.2112811 0.185392 0.128777 0.134969 0.174620 0.368046 0.663805 0.322940 0.209923 0.206060 0.250052	Routine Charges \$ 274,049 \$ 1,631,24  Ancillary Charges	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,208 \$ 1,953.82  Ancillary Charges	25,023 361,136 37,974 448 36,520 282,376 556,861 187,257 1,2457 1,884 	\$ 1,069.255 \$ 1,859.57 Ancillary Charges \$ \$ 569,448 \$ 68,525 \$ 56,891 \$ 108,917 \$ 206,140 \$ 84,707 \$ 235,642 \$ 92,436 \$ 585,610 \$ 298,976 \$ 50,328 \$ 13,008 \$ 13,008 \$ 13,008 \$ 13,260 \$ 13	\$ 3 \$ 49 \$ 5 \$ 6 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 71 \$ 5 \$ 2 \$ 36 \$ 5 \$ 36 \$ 5 \$ 36 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
Routine Charges Calculated Routine Charge Per Dierr Ancillary Cost Centers (from W/S C) (list below 09200   Observation (Non-Distinct) 5000   Observation (Non-Distinct) 5000   DELATING ROOM 5200   DELIVERY ROOM 5200   DELIVERY ROOM 5300   ANESTHESIOLOGY 5400   RADIOLOGY-DIAGNOSTIC 5500   RADIOLOGY-THERAPEUTIC 5700   OT SCAN 5800   MRI 6000   LABORATORY 6500   RESPIRATORY THERAPY 6600   PHYSICAL THERAPY 6600   PHYSICAL THERAPY 6600   PHYSICAL THERAPY 6600   PHYSICAL THERAPY 6600   PELECTROCARDIOLOGY 7000   ELECTROCARDIOLOGY 7000   ELECTROCARDIOLOGY 7100   MEDICAL SUPPLIES CHARGED TO PATIENTS 7200   IMPL. DEV. CHARGED TO PATIENTS 7400   RENAL DIALYSIS	d):	0.129011 0.096486 0.504800 0.0235111 0.169663 0.221577 0.030760 0.051683 0.125919 0.211281 0.185392 0.128777 0.134969 0.174620 0.368046 0.663805 0.322940 0.209606 0.209606	Routine Charges \$ 274,049 \$ 1,631.24  Ancillary Charges	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847 1,545 21,446 27,298 88,459	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,206 \$ 1,953.82  Ancillary Charges	25,023 361,136 37,974 448 36,520 282,376 556,861 302,287 70,961 187,257 12,457 1,884 - - 17,690 8,000 4,916,422 3,868	\$ 1,069,255 \$ 1,859,57 Ancillary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 206,140 \$ 84,707 \$ 235,642 \$ 92,436 \$ 585,610 \$ 585,610 \$ 13,008 \$ 13,008 \$ 13,560 \$ 73,400 \$ 89,922 \$ 22,524 \$ 648,356 \$ 648,356	\$ 3 \$ 49 \$ 5 \$ 6 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 71 \$ 5 \$ 2 \$ 36 \$ 5 \$ 36 \$ 5 \$ 36 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 09200 (Dbservation (Non-Distinct) 5000 (DPERATING ROOM 5100 (RECOVERY ROOM & LABOR ROOM 5300 (ANESTHESIOLOGY 5400 (RADIOLOGY-DIAGNOSTIC 5500 (RADIOLOGY-DIAGNOSTIC 5500 (RADIOLOGY-DIAGNOSTIC 5500 (RADIOLOGY-HERAPEUTIC 5700 (CT SCAN 5800 MRI 6000 (LABORATORY 6500 (RESPIRATORY THERAPY 6600 (PHYSICAL THERAPY 6700 (CCUPATIONAL THERAPY 6800 (SPEECH PATHOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7100 (MEDICAL SUPPLIES CHARGED TO PATIENTS 7300 (DRUGS CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS 7400 (RENAL DIALYSIS 9100 (ENERCENCY)	d):	0.129011 0.096486 0.504800 0.0235111 0.169663 0.221577 0.030760 0.051683 0.125919 0.211281 0.185392 0.128777 0.134969 0.174620 0.368046 0.663905 0.322940 0.209023 0.206060 0.250052 0.360723	Routine Charges \$ 274,049 \$ 1,631,24  Ancillary Charges	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,208 \$ 1,953.82  Ancillary Charges	25,023 361,136 37,974 448 36,520 282,376 556,861 187,257 1,2457 1,884 	\$ 1,069,255 \$ 1,859,57 Ancillary Charges \$ - \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 235,642 \$ 92,436 \$ 585,610 \$ 585,610 \$ 13,008 \$ 13,008 \$ 13,008 \$ 13,000 \$ 13,400 \$ 13,400 \$ 13,400 \$ 14,400 \$ 14,400 \$ 14,500 \$ 14,50	\$ 3 \$ 49 \$ 5 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2 \$ 5 \$ 5
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 19200 (Doservation (Non-Distinct) 5000 (DERATING ROOM 5100 (RECOVERY ROOM 5200 (DELIVERY ROOM & LABOR ROOM 5300 (ANESTHESIOLOGY 5400 (RADIOLOGY-DIAGNOSTIC 5500 (RADIOLOGY-DIAGNOSTIC 5500 (RADIOLOGY-THERAPEUTIC 5700 (CT SCAN 5600 (RESPIRATORY THERAPY 6500 (RESPIRATORY THERAPY 6700 (CCLUPATIONAL THERAPY 6800 (SPEECH PATHOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (REDICAL SUPPLIES CHARGED TO PATIENTS 7300 (DRUGS CHARGED TO PATIENTS 7300 (RENAL DIALYSIS 9100 (ENARCED TO PATIENTS	d):	0.129011 0.096486 0.504800 0.023511 0.169863 0.221577 0.030760 0.051683 0.125919 0.211281 0.185392 0.128777 0.134969 0.174620 0.368046 0.663305 0.322940 0.20923 0.206060 0.250052	Routine Charges \$ 274,049 \$ 1,631,24  Ancillary Charges	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,208 \$ 1,953.82  Ancillary Charges	25,023 361,136 37,974 448 36,520 282,376 556,861 187,257 1,2457 1,884 	\$ 1,069.255 \$ 1,859.57  Ancillary Charges \$ \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 206,140 \$ 84,707 \$ 235,642 \$ 92,436 \$ 585,610 \$ 299,976 \$ 50,328 \$ 13,068 \$ 13,560 \$ 73,400 \$ 8,972 \$ 22,524 \$ 648,356 \$ 121,392 \$ 121,392 \$ 121,392 \$ 142,521 \$ 16,345 \$ \$	\$ 3 \$ 49 \$ 5 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 366 \$ 2 \$ 5 \$ 5 \$ 5 \$ 5 \$ 71 \$ 5 \$ 2 \$ 36 \$ 5 \$ 36 \$ 5 \$ 36 \$ 5 \$ 5 \$ 70 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 19200 (Doservation (Non-Distinct) 5000 (DERATING ROOM 5100 (RECOVERY ROOM 5200 (DELIVERY ROOM & LABOR ROOM 5300 (ANESTHESIOLOGY 5400 (RADIOLOGY-DIAGNOSTIC 5500 (RADIOLOGY-DIAGNOSTIC 5500 (RADIOLOGY-THERAPEUTIC 5700 (CT SCAN 5600 (RESPIRATORY THERAPY 6500 (RESPIRATORY THERAPY 6700 (CCLUPATIONAL THERAPY 6800 (SPEECH PATHOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (ELECTROCARDIOLOGY 7000 (REDICAL SUPPLIES CHARGED TO PATIENTS 7300 (DRUGS CHARGED TO PATIENTS 7300 (RENAL DIALYSIS 9100 (ENARCED TO PATIENTS	d):	0.129011 0.096486 0.504800 0.0235111 0.169663 0.221577 0.030760 0.051683 0.125919 0.211281 0.185392 0.128777 0.134969 0.174620 0.368046 0.663905 0.322940 0.209023 0.206060 0.250052 0.360723	Routine Charges \$ 274,049 \$ 1,631,24  Ancillary Charges	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,208 \$ 1,953.82  Ancillary Charges	25,023 361,136 37,974 448 36,520 282,376 556,861 187,257 1,2457 1,884 	\$ 1,069,255 \$ 1,859,57 Ancillary Charges \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 205,140 \$ 92,436 \$ 92,436 \$ 585,640 \$ 585,640 \$ 298,976 \$ 50,328 \$ 13,008 \$ 13,560 \$ 73,400 \$ 92,252 \$ 22,524 \$ 643,356 \$ 121,392 \$ 142,521 \$ 16,345 \$ 16,345	\$ 3 \$ 49 \$ 5 \$ 6 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 71 \$ 5 \$ 2 \$ 36 \$ 5 \$ 36 \$ 5 \$ 36 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
Unreconciled Days  Routine Charges Calculated Routine Charge Per Dierr  Ancillary Cost Centers (from W/S C) (list below 19200   Observation (Non-Distinct) 5000   OPERATING ROOM 5100   RECOVERY ROOM 5200   DELIVERY ROOM & LABOR ROOM 5300   ANESTHESIOLOGY 5400   RADIOLOGY-DIAGNOSTIC 5500   RADIOLOGY-DIAGNOSTIC 5500   RADIOLOGY-HERAPEUTIC 5700   CT SCAN 5800   MRI 6000   LABORATORY 6500   RESPIRATORY THERAPY 6600   PHYSICAL THERAPY 6700   OCCUPATIONAL THERAPY 6800   SPEECH PATHOLOGY 6800   SPEECH PATHOLOGY 7000   ELECTROCARDIOLOGY 7000   ELECTROCARDIOLOGY 7000   ELECTROCARDIOLOGY 7000   ELECTROCARDIOLOGY 7000   ELECTROCARDIOLOGY 7101   MEDICAL SUPPLIES CHARGED TO PATIE 7200   IMPL DEV. CHARGED TO PATIENTS 7300   DRUGS CHARGED TO PATIENTS 7400   RENAL DIALLYSIS	d):	0.129011 0.096486 0.504800 0.0235111 0.169663 0.221577 0.030760 0.051683 0.125919 0.211281 0.185392 0.128777 0.134969 0.174620 0.368046 0.663805 0.322940 0.209023 0.206060 0.250052 0.360723	Routine Charges \$ 274,049 \$ 1,631,24  Ancillary Charges	7,439 131,833 20,115 2,130 28,299 168,872 155,124 317,775 19,174 180,022 15,847	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ 795,208 \$ 1,953.82  Ancillary Charges	25,023 361,136 37,974 448 36,520 282,376 556,861 187,257 1,2457 1,884 	\$ 1,069.255 \$ 1,859.57  Ancillary Charges \$ \$ 569,448 \$ 68,525 \$ 56,691 \$ 108,917 \$ 206,140 \$ 84,707 \$ 235,642 \$ 92,436 \$ 585,610 \$ 299,976 \$ 50,328 \$ 13,068 \$ 13,560 \$ 73,400 \$ 8,972 \$ 22,524 \$ 648,356 \$ 121,392 \$ 121,392 \$ 121,392 \$ 142,521 \$ 16,345 \$ \$	\$ 3 \$ 49 \$ 5 \$ 6 \$ 45 \$ 71 \$ 62 \$ 9 \$ 36 \$ 2 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 6 \$ 5 \$ 71 \$ 62 \$ 5 \$ 9 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5

### I. Out-of-State Medicaid Data:

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

CANDLER HOSPITAL

		Out-of-State Medica	aid FFS Primary	Out-of-State Medi Prir	caid Managed Care mary	Out-of-State Medica (with Medica	are FFS Cross-Overs id Secondary)	Included Elsewhe Secor	re & with Medicaid ndary)	Total Out-Of	-State Medicaid
	-									S -	\$ -
	-									\$ -	\$ -
	-									\$ -	\$ -
	-									\$ -	\$ -
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237,832 \$

249,792 \$

349,696

402,845

### I. Out-of-State Medicaid Data:

Medicare Cross-Over Bad Debt Payments

Other Medicare Cross-Over Payments (See Note D)

Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)

Calculated Payments as a Percentage of Cost

141 142

143

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

		Out-of-State Medi	caid FFS Primary		icaid Managed Care mary		are FFS Cross-Overs id Secondary)	Included Elsewh	Medicaid Eligibles (Not ere & with Medicaid ondary)	Total Out-O	f-State Medicaid
112	-									\$ -	\$ -
113	-									\$ -	\$ -
114	-									\$ -	\$ -
115	-									\$ -	\$ -
116	-									\$ -	\$ -
117	-									\$ -	\$ -
118	-									\$ -	\$ -
119	-									\$ -	\$ -
120	-									\$ -	\$ -
121	-									\$ -	\$ -
122	-									\$ -	\$ -
123 124	-									\$ -	\$ -
124										\$ -	\$ -
126										e ·	· ·
127										\$	\$ -
121		\$ 1,094,709	\$ 1,583,451	s -	\$ -	\$ -	\$ -	\$ 2,403,739	\$ 7.066.636	Ψ .	Ψ -
		\$ 1,094,709	\$ 1,565,451	• -	-	<b>5</b> -	-	\$ 2,403,739	\$ 7,000,030		
	Totals / Payments										
128	Total Charges (includes organ acquisition from Section K)	\$ 1,368,758	\$ 1,583,451	\$ -	\$ -	\$ -	\$ -	\$ 3,198,945	\$ 7,066,636	\$ 4,567,703	\$ 8,650,087
129	Total Charges per PS&R or Exhibit Detail	\$ 1,368,758	\$ 1,583,451	\$ -	\$ -	\$ -	\$ -	\$ 3,198,945	\$ 7,066,636		
130	Unreconciled Charges (Explain Variance)	- 1,000,000	- 1,000,101						- 1,000,000		
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 336,862	\$ 278,117	\$ -	\$ -	\$ -	\$ -	\$ 875,231	\$ 1,428,633	\$ 1,212,093	\$ 1,706,750
	_										
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 224,636	\$ 120,752					\$ 141,889	\$ 68,125	\$ 366,525	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		\$ 1,861					\$ -	\$ -	\$ -	\$ 1,861
134	Private Insurance (including primary and third party liability)							\$ 44,008	\$ 60,894	\$ 44,008	
135	Self-Pay (including Co-Pay and Spend-Down)	\$ 362	\$ 2,451						\$ 2,484	\$ 362	\$ 4,935
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 224,998	\$ 125,064	\$ -	\$ -			·			
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) (See Note F)							\$ 217,793		\$ 217,793	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 233,709	\$ 564,753	\$ 233,709	\$ 564,753

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).

111,864 \$

153,053

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

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

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.

Worksheet A Pi	rovider Tax Assessment Reconciliation:		_
TTO MONOCOTT	TOTAL TUANTOS SOCIO INCIDENTATION INCIDENTAT		
		W/S A Cost Center Dollar Amount 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 Hospi	ital 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 Differe	ence (Explain Here>)	\$ 4,667,963	
D	1d - T - A A D - 1 161 - 41 (for		
4	ider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)  Reclassification Code	(Reclassified to / (from))	
5	Reclassification Code  Reclassification Code	(Reclassified to / (from))  (Reclassified to / (from))	
6	Reclassification Code	(Reclassified to / (from))	
7	Reclassification Code	(Reclassified to / (from))	
•	Nediadamentalion odde	(Nedasanea to Thom)	
DSH U	UCC ALLOWABLE - Provider Tax Assessment Adjustments(from w/s A-8 of the Medicare cost report)		
8	Reason for adjustment Addback	\$ 4,667,963 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))	
12 13 14 15	UCC NON-ALLOWABLE Provider Tax Assessment Adjustments(from w/s A-8 of the Medicare cost report) Reason for adjustment Reason for adjustment Reason for adjustment Reason for adjustment Net Provider Tax Assessment Expense Included in the Cost Report	\$ 4,667,963	
DSH UCC Provi	ider Tax Assessment Adjustment:		
17 Gross	s Allowable Assessment Not Included in the Cost Report	\$ -	
Appo	ortionment 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	\$ -	
	der Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***	\$ -	
• • • • • • • • • • • • • • • • • • • •	ortionment 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 Medic	caid Primary Tax Assessment Adjustment to DSH UCC***	\$ -	

<sup>\*</sup> Assessment must exclude any non-hospital assessment such as Nursing Facility.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup>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.