EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	7.25	5/3/2018

D. General Cost Report Year Information 1/1/2017 - 12/31/2017

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided: CANDLER COUNTY HOSPITAL

	1/1/2017 through 12/31/2017		
2. Select Cost Report Year Covered by this Survey:	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: 6/1/2018

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	CANDLER COUNTY HOSPITAL	Yes	
5. Medicaid Provider Number:	000000316A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	111334	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes	

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

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2017 - 12/31/2017)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	$ -

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 218	$ 66,801	$67,019
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 19,921	$ 343,675	$363,596
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$20,139	$410,476	$430,615
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	1.08%	16.27%	15.56%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ -
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	$ -
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2017 - 12/31/2017)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	1,485

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	122,697
8. Outpatient Hospital Charity Care Charges	1,238,780
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	$ 1,361,477

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

	Total Patient Revenues (Charges)			Contractual Adjustments			
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11. Hospital	$ 2,160,793	$ -	$ -	$ 1,476,677	$ -	$ -	$ 684,116
12. Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14. Swing Bed - SNF			$ 5,906,475			$ 4,036,460	
15. Swing Bed - NF			$ -			$ -	
16. Skilled Nursing Facility			$ -			$ -	
17. Nursing Facility			$ -			$ -	
18. Other Long-Term Care			$ -			$ -	
19. Ancillary Services	$ 4,435,486	$ 20,798,221	$ -	$ 3,031,192	$ 14,213,416	$ -	$ 7,989,098
20. Outpatient Services		$ 18,829,921	$ -		$ 12,868,288	$ -	$ 5,961,633
21. Home Health Agency			$ -			$ -	
22. Ambulance			$ -			$ -	
23. Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24. ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25. Hospice			$ -			$ -	
26. Other	$ -	$ -	$ 2,244,187	$ -	$ -	$ 1,533,668	$ -
27. Total	$ 6,596,279	$ 39,628,142	$ 8,150,662	$ 4,507,869	$ 27,081,705	$ 5,570,128	$ 14,634,847
28. Total Hospital and Non Hospital		Total from Above	$ 54,375,083		Total from Above	$ 37,159,702	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 54,375,083	Total Contractual Adj. (G-3 Line 2)	$ 37,159,702
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)			+	$ -
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)			+	$ -
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	$ -
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	$ -
35. Adjusted Contractual Adjustments				37,159,702
36. Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) CANDLER COUNTY HOSPITAL

Line #	Cost Center Description		Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):										
1	03000	ADULTS & PEDIATRICS	$ 2,662,117	$ -	$ -	$ 1,686,881	**$ 975,236**	1,554	$ 3,013,721		**$ 627.56**
2	03100	INTENSIVE CARE UNIT	$ 679,022	$ -	$ -		**$ 679,022**	438	$ 692,429		**$ 1,550.28**
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
7	04000	SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100	SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300	NURSERY	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
11		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
12		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
13		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
14		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
15		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
16		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
17		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
18		Total Routine	$ 3,341,139	$ -	$ -	$ 1,686,881	$ 1,654,258	1,992	$ 3,706,150		
19		Weighted Average									$ 830.45

Line #	Observation Data (Non-Distinct)		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
20	09200	Observation (Non-Distinct)	507	-	-	**$ 318,173**	$ 92,234	$ 1,025,057	$ 1,117,291	**0.284772**

Line #	Ancillary Cost Centers (from W/S C excluding Observation) (list below):		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4		Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
21	5000	OPERATING ROOM	$ 1,201,457	$ -	$ -		**$ 1,201,457**	$ 181,772	$ 5,008,931	$ 5,190,703	**0.231463**
22	5400	RADIOLOGY-DIAGNOSTIC	$ 1,347,728	$ -	$ -		**$ 1,347,728**	$ 885,780	$ 10,951,009	$ 11,836,789	**0.113859**
23	6000	LABORATORY	$ 999,004	$ -	$ -		**$ 999,004**	$ 1,525,929	$ 6,746,845	$ 8,272,774	**0.120758**
24	6500	RESPIRATORY THERAPY	$ 333,167	$ -	$ -		**$ 333,167**	$ 925,969	$ 417,828	$ 1,343,797	**0.247930**
25	6600	PHYSICAL THERAPY	$ 812,195	$ -	$ -		**$ 812,195**	$ 658,461	$ 458,856	$ 1,117,317	**0.726915**
26	6700	OCCUPATIONAL THERAPY	$ 57,597	$ -	$ -		**$ 57,597**	$ 241,991	$ 19,024	$ 261,015	**0.220665**
27	6800	SPEECH PATHOLOGY	$ 5,980	$ -	$ -		**$ 5,980**	$ 18,102	$ 275	$ 18,377	**0.325407**
28	6900	ELECTROCARDIOLOGY	$ 193,373	$ -	$ -		**$ 193,373**	$ 56,443	$ 801,048	$ 857,491	**0.225510**
29	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 1,186,723	$ -	$ -		**$ 1,186,723**	$ 859,673	$ 2,565,731	$ 3,425,404	**0.346448**
30	7200	IMPL. DEV. CHARGED TO PATIENTS	$ 14,065	$ -	$ -		**$ 14,065**	$ -	$ 28,061	$ 28,061	**0.501229**
31	7300	DRUGS CHARGED TO PATIENTS	$ 910,976	$ -	$ -		**$ 910,976**	$ 3,102,802	$ 3,576,719	$ 6,679,521	**0.136383**
32	9100	EMERGENCY	$ 2,335,079	$ -	$ -		**$ 2,335,079**	$ 250,271	$ 6,731,121	$ 6,981,392	**0.334472**

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) CANDLER COUNTY HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net 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
33			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
34			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
35			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
36			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
37			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
38			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
39			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
40			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
41			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
42			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
43			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
44			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
45			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
46			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
47			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
48			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
49			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
50			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
51			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
52			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
53			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
54			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
55			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
56			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
57			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
58			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
59			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
60			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
61			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
62			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
63			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
64			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
65			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
66			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
67			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
68			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
69			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
70			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
71			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
72			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
73			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
74			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
75			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
76			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
77			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
78			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
79			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
80			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
81			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
82			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
83			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
84			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
85			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
86			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
87			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
88			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
89			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
90			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
91			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
92			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
93			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) CANDLER COUNTY HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net 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
94			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
95			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
96			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
97			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
98			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
99			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
100			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
101			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
102			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
103			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
104			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
105			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
106			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
107			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
108			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
109			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
110			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
111			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
112			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
113			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
114			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
115			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
116			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
117			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
118			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
119			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
120			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
121			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
122			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
123			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
124			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
125			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
126		**Total Ancillary**	$ 9,397,344	$ -	$ -	$ 9,397,344	$ 8,799,427	$ 38,330,505	$ 47,129,932	
127		**Weighted Average**								0.206143
128		**Sub Totals**	$ 12,738,483	$ -	$ -	$ 11,051,602	$ 12,505,577	$ 38,330,505	$ 50,836,082	

	Description	Amount
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)	$ -
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)	$ 594,898
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)	$ -
131.01	Other Cost Adjustments (support must be submitted)	$ -
132	**Grand Total**	**$ 10,456,704**
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 (01/01/2017-12/31/2017) CANDLER COUNTY HOSPITAL

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
			From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):				**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000	ADULTS & PEDIATRICS	$ 627.56		94		13		167		26		29		300		31.42%
2	03100	INTENSIVE CARE UNIT	$ 1,550.28		47		3		85		10		16		145		36.76%
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	$ -		-		-		-		-		-		-		
11		0	$ -		-		-		-		-		-		-		
12		0	$ -		-		-		-		-		-		-		
13		0	$ -		-		-		-		-		-		-		
14		0	$ -		-		-		-		-		-		-		
15		0	$ -		-		-		-		-		-		-		
16		0	$ -		-		-		-		-		-		-		
17		0	$ -		-		-		-		-		-		-		
18				**Total Days**	141		16		252		36		45		445		33.00%
19	Total Days per PS&R or Exhibit Detail				141		16		252		36		45				
20		Unreconciled Days (Explain Variance			-		-		-		-		-				
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21		Routine Charges			$ 187,069		$ 217,874		$ 366,959		$ 47,740		$ 75,731		$ 819,642		24.16%
21.01		Calculated Routine Charge Per Dier			$ 1,326.73		$ 13,617.13		$ 1,456.19		$ 1,326.11		$ 1,682.91		$ 1,841.89		
	Ancillary Cost Centers (from W/S C) (from Section G):				**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200	Observation (Non-Distinct		0.284772	$ 5,289	$ 45,821	$ 648	$ 37,386	$ 11,896	$ 199,435	$ -	$ -	$ 13,425	$ 101,201	$ 17,833	$ 282,642	37.15%
23	5000	OPERATING ROOM		0.231463	$ 20,876	$ 545,779	$ 10,046	$ 356,690	$ 11,760	$ 722,014	$ -	$ -	$ 7,418	$ 225,929	$ 42,682	$ 1,624,483	36.61%
24	5400	RADIOLOGY-DIAGNOSTIC		0.113859	$ 108,638	$ 653,437	$ 4,856	$ 819,977	$ 113,577	$ 1,655,131	$ 22,697	$ -	$ 61,550	$ 1,511,666	$ 249,768	$ 3,128,545	41.83%
25	6000	LABORATORY		0.120758	$ 176,545	$ 598,045	$ 18,210	$ 623,409	$ 197,578	$ 904,258	$ 28,271	$ -	$ 102,397	$ 824,443	$ 420,604	$ 2,125,712	41.98%
26	6500	RESPIRATORY THERAPY		0.247930	$ 84,415	$ 31,021	$ 175	$ 34,295	$ 164,848	$ 102,820	$ 21,167	$ -	$ 8,723	$ 35,075	$ 270,605	$ 168,136	35.91%
27	6600	PHYSICAL THERAPY		0.726915	$ 3,496	$ 13,279	$ 576	$ 5,286	$ 11,561	$ 31,824	$ 2,062	$ -	$ 2,961	$ 1,790	$ 17,695	$ 50,389	6.52%
28	6700	OCCUPATIONAL THERAPY		0.220665	$ -	$ -	$ -	$ -	$ 1,982	$ -	$ 543	$ -	$ 1,269	$ -	$ 2,525	$ -	1.45%
29	6800	SPEECH PATHOLOGY		0.325407	$ 698	$ -	$ -	$ -	$ 388	$ -	$ -	$ -	$ -	$ -	$ 1,086	$ -	5.91%
30	6900	ELECTROCARDIOLOGY		0.225510	$ 10,154	$ 72,315	$ 526	$ 30,405	$ 7,132	$ 148,097	$ 2,893	$ -	$ 6,637	$ 105,815	$ 20,705	$ 250,817	44.78%
31	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.346448	$ 77,014	$ 283,351	$ 9,724	$ 212,032	$ 104,207	$ 414,498	$ 11,141	$ -	$ 32,492	$ 256,524	$ 202,086	$ 909,881	40.90%
32	7200	IMPL. DEV. CHARGED TO PATIENTS		0.501229	$ -	$ -	$ -	$ 46	$ -	$ 5,491	$ -	$ -	$ -	$ 3,388	$ -	$ 5,537	31.81%
33	7300	DRUGS CHARGED TO PATIENTS		0.136383	$ 183,581	$ 108,610	$ 19,974	$ 124,329	$ 347,847	$ 445,767	$ 33,806	$ -	$ 68,310	$ 227,046	$ 585,208	$ 678,706	23.34%
34	9100	EMERGENCY		0.334472	$ 67,591	$ 560,072	$ 11,457	$ 1,018,557	$ 13,288	$ 852,273	$ 1,723	$ -	$ 48,627	$ 1,451,198	$ 94,059	$ 2,430,902	57.65%
35				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
36				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
37				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
38				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
39				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
40				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
41				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
42				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
43				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
44				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
45				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
46				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
47				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
48				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
49				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
50				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
51				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
52				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
53				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
54				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
55				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
56				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
57				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
58				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
59				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
60				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
61				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
62				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
63				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
64				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
65				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
66				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
67				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
68				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
69				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
70				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
71				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
72				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
73				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
74				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
75				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
76				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
77				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
78				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
79				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
80				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
81				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
82				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
83				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
84				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	

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

Cost Report Year (01/01/2017-12/31/2017) CANDLER COUNTY HOSPITAL

Line	Description		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
85		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
86		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
87		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
88		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
89		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
90		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
91		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
92		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
93		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
94		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
95		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
96		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
97		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
98		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
99		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
100		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
101		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
102		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
103		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
104		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
105		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
106		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
107		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
108		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
109		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
110		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
111		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
112		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
113		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
114		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
115		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
116		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
117		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
118		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
119		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
120		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
121		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
122		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
123		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
124		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
125		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
126		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
127		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
			738,297	2,911,730	76,192	3,262,412	986,064	5,481,607	124,303	-	353,809	4,744,075			
	Totals / Payments														
128	**Total Charges** ***(includes organ acquisition from Section J)***		**$ 925,366**	**$ 2,911,730**	**$ 294,066**	**$ 3,262,412**	**$ 1,353,023**	**$ 5,481,607**	**$ 172,043**	**$ -**	**$ 429,540** (Agrees to Exhibit A)	**$ 4,744,075** (Agrees to Exhibit A)	**$ 2,744,498**	**$ 11,655,749**	38.50%
129	Total Charges per PS&R or Exhibit Detail		$ 925,366	$ 2,911,730	$ 294,066	$ 3,262,412	$ 1,353,023	$ 5,481,607	$ 172,043	$ -	$ 429,540	$ 4,744,075			
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**												$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**		**$ 272,194**	**$ 619,953**	**$ 28,577**	**$ 712,169**	**$ 418,911**	**$ 1,095,794**	**$ 54,383**	**$ -**	**$ 110,846**	**$ 993,569**	$ 774,065	$ 2,427,916	41.18%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 242,025	$ 562,661	$ -	$ -	$ 52,052	$ 381,490	$ 12,687	$ -			$ 306,764	$ 944,151	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		$ -	$ -	$ 21,261	$ 647,113	$ -	$ -	$ -	$ -			$ 21,261	$ 647,113	
134	Private Insurance (including primary and third party liability)		$ -	$ -	$ -	$ -	$ -	$ 1,827	$ -	$ -			$ -	$ 1,827	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 6,475	$ 2,333	$ -	$ 517	$ -	$ -	$ -	$ -			$ 6,475	$ 2,850	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ 248,500	$ 564,994	$ 21,261	$ 647,630									
137	Medicaid Cost Settlement Payments (See Note B)		$ -	$ (13,058)	$ -	$ -							$ -	$ (13,058)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)		$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)						$ 293,985	$ 552,557	$ -	$ -			$ 293,985	$ 552,557	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)						$ -	$ -	$ 37,381	$ -			$ 37,381	$ -	
141	Medicare Cross-Over Bad Debt Payments						$ -	$ -	$ -	$ -			$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)						$ 19,173	$ 91,535	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 19,173	$ 91,535	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)										$ 218	$ 66,801			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)										$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**		$ 23,694	$ 68,017	$ 7,316	$ 64,539	$ 53,701	$ 68,385	$ 4,315	$ -	$ 110,628	$ 926,768	$ 89,026	$ 200,941	
146	**Calculated Payments as a Percentage of Cost**		91%	89%	74%	91%	87%	94%	92%	0%	0%	7%	88%	92%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & (**						797								
148	**Percent of cross-over days to total Medicare days from the cost report**						32%								

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 s
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 pay
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 pa

NOTE: Inpatient uninsured payment rate is outside normal ranges, please verify this is correct.

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2017-12/31/2017) CANDLER COUNTY HOSPITAL

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
			From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
		Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000	ADULTS & PEDIATRICS	$ 627.56		-		-		-		-		-	
2	03100	INTENSIVE CARE UNIT	$ 1,550.28		-		-		-		-		-	
3	03200	CORONARY CARE UNIT	$ -		-		-		-		-		-	
4	03300	BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
6	03500	OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-	
7	04000	SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100	SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200	OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300	NURSERY	$ -		-		-		-		-		-	
11			$ -		-		-		-		-		-	
12			$ -		-		-		-		-		-	
13			$ -		-		-		-		-		-	
14			$ -		-		-		-		-		-	
15			$ -		-		-		-		-		-	
16			$ -		-		-		-		-		-	
17			$ -		-		-		-		-		-	
18				**Total Days**	-		-		-		-		-	
19		Total Days per PS&R or Exhibit Detail			-		-		-		-			
20		Unreconciled Days (Explain Variance)			-		-		-		-			
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21		Routine Charges			$ -		$ -		$ -		$ -		$ -	
21.01		Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
		Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200	Observation (Non-Distinct)		0.284772	-	-	-	-	-	-	-	-	$ -	$ -
23	5000	OPERATING ROOM		0.231463	-	-	-	-	-	-	-	-	$ -	$ -
24	5400	RADIOLOGY-DIAGNOSTIC		0.113859	-	-	-	-	-	-	-	-	$ -	$ -
25	6000	LABORATORY		0.120758	-	-	-	-	-	-	-	-	$ -	$ -
26	6500	RESPIRATORY THERAPY		0.247930	-	-	-	-	-	-	-	-	$ -	$ -
27	6600	PHYSICAL THERAPY		0.726915	-	-	-	-	-	-	-	-	$ -	$ -
28	6700	OCCUPATIONAL THERAPY		0.220665	-	-	-	-	-	-	-	-	$ -	$ -
29	6800	SPEECH PATHOLOGY		0.325407	-	-	-	-	-	-	-	-	$ -	$ -
30	6900	ELECTROCARDIOLOGY		0.225510	-	-	-	-	-	-	-	-	$ -	$ -
31	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.346448	-	-	-	-	-	-	-	-	$ -	$ -
32	7200	IMPL. DEV. CHARGED TO PATIENTS		0.501229	-	-	-	-	-	-	-	-	$ -	$ -
33	7300	DRUGS CHARGED TO PATIENTS		0.136383	-	-	-	-	-	-	-	-	$ -	$ -
34	9100	EMERGENCY		0.334472	-	-	-	-	-	-	-	-	$ -	$ -
35				-	-	-	-	-	-	-	-	-	$ -	$ -
36				-	-	-	-	-	-	-	-	-	$ -	$ -
37				-	-	-	-	-	-	-	-	-	$ -	$ -
38				-	-	-	-	-	-	-	-	-	$ -	$ -
39				-	-	-	-	-	-	-	-	-	$ -	$ -
40				-	-	-	-	-	-	-	-	-	$ -	$ -
41				-	-	-	-	-	-	-	-	-	$ -	$ -
42				-	-	-	-	-	-	-	-	-	$ -	$ -
43				-	-	-	-	-	-	-	-	-	$ -	$ -
44				-	-	-	-	-	-	-	-	-	$ -	$ -
45				-	-	-	-	-	-	-	-	-	$ -	$ -
46				-	-	-	-	-	-	-	-	-	$ -	$ -
47				-	-	-	-	-	-	-	-	-	$ -	$ -
48				-	-	-	-	-	-	-	-	-	$ -	$ -
49				-	-	-	-	-	-	-	-	-	$ -	$ -
50				-	-	-	-	-	-	-	-	-	$ -	$ -
51				-	-	-	-	-	-	-	-	-	$ -	$ -
52				-	-	-	-	-	-	-	-	-	$ -	$ -
53				-	-	-	-	-	-	-	-	-	$ -	$ -
54				-	-	-	-	-	-	-	-	-	$ -	$ -
55				-	-	-	-	-	-	-	-	-	$ -	$ -
56				-	-	-	-	-	-	-	-	-	$ -	$ -
57				-	-	-	-	-	-	-	-	-	$ -	$ -
58				-	-	-	-	-	-	-	-	-	$ -	$ -
59				-	-	-	-	-	-	-	-	-	$ -	$ -
60				-	-	-	-	-	-	-	-	-	$ -	$ -
61				-	-	-	-	-	-	-	-	-	$ -	$ -
62				-	-	-	-	-	-	-	-	-	$ -	$ -
63				-	-	-	-	-	-	-	-	-	$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2017-12/31/2017) CANDLER COUNTY HOSPITAL

Line					Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
64				-	-	-	-	-	-	-	-	-	$ -	$ -
65				-	-	-	-	-	-	-	-	-	$ -	$ -
66				-	-	-	-	-	-	-	-	-	$ -	$ -
67				-	-	-	-	-	-	-	-	-	$ -	$ -
68				-	-	-	-	-	-	-	-	-	$ -	$ -
69				-	-	-	-	-	-	-	-	-	$ -	$ -
70				-	-	-	-	-	-	-	-	-	$ -	$ -
71				-	-	-	-	-	-	-	-	-	$ -	$ -
72				-	-	-	-	-	-	-	-	-	$ -	$ -
73				-	-	-	-	-	-	-	-	-	$ -	$ -
74				-	-	-	-	-	-	-	-	-	$ -	$ -
75				-	-	-	-	-	-	-	-	-	$ -	$ -
76				-	-	-	-	-	-	-	-	-	$ -	$ -
77				-	-	-	-	-	-	-	-	-	$ -	$ -
78				-	-	-	-	-	-	-	-	-	$ -	$ -
79				-	-	-	-	-	-	-	-	-	$ -	$ -
80				-	-	-	-	-	-	-	-	-	$ -	$ -
81				-	-	-	-	-	-	-	-	-	$ -	$ -
82				-	-	-	-	-	-	-	-	-	$ -	$ -
83				-	-	-	-	-	-	-	-	-	$ -	$ -
84				-	-	-	-	-	-	-	-	-	$ -	$ -
85				-	-	-	-	-	-	-	-	-	$ -	$ -
86				-	-	-	-	-	-	-	-	-	$ -	$ -
87				-	-	-	-	-	-	-	-	-	$ -	$ -
88				-	-	-	-	-	-	-	-	-	$ -	$ -
89				-	-	-	-	-	-	-	-	-	$ -	$ -
90				-	-	-	-	-	-	-	-	-	$ -	$ -
91				-	-	-	-	-	-	-	-	-	$ -	$ -
92				-	-	-	-	-	-	-	-	-	$ -	$ -
93				-	-	-	-	-	-	-	-	-	$ -	$ -
94				-	-	-	-	-	-	-	-	-	$ -	$ -
95				-	-	-	-	-	-	-	-	-	$ -	$ -
96				-	-	-	-	-	-	-	-	-	$ -	$ -
97				-	-	-	-	-	-	-	-	-	$ -	$ -
98				-	-	-	-	-	-	-	-	-	$ -	$ -
99				-	-	-	-	-	-	-	-	-	$ -	$ -
100				-	-	-	-	-	-	-	-	-	$ -	$ -
101				-	-	-	-	-	-	-	-	-	$ -	$ -
102				-	-	-	-	-	-	-	-	-	$ -	$ -
103				-	-	-	-	-	-	-	-	-	$ -	$ -
104				-	-	-	-	-	-	-	-	-	$ -	$ -
105				-	-	-	-	-	-	-	-	-	$ -	$ -
106				-	-	-	-	-	-	-	-	-	$ -	$ -
107				-	-	-	-	-	-	-	-	-	$ -	$ -
108				-	-	-	-	-	-	-	-	-	$ -	$ -
109				-	-	-	-	-	-	-	-	-	$ -	$ -
110				-	-	-	-	-	-	-	-	-	$ -	$ -
111				-	-	-	-	-	-	-	-	-	$ -	$ -
112				-	-	-	-	-	-	-	-	-	$ -	$ -
113				-	-	-	-	-	-	-	-	-	$ -	$ -
114				-	-	-	-	-	-	-	-	-	$ -	$ -
115				-	-	-	-	-	-	-	-	-	$ -	$ -
116				-	-	-	-	-	-	-	-	-	$ -	$ -
117				-	-	-	-	-	-	-	-	-	$ -	$ -
118				-	-	-	-	-	-	-	-	-	$ -	$ -
119				-	-	-	-	-	-	-	-	-	$ -	$ -
120				-	-	-	-	-	-	-	-	-	$ -	$ -
121				-	-	-	-	-	-	-	-	-	$ -	$ -
122				-	-	-	-	-	-	-	-	-	$ -	$ -
123				-	-	-	-	-	-	-	-	-	$ -	$ -
124				-	-	-	-	-	-	-	-	-	$ -	$ -
125				-	-	-	-	-	-	-	-	-	$ -	$ -
126				-	-	-	-	-	-	-	-	-	$ -	$ -
127				-	-	-	-	-	-	-	-	-	$ -	$ -
					-	-	-	-	-	-	-	-		

Totals / Payments

Line	Description	FFS Primary		Managed Care Primary		Cross-Overs		Other Eligibles		Total Out-Of-State Medicaid	
128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)									$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2017-12/31/2017) CANDLER COUNTY HOSPITAL

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -	$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments					$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -	$ -	$ -
143.02	**Calculated Payment Shortfall / (Longfall)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (01/01/2017-12/31/2017) CANDLER COUNTY HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section D as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (01/01/2017-12/31/2017) CANDLER COUNTY HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey
Note B: Enter Organ Acquisition Payments in Section E as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (01/01/2017-12/31/2017) CANDLER COUNTY HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ -		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		$ -	0	***(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 ---------->)	0	$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(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*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

		Dollar Amount
17	Gross Allowable Assessment Not Included in the Cost Report	$ -

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*