3/31/2020

DSH Version 8.00

State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part II 9/30/2019

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy 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 COUNTY HOSPITAL 1. Select Your Facility from the Drop-Down Menu Provided: 1/1/2019 through 12/31/2019 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) 3a. Date CMS processed the HCRIS file into the HCRIS database. Correct? Data If Incorrect, Proper Information CANDLER COUNTY HOSPITAL 4. Hospital Name: Yes 5. Medicaid Provider Number: 000000316A 6. Medicaid Subprovider Number 1 (Psychiatric or Rehab): 7. Medicaid Subprovider Number 2 (Psychiatric or Rehab): 8. Medicare Provider Number: Yes Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal): Non-State Govt. Yes 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 14. State Name & Number 15. State Name & Number (List additional states on a separate attachment) E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2019 - 12/31/2019) 1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1) 2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) 3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) 4. Total Section 1011 Payments Related to Hospital Services (See Note 1) 5, Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1) 6 Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) 7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1) 8. Out-of-State DSH Payments (See Note 2) Total Inpatient Outpatient 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B) 632 147,566 \$148,198 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B) 28.205 440,295 \$468,500 11, Total Cash Basis Patient Payments Reported on Exhibit 8 (Agrees to Column (N) on Exhibit 8, less physician and non-hospital portion of payments) \$28,837 \$587,861 \$616,698 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments: 2.19% 25.10% 24.03% 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

12/31/2019

1/1/2019

D. General Cost Report Year Information

Contractual Adjustments (formulas below can be overwritten if amounts

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 (01/01/2019 - 12/31/2019)

| | F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR) | | |
|----|---|-------------------------|---------------------------------|
| 1 | Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) | 1,171 | (See Note in Section F-3, below |
| | F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Rat | io (LIUR) Calculation): | |
| 2 | 2. Inpatient Hospital Subsidies | - | |
| 3 | 8. Outpatient Hospital Subsidies | - | |
| 4 | Unspecified I/P and O/P Hospital Subsidies | - | |
| 5 | 5. Non-Hospital Subsidies | - | |
| 6 | 5. Total Hospital Subsidies | \$ - | |
| | | | |
| | Inpatient Hospital Charity Care Charges | 20,279 | |
| | 3. Outpatient Hospital Charity Care Charges | 524,056 | |
| ξ |). Non-Hospital Charity Care Charges | | |
| 10 |). Total Charity Care Charges | \$ 544,335 | |
| | | | |

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, For

| the data should be updated to the hospital's version of the cost report. | | 110000 | A CONTRACTOR OF THE PARTY OF TH | Continue | goo/ | | | | | are mounty, | | THE RESERVE OF LABOUR. | | |
|--|----------------------|---------------------------------------|--|-------------------|------|----------------|-------|-----------------|----------|-------------------|----------|------------------------|-----------|------------|
| Formulas can be overwritten as needed with actual data. | _ | | | | | | | S _i | 92 | | | | | |
| 11. Hospital | | \$1,892,647.00 | | | l I— | | \$ | 1,447,177 | \$ | - | \$ | | \$ | 445,470 |
| 12. Subprovider I (Psych or Rehab) | | \$0.00 | | | | | \$ | | \$ | | \$ | | \$ | - |
| 13, Subprovider II (Psych or Rehab) | | \$0.00 | | | | | \$ | - | \$ | | \$ | - | \$ | - |
| 14, Swing Bed - SNF | | Parameter 1 | | | | \$4,091,364.00 | | | | | \$ | 3,128,384 | 23310 | |
| 15. Swing Bed - NF | | | | | | \$0.00 | He. | | 300 | | \$ | | 1200 | |
| 16 Skilled Nursing Facility | 375600 | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 5.8 | | | \$0.00 | - | | LUIC | | \$ | | | |
| 17. Nursing Facility | | | 研究 長年 | | | \$0.00 | | | | | \$ | - | ==010 | |
| 18. Other Long-Term Care | | | 188 | | | \$0.00 | 10000 | | | | \$ | - | PROPERTY. | |
| 19. Ancillary Services | | \$3,460,694.00 | | 24,632,282.00 | | | \$ | 2,646,154 | \$ | 18,834,610 | \$ | - | \$ | 6,612,212 |
| 20. Outpatient Services | | | | 18,763,087.00 | | | 180 | | \$ | 14,346,841 | \$ | - | \$ | 4,416,246 |
| 21. Home Health Agency | | | - SECTION AND ADDRESS OF THE PERSON AND ADDR | | | \$0.00 | | | | | \$ | - | To The | |
| 22. Ambulance | THE RESERVE TO SERVE | SOFT REAL PROPERTY. | | | \$ | - | | | | | \$ | - | 1000 | |
| 23 Outpatient Rehab Providers | | | | | | \$0.00 | \$ | | \$ | - | \$ | - | \$ | - |
| 24. ASC | | \$0_00 | | \$0.00 | | | \$ | - | \$ | | \$ | | \$ | - |
| 25. Hospice | | | | | | \$0.00 | | | 3137 | | \$ | - | | 100 |
| 26. Other | | \$0.00 | | \$0.00 | | \$8,321,841.00 | \$ | - | \$ | - | \$ | 6,363,139 | \$ | - |
| | 1.5 | | | | | | | | | | | | | |
| 27. Total | \$ | 5,353,341 | \$ | 43,395,369 | \$ | 12,413,205 | \$ | 4,093,331 | \$ | 33,181,451 | \$ | 9,491,523 | \$ | 11,473,928 |
| | | | | | | | | | | | | | | |
| 00 Tetal Day Cost Daged | | Total Dation | 4 Daysanii | (C 2 Line 4) | | 61,161,915 | | Total Cont | | Ad: (C 21:++ 2) | | 40,790,065 | | |
| Total Per Cost Report Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on wo | arkahaat C 2 I | | | es (G-3 Line 1) | L | 01,101,910 | | rotal Cont | ractual | Adj. (G-3 Line 2) | \vdash | 40,790,000 | | |
| | DIKSHEEL G-3, L | ine 2 (impact is | a decrea | se in het patient | | | | | | | | | | |
| revenue) | | | | | | | | | | | + | 5,676,233 | | |
| 31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCI | LUDED on worl | ksheet G-3, Line | 2 (impad | t is a decrease | | | | | | | 1 | I | | |
| in net patient revenue) | | | | | | | | | | | + | I | | |
| 32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Re | venue INCLUD | ED on workshee | et G-3, Li | ne 2 (impact is | | | | | | | | | | |
| a decrease in net patient revenue) | | | | , , | | | | | | | | 300,007 | | |
| 34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes | INCLUDED on | workshoot C 2 | Lino 2 /in | anact is an | | | | | | | T | 300,007 | | |
| increase in net patient revenue) | INCTODED OIL | WOLKSHEEL G-2 | Line Z (iii | ilpact is all | | | | | | | 1 | | | |
| · | | | | | | | | | | | - | | | |
| 35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Ch | | rges related to in | nsured pa | atients | | | | | | | | 1 | | |
| INCLUDED on worksheet G-3, Line 2 (impact is an increase in net pa | tient revenue)" | | | | | | | | | | -1 | | | |
| 35. Adjusted Contractual Adjustments | | | | | | | | | | | | 46,766,305 | | |
| 2-10% | | | | | | | | | | | | | | |
| 36. Unreconciled Difference | | Unreconciled D | ifference | (Should be \$0) | \$ | | | Unreconciled Di | fference | e (Should be \$0) | \$ | - | | |

G. Cost Report - Cost / Days / Charges

| Cost Report Year (01/01/2019-12/31/2019) | CANDLER COUNTY HOSPITAL |
|--|-------------------------|

| NOTE: | ine # Cost Center Description | Total Allowable Cost | Intern & Resident Costs Removed on Cost Report * | RCE and Therapy Add-Back (If Applicable) | | Total Cost | VP Days and VP Ancillary Charges | I/P Routine Charges and O/P Ancillary Charges | Total Charges | Medicald Per Diem / Cost or Other Ratios |
|---|--|---|---|--|--|---|--|--|--|--|
| hospital. comple hospital data shoul | All data in this section must be verified by the If data is already present in this section, it was eted using CMS HCRIS cost report data. If the has a more recent version of the cost report, the ld be updated to the hospital's version of the cost ormulas can 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 Worksheel 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 |
| | outine Cost Centers (list below): | | | | | | | | · | |
| _ | 3000 ADULTS & PEDIATRICS | \$ 2,070,387 | | \$ - | \$1,037,433.00 | | 1,850 | \$0.00 | STATE OF THE PARTY | \$ 558.35 |
| | 3100 INTENSIVE CARE UNIT | \$ 663,657 | | \$ - | No. of Concession, Name of Street, or other party of the last of t | \$ 663,657 | 250 | \$0.00 | MG CONT. H | \$ 2,654.63 |
| | 3200 CORONARY CARE UNIT | \$ - | | \$ - | | \$ - | · · | \$0.00 | División in a | \$ - |
| | 3300 BURN INTENSIVE CARE UNIT | - | \$ - | \$ - | | \$ - | - | \$0.00 | | \$ - |
| | 3400 SURGICAL INTENSIVE CARE UNIT | - | \$ - | \$ - | | \$ - | | \$0.00 | | \$ - |
| 1 | 3500 OTHER SPECIAL CARE UNIT | \$ - | | \$ - | | \$ - | - | \$0.00 | | \$ - |
| | 4000 SUBPROVIDER I | \$ - | \$ - | \$ - | | \$ - | - | \$0.00 | | \$ - |
| | 4100 SUBPROVIDER II | \$ - | | \$ - | | \$ - | | \$0.00 | | \$ - |
| | 4200 OTHER SUBPROVIDER | \$ - | | \$ - | | \$ - | | \$0.00 | Name of Street | \$ - |
| | 4300 NURSERY | \$ - | | \$ - | | \$ - | - | \$0.00 | | \$ - |
| 11 | | \$ - | \$ - | \$ - | THE THE PROPERTY. | \$ - | - | \$0.00 | THE PROPERTY IN | \$ - |
| 12 | | \$ - | \$ - | \$ - | | \$ - | - | \$0.00 | | \$ - |
| 13 | | \$ - | \$ - | \$ - | THE RESERVE | \$ - | | \$0.00 | ALTERNATION AND PARTY. | \$ - |
| 14 | | \$ - | \$ - | \$ - | DESCRIPTION OF REAL PROPERTY. | \$ - | | \$0.00 | THE REAL PROPERTY. | \$ - |
| 15 | | \$ - | \$ - | \$ - | | \$ - | - | \$0.00 | SHOUTH THESE | \$ - |
| 16 | | \$ - | | \$ - | | \$ - | - | \$0.00 | THE REAL PROPERTY. | \$ - |
| 17 | | \$ - | \$ - | \$ - | ECHESS CENT | \$ - | | \$0.00 | STATE OF STREET | \$ - |
| 18 19 | Total Routine Weighted Average | \$ 2,734,044 | \$ - | \$ - | \$ 1,037,433 | \$ 1,696,611 | 2,100 | \$ - | | \$ 807.91 |
| 19 | vveigilled Average | | | | | | | | | \$ 007.91 |
| | | | Hospital | College | | | | | | |
| O | hservation Data (Non-Distinct) | | 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 |
| - | bservation Data (Non-Distinct) | Ī | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02 | Diems Above Multiplied by Days) | Cost Report Worksheet C, Pt. I, Col. 6 | - Cost Report Worksheet C, Pt. I, Col. 7 | Cost Report Worksheet C, Pt. I, Col. 8 | Cost-to-Charge Ratio |
| | bservation Data (Non-Distinct) 200 Observation (Non-Distinct) | Í | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02 | Diems Above | Cost Report Worksheet C, Pt. I, | - Cost Report Worksheet C, Pt. I. | Cost Report Worksheet C, Pt. I, | |
| - | | Cost Report Worksheet B, Part I, Col. 26 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02 | Diems Above Multiplied by Days) | Cost Report Worksheet C, Pt. I, Col. 6 | - Cost Report Worksheet C, Pt. I, Col. 7 | Cost Report Worksheet C, Pt. I, Col. 8 | Cost-to-Charge Ratio |
| 20 09 | Observation (Non-Distinct) | Worksheet B, Part I, Col. 26 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8 929 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, Col. 8 Cost Report Worksheet C. Part I, Col. 2 and | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02 | Diems Above Multiplied by Days) \$ 518,707 | Cost Report Worksheet C, Pt. I. Col. 6 \$71,645.00 Inpatient Charges Cost Report Worksheet C, Pt. I. | Cost Report Worksheet C, Pt I, Col. 7 \$1,641,185.00 Outpatient Charges - Cost Report Worksheet C, Pt I, | Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,712,830 Total Charges - Cost Report Worksheet C, Pt. I, | Cost-to-Charge Ratio 0.302836 Medicaid Calculated |
| 20 <u>09</u> | Observation (Non-Distinct) ncillary Cost Centers (from W/S C excluding Obser | Worksheet B, Part I, Col. 26 vation) (list below): | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8 929 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)* | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, Col. 8 Cost Report Worksheet C. Part I, Col. 2 and Col. 4 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02 | Diems Above Multiplied by Days) \$ 518,707 Calculated | Cost Report Worksheet C, Pt. I. Col. 6 \$71,645.00 inpatient Charges Cost Report Worksheet C, Pt. I. Col. 6 | Cost Report Worksheet C, Pt I, Col. 7 \$1,641,185.00 Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 | Cost Report Worksheet C, Pt. I, Col. 8 \$ 1.712,830 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 | 0.302836 0.302836 Medicaid Calculated Cost-to-Charge Ratio |
| 20 <u>09</u> | ozoo Observation (Non-Distinct) noillary Cost Centers (from W/S C excluding Obser | Worksheet B, Part I, Col. 26 vation) (list below): \$866,459.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8 929 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONL Y)* | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, Col. 8 Cost Report Worksheet C, Part I, Col. 2 and Col. 4 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02 | Diems Above Multiplied by Days) \$ 518,707 Calculated \$ 866,459 | Cost Report Worksheet C, Pt. I. Col. 6 \$71,645.00 Inpatient Charges Cost Report Worksheet C, Pt. I. Col. 6 \$90,877.00 | Cost Report Worksheet C, Pt. I. Col. 7 \$1,641,185.00 Outpatient Charges - Cost Report Worksheet C, Pt. I. Col. 7 \$5,147,081.00 | Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,712,830 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 5,237,958 | Cost-to-Charge Ratio 0.302836 Medicaid Calculated Cost-to-Charge Ratio 0.165419 |
| 20 | ozoo Observation (Non-Distinct) ncillary Cost Centers (from W/S C excluding Observation (Non-Distinct) | Worksheet B, Part I, Col. 26 vation) (list below): \$866,459.00 \$1,444,517.00 | Observation Days - Cost Report W/S S- 3, Pt 1, Line 28, Col. 8 929 Cost Report Worksheet B, Part 1, Col. 25 (Intern & Resident Offset ONLY)* | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, Col. 8 Cost Report Worksheet C, Part I, Col. 2 and Col. 4 \$0.00 \$0.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02 | Diems Above Multiplied by Days) \$ 518,707 Calculated \$ 866,459 \$ 1,444,517 | Cost Report Worksheet C, Pt. 1, Col. 6 \$71,645.00 Inpatient Charges Cost Report Worksheet C, Pt. 1, Col. 6 \$90,877.00 \$619,158.00 | Cost Report Worksheet C, Pt I, Col. 7 \$1,641,185.00 Outpatient Charges - Cost Report Worksheet C, Pt I, Col. 7 \$5,147,081.00 \$12,000,127.00 | Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,712,830 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 5,237,958 \$ 12,619,285 | Cost-to-Charge Ratio 0.302836 Medicaid Calculated Cost-to-Charge Ratio 0.165419 0.114469 |
| 20 | ocillary Cost Centers (from W/S C excluding Observation (Non-Distinct) OPERATING ROOM ARDIOLOGY-DIAGNOSTIC BO LABORATORY | Worksheet B, Part I, Col. 26 vation) (list below): \$866,459.00 \$1,444,517.00 \$1,204,141.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8 929 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONL Y)* | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28:01, Col. 8 Cost Report Worksheet C, Part I, Col. 2 and Col. 4 \$0.00 \$0.00 \$0.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02 | Diems Above Multiplied by Days) \$ 518,707 Calculated \$ 866,459 \$ 1,444,517 \$ 1,204,141 | Cost Report Worksheet C, Pt. 1, Col. 6 \$71,645.00 Inpatient Charges Cost Report Worksheet C, Pt. 1, Col. 6 \$90,877.00 \$619,158.00 \$1,014,974.00 | Cost Report Worksheet C, Pt I, Col. 7 \$1,641,185.00 Outpetient Charges - Cost Report Worksheet C, Pt I, Col. 7 \$5,147,081.00 \$12,000,127.00 \$10,157,601.00 | Cost Report Worksheet C, Pt. I, Col. 8 \$ 1.712,830 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 5,237,958 \$ 12,619,285 \$ 11,172,575 | Cost-to-Charge Ratio 0.302836 Medicaid Calculated Cost-to-Charge Ratio 0.165419 0.114469 0.107776 |
| 20 | ncillary Cost Centers (from W/S C excluding Obsertion Operating ROOM 50 OPERATING ROOM 54 RADIOLOGY-DIAGNOSTIC 60 LABORATORY 65 RESPIRATORY THERAPY | Worksheet B, Part I, Col. 26 vation) (list below): \$866,459.00 \$1,444,517.00 \$1,204,141.00 \$259,711.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8 929 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)* \$ - \$ - \$ - \$ - \$ - | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, Col. 8 Cost Report Worksheet C, Part I, Col. 2 and Col. 4 \$0.00 \$0.00 \$0.00 \$0.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02, Col. 8 | Diems Above Multiplied by Days) \$ 518,707 Calculated \$ 866,459 \$ 1,444,517 \$ 1,204,141 \$ 259,711 | Cost Report Worksheet C, Pt. I, Col. 6 \$71,645.00 Inpatient Charges Cost Report Worksheet C, Pt. I, Col. 6 \$90,877.00 \$619,158.00 \$1,014,974.00 \$580,151.00 | Cost Report Worksheet C, Pt I, Col. 7 \$1,641,185.00 Outpatient Charges - Cost Report Worksheet C, Pt I, Col. 7 \$5,147,081.00 \$12,000,127.00 \$10,157,601.00 \$429,791.00 | Cost Report Worksheet C, Pt. I, Col. 8 \$ 1.712,830 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 5,237,958 \$ 12,619,285 \$ 11,172,575 \$ 1,009,942 | 0.302836 Medicaid Calculated Cost-to-Charge Ratio 0.165419 0.114469 0.107776 0.257154 |
| 20 | ncillary Cost Centers (from W/S C excluding Obser 50 OPERATING ROOM 54 RADIOLOGY-DIAGNOSTIC 60 LABORATORY 65 RESPIRATORY THERAPY 66 PHYSICAL THERAPY | vation) (list below): \$866,459.00 \$1,444,517.00 \$1,204,141.00 \$259,711.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8 929 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONL Y)* \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, Col. 8 Cost Report Worksheet C, Part I, Col. 2 and Col. 4 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02, Col. 8 | Diems Above Multiplied by Days) \$ 518,707 Calculated \$ 866,459 \$ 1,444,517 \$ 1,204,141 \$ 259,711 \$ 585,497 | Cost Report Worksheet C, Pt. I. Col. 6 \$71,645.00 Inpatient Charges Cost Report Worksheet C, Pt. I. Col. 6 \$90,877.00 \$619,158.00 \$1,014,974.00 \$580,151.00 \$513,691.00 | Cost Report Worksheet C, Pt. I, Col. 7 \$1,641,185.00 Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$5,147,081.00 \$12,000,127.00 \$10,157,601.00 \$429,791.00 \$5585,984.00 | Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,712,830 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 5,237,958 \$ 12,619,285 \$ 11,172,575 \$ 1,009,942 \$ 1,099,675 | 0.302836 Medicaid Calculated Cost-to-Charge Ratio 0.165419 0.114469 0.107776 0.257154 0.532427 |
| 20 | ncillary Cost Centers (from W/S C excluding Observation (Non-Distinct) sol Operating ROOM 4 RADIOLOGY-DIAGNOSTIC 50 LABORATORY 65 RESPIRATORY THERAPY 66 PHYSICAL THERAPY 67 OCCUPATIONAL THERAPY | vation) (list below): \$866,459.00 \$1,444,517.00 \$1,204,141.00 \$259,711.00 \$585,497.00 | Observation Days - Cost Report W/S S- 3, Pt 1, Line 28, Col. 8 929 Cost Report Worksheet B, Part 1, Col. 25 (Intern & Resident Offset ONL Y)* \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, Col. 8 Cost Report Worksheet C, Part I, Col 2 and Col. 4 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02, Col. 8 | Diems Above Multiplied by Days) \$ 518,707 Calculated \$ 866,459 \$ 1,444,517 \$ 1,204,141 \$ 259,711 \$ 585,497 \$ 86,355 | Cost Report Worksheet C, Pt. 1, Col. 6 \$71,645.00 Inpatient Charges Cost Report Worksheet C, Pt. 1, Col. 6 \$90,877.00 \$619,158.00 \$1,014,974.00 \$580,151.00 \$513,691.00 \$129,042.00 | Cost Report Worksheet C, Pt I, Col. 7 \$1,641,185.00 Outpatient Charges - Cost Report Worksheet C, Pt I, Col. 7 \$5,147,081.00 \$12,000,127.00 \$10,157,601.00 \$429,791.00 \$585,984.00 \$17,187.00 | Cost Report Worksheet C, Pt. I, Col. 8 \$ 1.712,830 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 5,237,958 \$ 12,619,285 \$ 11,172,575 \$ 1,009,627 \$ 1,099,675 \$ 146,229 | 0.302836 Medicaid Calculated Cost-to-Charge Ratio 0.165419 0.114469 0.107776 0.257154 0.532427 0.590546 |
| 20 | ncillary Cost Centers (from W/S C excluding Observation (Non-Distinct) 100 OPERATING ROOM 101 RADIOLOGY-DIAGNOSTIC 102 LABORATORY 103 RESPIRATORY THERAPY 104 PHYSICAL THERAPY 105 RECOUPATIONAL THERAPY 105 RESPIRATORY THERAPY 105 COUPATIONAL THERAPY 105 OCCUPATIONAL THERAPY 105 SPEECH PATHOLOGY | Worksheet B, Part I, Col. 26 vation) (list below): \$866,459.00 \$1,444,517.00 \$1,204,141.00 \$259,711.00 \$585,497.00 \$86,355.00 \$3,819.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8 929 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONL Y)* \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28:01, Col. 8 Cost Report Worksheet C, Part I, Col. 2 and Col. 4 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02, Col. 8 | Diems Above Multiplied by Days) \$ 518,707 Calculated \$ 866,459 \$ 1,444,517 \$ 1,204,141 \$ 259,711 \$ 585,497 \$ 86,355 \$ 3,819 | Cost Report Worksheet C, Pt. 1, Col. 6 \$71,645.00 Inpatient Charges Cost Report Worksheet C, Pt. 1, Col. 6 \$90,877.00 \$619,158.00 \$1,014,974.00 \$580,151.00 \$513,691.00 \$129,042.00 \$4,818.00 | Cost Report Worksheet C, Pt. I, Col. 7 \$1,641,185.00 Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$5,147,081.00 \$12,000,127.00 \$10,157,601.00 \$429,791.00 \$585,984.00 \$17,187.00 \$5,785.00 | Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,712,830 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 5,237,958 \$ 12,619,285 \$ 11,172,575 \$ 1,009,942 \$ 1,099,675 \$ 146,229 \$ 10,603 | 0.302836 Medicaid Calculated Cost-to-Charge Ratio 0.165419 0.114469 0.107776 0.257154 0.532427 0.590546 0.360181 |
| 20 | ncillary Cost Centers (from W/S C excluding Observation (Non-Distinct) sol Operating ROOM 4 RADIOLOGY-DIAGNOSTIC 50 LABORATORY 65 RESPIRATORY THERAPY 66 PHYSICAL THERAPY 67 OCCUPATIONAL THERAPY | vation) (list below): \$866,459.00 \$1,444,517.00 \$1,204,141.00 \$259,711.00 \$585,497.00 | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8 929 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)* \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ | Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, Col. 8 Cost Report Worksheet C, Part I, Col 2 and Col. 4 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 | Observation Days Cost Report W/S S- 3, Pt. I, Line 28.02, Col. 8 | Diems Above Multiplied by Days) \$ 518,707 Calculated \$ 866,459 \$ 1,444,517 \$ 1,204,141 \$ 259,711 \$ 585,497 \$ 86,355 | Cost Report Worksheet C, Pt. 1, Col. 6 \$71,645.00 Inpatient Charges Cost Report Worksheet C, Pt. 1, Col. 6 \$90,877.00 \$619,158.00 \$1,014,974.00 \$580,151.00 \$513,691.00 \$129,042.00 | Cost Report Worksheet C, Pt. I, Col. 7 \$1,641,185.00 Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$5,147,081.00 \$12,000,127.00 \$10,157,601.00 \$429,791.00 \$585,984.00 \$17,187.00 \$5,785.00 | Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,712,830 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 5,237,958 \$ 12,619,285 \$ 11,172,575 \$ 1,009,942 \$ 1,099,675 \$ 146,229 \$ 10,603 \$ 888,751 | 0.302836 Medicaid Calculated Cost-to-Charge Ratio 0.165419 0.114469 0.107776 0.257154 0.532427 0.590546 |

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2019-12/31/2019) CANDLER COUNTY HOSPITAL

| Line # | Cost Center Description | Total Allowabie Cost | Intern & Resident Costs Removed on Cost Report * | | Total | Cost | VP Days and VP | VP Routine Charges and O/P Ancillary Charges | Total Charges | Medicald Per Diem / Cost or Other Ratios |
|-----------|--------------------------|-------------------------|--|------------------|----------------|-----------|------------------|--|---------------|---|
| | RUGS CHARGED TO PATIENTS | \$818,146.00 | | \$0.00 | berendinger \$ | 818,146 | \$2,283,108.00 | \$3,796,756.00 | | 0.134566 |
| | MERGENCY | \$2,156,708.00 | | \$0.00 | | 2,156,708 | \$89,000.00 | \$5,642,832.00 | | 0.376269 |
| | | \$0.00 | | \$0.00 | \$ | - | \$0.00 | \$0.00 | | - 0.010200 |
| | | \$0.00 | | \$0.00 | \$ | -1 | \$0.00 | \$0.00 | | |
| | | \$0.00 | | \$0.00 | \$ | - | \$0.00 | \$0.00 | | |
| \vdash | | \$0.00 | | \$0,00 | \$ | - | \$0.00 | \$0.00 | | - |
| \vdash | | \$0.00 \$0.00 | \$ - | \$0.00 \$0.00 | \$ | - | \$0.00 \$0.00 | \$0.00 \$0.00 | | |
| \vdash | | \$0.00 | | \$0.00 | \$ | | \$0.00 | | \$ - | - |
| \vdash | | \$0.00 | \$ - | \$0.00 | \$ | - | \$0.00 | \$0.00 | | |
| | | | \$ - | \$0.00 | \$ | - 1 | \$0,00 | \$0.00 | | - |
| | | \$0.00 | \$ - | \$0.00 | \$ | - | \$0.00 | \$0.00 | \$ - | - |
| | | | \$ - | \$0.00 | \$ | 1 | \$0.00 | \$0.00 | | - |
| | | \$0.00 | | \$0.00 | \$ | - | \$0.00 | \$0.00 | | <u> </u> |
| \vdash | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | - |
| \vdash | | \$0.00 | | \$0.00 | \$ | | \$0.00 | | \$ - | |
| - | | | \$ - | \$0.00 \$0.00 | \$ | | \$0.00 \$0.00 | \$0.00 \$0.00 | | - |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | <u>-</u> |
| \vdash | | \$0.00 | \$ - | \$0.00 | \$ | | \$0.00 | \$0.00 | | - |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | |
| | | | \$ - | \$0.00 | \$ | | \$0.00 | | \$ - | |
| | | \$0.00 | \$ - | \$0.00 | \$ | - | \$0.00 | \$0.00 | \$ - | |
| | | \$0.00 | | \$0.00 | \$ | - 1 | \$0.00 | \$0.00 | \$ - | - |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | | \$ - | |
| | | \$0.00 | | \$0.00 | \$ | - | \$0.00 | \$0.00 | | - |
| | | \$0.00 | | \$0.00 | \$ | - | \$0.00 | \$0.00 | | - |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | | \$ - | |
| \vdash | | \$0.00 \$0.00 | \$ - | \$0.00 \$0.00 | \$ | - | \$0.00 \$0.00 | \$0.00 \$0.00 | | - |
| - | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | |
| | | | \$ - | \$0.00 | \$ | - | \$0.00 | \$0.00 | | |
| | - | \$0.00 | | \$0.00 | \$ | | \$0.00 | | \$ - | |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | |
| | | \$0.00 | \$ - | \$0,00 | \$ | - 1 | \$0,00 | \$0,00 | \$ - | |
| | | \$0.00 | | \$0,00 | \$ | - | \$0.00 | \$0.00 | | |
| | | | \$ - | \$0,00 | \$ | - | \$0.00 | \$0.00 | | |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | - |
| | | \$0.00 | \$ - | \$0.00 | \$ | - | \$0.00 | \$0.00 | | |
| + | | | \$ - \$ - | \$0.00 \$0.00 | \$ | | \$0.00 \$0.00 | \$0.00 \$0.00 | | <u> </u> |
| | | | \$ - | \$0.00 | \$ | - | \$0.00 | | \$ - | |
| - | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | |
| | | \$0.00 | | \$0.00 | \$ | - | \$0.00 | \$0,00 | | |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | |
| | | \$0.00 | \$ - | \$0.00 | \$ | - 1 | \$0.00 | \$0.00 | \$ - | |
| | | | \$ - | \$0.00 | \$ | - | \$0.00 | \$0.00 | \$ - | - |
| | | \$0.00 | | \$0.00 | \$ | - | \$0,00 | \$0.00 | | - |
| | | \$0.00 | | \$0.00 | \$ | - | \$0.00 | \$0.00 | | - |
| | | \$0.00 | | \$0,00 | \$ | | \$0.00 | \$0.00 | | - |
| | | \$0.00 | | \$0,00 | \$ | | \$0.00 | \$0.00 | | - |
| | | | \$ - | \$0.00 | \$ | - | \$0.00 | \$0.00 | | |
| | | \$0.00 \$0.00 | | \$0.00 \$0.00 | \$ \$ | | \$0.00 \$0.00 | \$0.00 \$0.00 | | - |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | |
| - | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | |
| | | \$0.00 | | \$0.00 | \$ | | \$0.00 | \$0.00 | | |

39 90

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2019-12/31/2019) CANDLER COUNTY 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 | UP Routine Charges and O/P Ancillary Charges | Total Charges | Medicald Per Blem / Gost or Other Ratics |
|-----------|--|----------------------------|--|--|-------------------------------|---------------------------------------|--|---------------|---|
| | | \$0.00 | \$ -1 | \$0.00 | \$ - | \$0.00 | \$0.00 | \$ - | T |
| | | \$0.00 | \$ - | \$0.00 | - \$ | \$0.00 | \$0.00 | \$ - | - |
| | | \$0.00 | | \$0.00 | - \$ | \$0.00 | \$0.00 | \$ - | - |
| | | \$0.00 | | \$0.00 | - \$ | \$0.00 | \$0.00 | | |
| | | \$0.00 | | \$0.00 | - | \$0.00 | \$0.00 | | - |
| | | \$0.00 | \$ - | \$0.00 | - | \$0.00 | \$0.00 | | |
| | | \$0.00 | | \$0.00 | - | \$0.00 | \$0.00 | | - |
| | | \$0.00 | | \$0.00 | \$ - | \$0.00 | \$0.00 | | - |
| _ | | | \$ - | \$0.00 \$0.00 | \$ - | \$0.00 | \$0.00 | | - |
| | | | | \$0.00 | \$ - | \$0.00 \$0.00 | \$0.00 \$0.00 | | - |
| | | \$0.00 | | \$0.00 | \$ - | \$0.00 | \$0.00 | | - |
| | | | \$ - | \$0.00 | \$ - | \$0.00 | \$0.00 | | |
| _ | | \$0.00 | \$ - | \$0.00 | \$ - | \$0.00 | | \$ - | |
| | | \$0.00 | | \$0.00 | \$ - | \$0.00 | \$0.00 | | |
| | | | \$ - | \$0.00 | \$ - | \$0.00 | \$0.00 | | |
| | | | \$ - | \$0.00 | \$ - | \$0.00 | \$0.00 | | |
| | | \$0.00 | \$ - | \$0.00 | \$ - | \$0.00 | \$0.00 | | |
| | | | \$ - | \$0.00 | \$ - | \$0.00 | | \$ - | - |
| | | \$0.00 | \$ - | \$0.00 | \$ - | \$0.00 | \$0.00 | \$ - | |
| | | \$0,00 | \$ - | \$0.00 | \$ - | \$0.00 | \$0.00 | \$ - | - |
| | | \$0,00 | \$ - | \$0.00 | \$ - | \$0,00 | \$0.00 | \$ - | - 1 |
| | | \$0.00 | \$ - | \$0.00 | \$ - | \$0.00 | \$0.00 | \$ - | - 1 |
| | | \$0.00 | | \$0.00 | \$ - | \$0.00 | | \$ - | - |
| | | \$0.00 | | \$0.00 | \$ - | \$0.00 | \$0.00 | | - |
| | | \$0.00 | \$ - | \$0.00 | \$ - | \$0.00 | \$0.00 | | |
| | | \$0.00 | \$ - | \$0.00 | \$ - | \$0.00 | \$0.00 | | |
| | | \$0.00 | | \$0.00 | \$ - | \$0.00 | \$0.00 | | - |
| | | | | \$0.00 | \$ - | \$0.00 | | \$ - | - |
| | | \$0.00 | | \$0.00 | \$ - | \$0.00 | \$0.00 | | - |
| | | \$0.00 | | \$0.00 | \$ - | \$0.00 | \$0.00 | | - |
| | | | | \$0.00 | - | \$0.00 | | \$ - | |
| - | | \$0.00 | | \$0.00 \$0.00 | - | \$0.00 | \$0.00 | | - |
| | | \$0.00 | | \$0.00 | \$ - \$ - | \$0.00 \$0.00 | \$0.00 \$0.00 | | - |
| | | | | | | | | | - 1 |
| | Total Ancillary | \$ 8,831,114 | \$ - | - | \$ 8,831,114 | \$ 6,301,334 | \$ 43,017,392 | \$ 49,318,726 | |
| | Weighted Average | | | | | | | | 0.189579 |
| | Sub Totals F, SNF, and Swing Bed Cost for Medicaid (Orksheet D, Part V, Title 19, Column 5-7, L | | | | \$ 10,527,725 \$554,273.00 | \$ 6,301,334 | \$ 43,017,392 | \$ 49,318,726 | MATTER NE |
| NF | F, SNF, and Swing Bed Cost for Medicare or orksheet D, Part V, Title 18, Column 5-7, L | Sum of applicable Cost R | eport Worksheet D-3, | Title 18, Column 3, Line 200 and | \$2,112,272.00 | | | | |
| NF | , SNF, and Swing Bed Cost for Other Pay | ers (Hospital must calcula | te. Submit support for a | calculation of cost.) | | | | | |
| | her Cost Adjustments (support must be sul | | | , | | | | | |
| Oti | Grand Total | Jimed) | | | ¢ 7.004.400 | l | | | |
| | Grand Total | | | | \$ 7,861,180 | | | | |
| _ | tal Intern/Resident Cost as a Percent of O | | | | 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:

| et Record Year (01/01/2019-12/31/2019) | CANDLER COUNTY | THE STATE OF THE S | And a second | 170 A | | | | FS Cipes Overs (with | | dous Eightes (Na | 為必查 | | | |
|---|--|--|--|--|--------------------------------------|---|--|---|---|--|--|---|--|--|
| ine # Cost Center Description | Reclicate Per Diem Cost for Routine Cost Centers | Medicald Cost to Charge Ratio for Ancillary Cost Centers | Inpatient | Outpatient | In-State Medicald // | Outpatient | Inpatient | Outpatient | Inputient | Outpatient | inpatient (See Exhibit A) | Outpallent (See Exhibit A) | Total In St | Outpatient |
| | From Section G | From Section 6 | 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 FS&R Summery (Note A) | From PS&R Summery (Note A) | From PS&R Summary (Note A) | From PS&R Summery (Note A) | From Hospitel's Own Internet Analysis | From Hospital's Own Internal Analysis | | |
| Judine Cost Centers (from Section G): DOD ADULTS & PEDIATRICS DOD INTENSIVE CARE UNIT COC CORONARY CARE UNIT COC CORONARY CARE UNIT COC CORONARY CARE UNIT COC UNITENSIVE CARE UNIT COC UNITENSIVE CARE UNIT COC OTHER SPECIAL CARE UNIT COC OTHER SPECIAL CARE UNIT COC UNITENSIVE CARE UNIT COC OTHER SUBPROVIDER COC OTHER SUBPROVIDER NURSERY | \$ 558,35 \$ 2,654 63 \$ | | Days 173 45 | | Days 5. 1. | | Days 97 63 | | Days 5 2 | | Days 94 27. | | Days 280 1111 | |
| al Days per PS&R or Exhibit Detail Unreconciled Days (f | | Total Days | 218 | | 6 | | 160 | | 7 | | 121 | | 391 | |
| Routine Charges Calculated Routine Charge Per Diem | | | Routine Charges \$ 264,533 \$ 1,213,45 | | Routine Charges \$ 5,446 \$ 907.67 | | Routine Charges \$ 251.250 \$ 1,570.31 | | Routine Charges \$ 9.858 \$ 1,408.29 | | Routine Charges \$ 74,435 \$ 615.17 | | Routine Charges \$ 531,087 \$ 1,358,28 | |
| sillary Cost Centers (from Wis C) (from Section O) Observation (Non-Dissino) S0 OPERATING ROOM S1 RADIOLOGY-DIAGNOSTIC 60 LABORATORY 65 RESPIRATORY THERAPY 68 PHYSICAL THERAPY 67 OCCUPATIONAL THERAPY 68 SEECH PATHOLOGY 69 SEEECH PATHOLOGY 69 SEEECH PATHOLOGY 71 MEDICAL SUPPLIES CHARGED TO PATIENTS 73 DRUGS CHARGED TO PATIENTS 73 DRUGS CHARGED TO PATIENTS 91 EMERGENCY | | 0.302836 0.165419 0.114469 0.107776 0.257154 0.532427 0.590548 0.360181 0.226340 0.334574 0.054842 0.134566 0.376259 | Ancillary Charges 11,895 11,895 12,9595 226,094 62,635 8,269 4,387 7,99 12,850 67,595 212,930 53,280 | Ancillary Charges 611,985 470,193 720,280 19,889 336 31,935 326,258 46 108,432 329,657 | Ancillary Charges 3 478 2 2353 9 289 | Ancillary Charges 3,838 546,689 715,920 748,890 16,618 10,705 | Ancillary Charges 5,646 15,865 70,629 166,010 64,924 7,281 292 758 4,404 55,768 224,206 15,188 | Ancillary Charges 990,799 6900,197 1,743,642 1,145,190 1313,386 36,683 2,337 233 145,605 462,750 92 566,204 844,076 | Ancillary Charges 1,584 9,249 5,688 181 | Ancillary Charges 410,625 907,853 849,522 40,447 28,488 542 542 29,53 2237,489 261,683 | Ancillary Charges 8.805 21.118 90,360 114.839 10.469 292 | 203.107 1.420.316 965.923 42.477 13.190 3.306 98.054 271.787 23.3 386.256 1.331.999 | Andilary Charges \$ 22,839 \$ 31,548 \$ 31,548 \$ 407,081 \$ 127,740 \$ 15,570 \$ 467,081 \$ 15,570 \$ 1,557 \$ 17,580 \$ 12,7237 \$ 1,587 \$ 1,7890 \$ 172,237 \$ 1,587 \$ 1, | Aneillary Charges 3 575,46 58 5 75,46 76 5 2,169 665 5 2,169 665 5 3,857 664 5 3,857 664 5 3,857 664 5 195,457 665 5 233 5 195,457 665 5 233 5 195,457 665 5 233 5 233 65 5 235 65 5 23 |

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

Cool Report Year (\$1,01,0019-12,31,0011) CANDLER COUNTY HOSPITAL

| | | | | | | | | Iti-State Medicare F | FS Cross-Overs (with | Jin Stille Office Mc | dicad Eligelis (No. | 古居里生 | | | |
|---------------|--|--|-------------|-------------|-----------------|--------------------|----------------------|----------------------|----------------------|----------------------|---------------------|------|-----------|------------|---------------|
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| - | | E-1 | | | | | | | | | | | | \$. | \$ - |
| | | | · · | - | | | | | - | | | | | \$ - | 5 - |

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

CONTRIBUTE YES AUTOMOTIVE TO THE COUNTY HOSPITAL

| | Totals / Payments | in State Medicale FFS P | tenary inst | State Medical I Managed Calle Plynary | In-State Medicars FFS C Medicard Seco | | in State Char Midical Eliginis (No. | Unnured | Total in State Medicad |
|------------|--|--|-------------------------|---------------------------------------|--|------------------|-------------------------------------|--|--------------------------------|
| | | | | | | | | | |
| 128 | Total Charges (includes organ acquisition from Section J) | \$ 1,070,424 \$ | 2,689,359 \$ | 32,442 \$ 3,614,421 | \$ 883,281 \$ | 6,059,143 | \$ 36,223 \$ 3,108,554 | \$ 503,365 \$ 4,855,197 \$ (Agrees to Exhibit A) (Agrees to Exhibit A) | 2,022,371 \$ 15,471,477 46.34% |
| 129 130 | Total Charges per PS&R or Exhibit Detail Unreconciled Charges (Explain Variance) | \$ 1,070,424 \$ | 2,689.359 \$ | 32,442 S 3,614,421 | \$ 883,281 S | 6,059,143 | \$ 36,223 \$ 3,108,554 | \$ 503,365 \$ 4,855,197 | |
| | | | | | | | | | |
| 131 | Total Calculated Cost (includes organ acquisition from Section J) | \$ 359,077 \$ | 518,789 \$ | 10,562 \$ 789,931 | \$ 328,636 \$ | 1,174,635 | \$ 12,418 \$ 536,965 | \$ 198,758 \$ 1,024,076 \$ | 710,693 \$ 3,020,320 63.02% |
| 132 | Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down) | \$ 302,319 \$ | 484.912 | | \$ 37,529 \$ | 431,966 | \$ 23,586 | | 339,848 \$ 940,464 |
| 133 | Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E) | | 3 | 20,128 \$ 604,650 | | | \$ 277 \$ 9,973 | \$ | 20.405 \$ 614.623 |
| 134 | Private Insurance (including primary and third party liability) | | | | | | \$ 9.063 \$ 76,082 | 5 | 9.063 \$ 76.082 |
| 135 | Self-Pay (including Co-Pay and Spend-Down) | S | 1,476 | \$ 3,244 | \$ | 1.826 | | 5 | - \$ 6.546 |
| 136 | Total Allowed Amount (rom Medicaid PS&R or RA Detail (All Payments) | \$ 302,319 \$ | 486,388 \$ | 20,128 \$ 607,894 | | | | | |
| 137 | Medicaid Cost Settlement Payments (See Note 8) | S | 4,117 | | | | | 2 | - \$ 4,117 |
| 138 | Other Medicaid Payments Reported on Cost Report Year (See Note C) | | | | | | | \$ | - s - |
| 139 | Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) | | | | \$ 250,315 \$ | 662,947 | | 5 | 250,315 \$ 662,947 |
| 140 | Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles) | | | | | | \$ 332,742 | \$ | - \$ 332,742 |
| 141 | Medicare Cross-Over Bad Debt Payments | | | | \$ 10,392 \$ | 89,643 | | [Agrees to Exhibit B and [Agrees to Exhibit B and] | 10,392 \$ 89,643 |
| 142 | Other Medicare Cross-Over Payments (See Note D) | | | | | | | B-1) B-1) \$ | - 8 - |
| 143 | Payment from Hospital Uninsured During Cost Report Year (Cash Basis) | | | | | | | \$ 632 \$ 147,566 | |
| 144 | Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits 8 & B-1 (from Se | ction E) | | | | | | s - s - | |
| 145 146 | Calculated Payment Shortfall / (Longfall) {PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH} Calculated Payments as a Percentage of Cost | \$ 56,758 \$ 84% | 28.284 \$ 95% | (9,566) \$ 182,037 191% 77% | \$ 30,400 S | (11,747) 101% | \$ 3.078 \$ 94.582 75% 82% | \$ 198,126 \$ 876,510 \$ 0% 14% | 80,670 \$ 293,156 89% 90% |
| 147 148 | Total Medicare Days from W/IS S-3 of the Cost Report Excluding Swing-Bed (C/R, W/IS S-3, Pt. I, C Percent of cross-over days to total Medicare days from the cost report | col. 6, Sum of Lns. 2, 3, 4, 14, 16, 1 | 7, 18 fess lines 5 & 6) | | 444 36% | | | | |
| | N. A. The second | | | | | | | | |

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 0 - Other Medicaid Payments such as Dutiers and Non-Claim Specific payments. DSH payments should NOT be included. Up Ly payments made on a state fiscal year basis should be reported in Section C of the survey. Note 0 - Should include other Medicaid repayments paid based on the Medicaider corts-over payments paid based on the Medicaid or cost payments paid based on the Medicaid Managed Care payments paid based on the Medicaid Managed Care payments paid based on the Medicaid Managed Care payments payments, capitation and sub-capitation payments.

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

1. Out-of-State Medicaid Data:

9

?1 ?1.01

| Cost Report | Ye ir (01/01/20 19-12/31/261 9) | CANDLER COUNTY | 'HOSPITAL | | | | | | | | | | |
|---|--|--|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|---|---|-------------------------------|----------------------------|---|
| | | Medicaid Per | Medicaid Cost to | Out of State Me | dicald FFS Primary | | icad Managed Care maty | | rare FFS Cross-Overs aid Secoridary) | Out-of-State Other Medicald Eligibles (Not Included Elsewhere) | | Total Out OFState Medicald | |
| Line # | Cost Center Description | Diem Cost for Routine Cost Centers | Charge Ratio for Ancillary Cost Centers | Inpatient | Outpatient | Inpatient | Outpatient | Inpatient | Outpatient | Inputient | Outpatient | Inpatient | Outpatient |
| | | From Section G | From Section G | From PS&R Summary (Note A) | From PS&R Summery (Note A) | From PS&R Summary (Note A) | | |
| Routine Cost | t Centers (list below): | | | Days | | Days | | Days | | Days | | Days | |
| 03100 INTER 03200 CORO 03300 BURN 03400 SURO 03500 OTHE 04000 SUBF 04100 SUBF | LTS & PEDIATRICS NSIVE CARE UNIT ONARY CARE UNIT ONARY CARE UNIT IN INTENSIVE CARE UNIT SICAL INTENSIVE CARE UNIT ER SPECIAL CARE UNIT PROVIDER I ER SUBPROVIDER SERY | \$ 558.35 \$ 2,654.63 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - | | | | | | | | | | | |
| otal Days pe | er PS&R or Exhibit Detail Unreconciled Days | \$ - \$ - \$ - | Total Days | - Routine Charges | | - Routine Charges | | Routine Charges | | Routine Charges | | Routine Charges | |
| | ne Charges lated Routine Charge Per Diem | | <u> </u> | \$ - | | \$ - | | \$ | | \$ - | | \$ - | |
| 09200 Obser 50 OPER 54 RADK 60 LABO 65 RESP 66 PHYS 67 OCCU 68 SPEE 69 ELEC 71 MEDIC 72 IMPL. | st Centers (from W/S C) (list below): vyation (Non-Distinct) AATING ROOM OLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY SICAL THERAPY SICH PATHOLOGY STROCARDIOLOGY DAT COMMISSION OF STROCARDIOLOGY DEV. CHARGED TO PATIENTS SE CHARGED TO PATIENTS RESERVEY | | 0.302836 0.165419 0.114469 0.107776 0.257154 0.532427 0.590546 0.360181 0.26340 0.334974 0.054642 0.134566 0.376269 | Ancillary Charges | Ancillary Charges | Ancillary Charges | Ancillary Charges S | Ancillary Charge \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ |
| | | | - | | | | | | | | | | \$ \$ \$ \$ |
| _ | | OR OTHER DESIGNATION OF THE PERSON NAMED IN | | | | <u> </u> | - | | | | | | S |

I. Out-of-State Medicaid Data:

Cost Report Year (01:01:2019-12/31/2019) GANDLER COUNTY HOSPITAL Out-of-State Medicald Managed Care Primary Out-of-State Medicare FFS Cross-Overs (with filedicard Secondary) Out-of-State Other Medicald Eligibles (Not Included Elsewhere) Out-of-State Medicald FFS Primary Total Out-Of-State Medicald

I. Out-of-State Medicaid Data:

| | Cost Preport Year (91/01/2019 12/31/2019) CANDLER COUNTY HOSPITAL | | | | | |
|------------|---|-----------------------------------|--|--|---|-----------------------------|
| | | Out-of-State Modicaid 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 |
| 112 113 | | | | | | \$ - \$ - |
| 114 | | | | | | \$ - \$ - |
| 115 116 | 1000000 | | | | | \$ - \$ - |
| 117 | | | | | | \$ - \$ |
| 118 | | | | | | s - s - |
| 119 120 | MEDIA! | | | | | \$ - \$ - |
| 121 | | | | | | \$ - \$ |
| 122 | 150 M (S) M | | | | | \$ - \$ - |
| 123 124 | | | | | | \$ - \$ - |
| 125 | | | | | | \$ - \$ |
| 126 | | | | | | \$ - \$ - |
| 127 | | s - s - | \$ \$. | s - s - | s - s - | \$ - \$ - |
| | Totals / Payments | | | | | |
| 128 | Total Charges (includes organ acquisition from Section K) | \$ - \\$ - | \$ - \$ - | \$ - \$ - | \$ - \$ - | \$ - \$ |
| 129 130 | Total Charges per PS&R or Exhibit Detail Unreconciled Charges (Explain Variance) | \$ - \$ - | \$ - \ \\$ - \ \ | \$ - \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | \$ - \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | |
| 131 | Total Calculated Cost (includes organ acquisition from Section K) | \$ - \$ - | \$ - \$ - | \$ - \$ - | \$ - \$ - | \$ - \$ - |
| 132 | Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down) | | | | | \$ - \$ - |
| 133 134 | Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E) 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) | \$ - \$ - | \$ - \$ - | | | The second second |
| 137 | Medicaid Cost Settlement Payments (See Note B) Other Medicaid Payments Reported on Cost Report Year (See Note C) | | | | | \$ - \$ |
| 138 139 | Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) | | | | | 5 - 5 |
| 140 | Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles) | | | | | s - s - |
| 141 | Medicare Cross-Over Bad Debt Payments | | | | | \$ - 5 - |
| 142 | Other Medicare Cross-Over Payments (See Note D) | | | | L | \$ - 5 - |
| 143 144 | Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH) Calculated Payments as a Percentage of Cost | s - s - 0% | S - S - 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

| | Total | Commercial property | | Revenue for | Total | in-State Medicard FFS Primary | | In State Medicals Menaged Care Primary | | In-State Medicare FFS Cross-Divers (with Medicald Secondary) | | In State Other Medical Eligibles (Not noused Elsewhere) | | Unit His Wed | |
|---|---|--|---|--|---|---|--|---|---|---|---|--|---|--|--|
| | Cityan Acquisition Cost | Additional Add-in Interroffesizient Cost | Total Adjusted Organ Adquisition Cost | Medicald/ Cross- Over / Unincured Organs Bold | Organs (Count) | Charges | Useable Organs (Count) | Charges | Useable Organs (Count) | Charges | Useshie Organs (Count) | Charges | Useable Organs (Count) | Charges | Useable Organ (Count) |
| | Cost Report Worsheet D-4 Pt III. Col. 1. Ln 61 | Add-On Cost Factor on Section G. Line 133 x Total Cost Report Organ Acquisition Cost | Sum of Cost Report Organ Acquisition Cost and the Add- On Cost | Similar to Instructions from Cost Report W/S Q-4 Pt. III. Col. 1. Ln 66 (substitute Medicaler with Medicaler Cross Over 8 uninsured). See Note C helow. | Cost Report Worksheet G- 4, Pt. III, Line 62 | From Paid Claims Data or Provider Logs (Note A) | From Feid 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) | Fron: 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 Date or Provider Logs (Note A) | From Hospital's Own Internal Analysis | From Hospita's On Infernal Analysis |
| un Acquisition Cost Centers (list below Lung Acquisition | \$0.00 | s . | s -1 | | 0 | | | | | | | | | | |
| Kidney Acquisition | \$0.00 | | s - | | 0 | | | | | | | | | | |
| | \$0.00 | s - | s - | | 0 | | | | | | | | | | |
| Liver Acquisition | \$0.00 | ls - | s - | | 0 | | | | | | | | | | |
| Liver Acquisition Heart Acquisition | | | | | 0 | | | | | | | | | | |
| | \$0.00 | \$ - | | | | | | | | | | | | | |
| Heart Acquisition | | | \$ - | | 0 | | | L | | | I. | | | 1 | 1 |
| Heart Acquisition Pancreas Acquisition | \$0.00 | 5 | \$ - \$ - | | 0 | | | | | | | | | | |

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 H 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 itable 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

| | Crean Organ Acquismon Gosi | Additional Add-in Intern/Ratidect Cost | Total Adjusted Organ Acquisition Cost | Revenue for Medicald/ Cross- Over / Uninsured Organs Gold | Total Useable Organs (Count) | Our of State Medicaid FES Primary | | Out of State Medicard Managed Care Primary | | Dut of State West one FFS Cross Overs rulin Moreous Secondary) | | Out of State Other Medicard Eighties (feet included Electrone) | |
|--|--|---|---|--|---|---|---|---|---|---|---|--|---|
| | | | | | | Charges | Useable Organs (Count) | Charges | Useable Organs (Count) | Charges | Useable Organs (Count) | Charges | Useable Organs (Count) |
| an Acquisition Cost Centers (list below): | Gosl Report Worksheet D-4, Pt III, Gal 1, En 61 | Asta-On Cost Factor on Section S. Line 133 x Total Cost Report Organ Acquisition Cost | Sum of Cost Report Organ Acquisition Gost and the Add- On Cost | Similar to Instructions from Cost Report W/S D-4 Pt. III. Col. 1. Ln 66 isubstitule Medicare with Medicard Cross-Over 8 uninsured). See Note C below | Cost Report Worksheet D- 4, F1, III, Line 62 | From Paid Claims Data or Provider Logs (Note A) | From Peid Clisms Date or Provider Logs (Note A) | From Paid Claims Data or Provider Logs (Note A) | From Peid 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 Dete or Provider Logs (Note A) | Erom Paid Claims Date or Provider Logs (Note A) |
| an Acquisition Cost Centers (list below): | | 1. | ls -i | | | | | | | | | | |
| i una Acquisition | S - | S - | | | | | | | 1 1 | 1 1 | | 1 1 | -1 |
| Lung Acquisition Kidney Acquisition | \$ - | 1 | 5 - | s . | 0 | | | | | | | | - |
| | \$ - | 1 | 1 | \$ - | 0 | | | | | | | | |
| Kidney Acquisition | S - S - S - | 1 | 1 | \$ - \$ - | 0 | | | | | | | | |
| Kidney Acquisition Liver Acquisition | S - | 1 | 1 | \$ - \$ - \$ - \$ - | 0 0 | | | | | | | | |
| Kidney Acquisition Liver Acquisition Heart Acquisition | \$ - \$ - | \$ - \$ - | 1 | \$ - \$ - \$ - \$ - | 0 0 0 | | | | | | | | |
| Kirdney Acquisition Liver Acquisition Heart Acquisition Pancreas Acquisition | \$ - \$ - | S | 1 | \$ - \$ - \$ - \$ - \$ - | 0 0 0 | | | | | | | | |
| Kidney Acquisition Liver Acquisition Heart Acquisition Pancreas Acquisition Intestinal Acquisition | S | S | S | \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - | 0 | | | | | | | | |

Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicald 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 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 (| 01/01/2019-12/31/2019) CANDLER COUNTY HOSPITAL | | |
|--------------------|--|---------------|--|
| | | | |
| Worksheet A Pro | ovider Tax Assessment Reconciliation: | | |
| | | | W/S A Cost Center |
| | | Dollar Amount | Line |
| 1 Hospita | al Gross Provider Tax Assessment (from general ledger)* | | |
| | g Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment | | (WTB Account #) |
| 2 Hospita | al 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 Differen | nce (Explain Here>) | s - | |
| o Dinoisi | , Laboratoria de la companyo de la c | | |
| Provide | er Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report) | | |
| 4 | Reclassification Code | 4 | (Reclassified to / (from)) |
| 5 | Reclassification Code | 4 | (Reclassified to / (from)) |
| 6 | Reclassification Code | | (Reclassified to / (from)) |
| 7 | Reclassification Code | | (Reclassified to / (from)) |
| DSH III | CC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report) | | |
| 8 | Reason for adjustment | | (Adjusted to / (from)) |
| 9 | Reason for adjustment | 1 | (Adjusted to / (from)) |
| 10 | Reason for adjustment | | (Adjusted to / (from)) |
| 11 | Reason for adjustment | | (Adjusted to / (from)) |
| | | -0. | |
| DSH UC | CC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report) | <u></u> | |
| 12 | Reason for adjustment | | |
| 13 | Reason for adjustment | | |
| 14 | Reason for adjustment | | |
| 15 | Reason for adjustment | | |
| 40 7 / 111 | 1 Decided Technology of Ferrors Included in the Oast Deced | | |
| 16 Total N | et Provider Tax Assessment Expense Included in the Cost Report | \$ - | |
| DSH UCC Provide | er Tax Assessment Adjustment: | | |
| | | | |
| 17 Gross A | Allowable Assessment Not Included in the Cost Report | \$ - | |
| Apporti | ionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured: | | |
| 18 | Medicaid Hospital Charges Sec. G | 17,493,848 | |
| 19 | Uninsured Hospital Charges Sec. G | 5,358,562 | |
| 20 | Total Hospital Charges Sec. G | 49,318,726 | |
| 21 | Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC | 35.47% | |
| 22 | Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC | 10.87% | |
| 23 | Medicaid Provider Tax Assessment Adjustment to DSH UCC | \$ - | |
| 24 | Uninsured Provider Tax Assessment Adjustment to DSH UCC | \$ - | |
| 25 Provide | r Tax Assessment Adjustment to DSH UCC | \$ - | |

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

^{**} The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.