

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2021	06/30/2022

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	07/01/2021	06/30/2022
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000001867A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110011

B. DSH Qualifying Information

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

During the DSH Examination Year:

- | 1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.) | <table border="1" style="margin: 0 auto;"> <tr> <th style="text-align: center;">DSH Examination Year (07/01/21 - 06/30/22)</th> </tr> <tr> <td style="text-align: center;">Yes</td> </tr> </table> | DSH Examination Year (07/01/21 - 06/30/22) | Yes |
|--|--|--|-----|
| DSH Examination Year (07/01/21 - 06/30/22) | | | |
| Yes | | | |
| 2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age? | <table border="1" style="margin: 0 auto;"> <tr> <td style="text-align: center;">No</td> </tr> </table> | No | |
| No | | | |
| 3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987? | <table border="1" style="margin: 0 auto;"> <tr> <td style="text-align: center;">No</td> </tr> </table> | No | |
| No | | | |
| 3a. Was the hospital open as of December 22, 1987? | <table border="1" style="margin: 0 auto;"> <tr> <td style="text-align: center;">Yes</td> </tr> </table> | Yes | |
| Yes | | | |
| 3b. What date did the hospital open? | <table border="1" style="margin: 0 auto;"> <tr> <td style="text-align: center;">11/1/1949</td> </tr> </table> | 11/1/1949 | |
| 11/1/1949 | | | |

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2021 - 06/30/2022**
(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.) \$ 2,871,271

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2021 - 06/30/2022**
(Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.) \$ 2,035,576

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2021 - 06/30/2022** \$ 4,906,847

Certification:

1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?**
Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.

Answer
Yes

Explanation for "No" answers:

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Carol S. Crews
Hospital CEO or CFO Signature

Carol S. Crews
Hospital CEO or CFO Printed Name

CFO
Title

770-836-9745
Hospital CEO or CFO Telephone Number

1/3/2024
Date

c crews@tanner.org
Hospital CEO or CFO E-Mail

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

Hospital Contact:	
Name	Carol S. Crews
Title	CFO
Telephone Number	770-836-9745
E-Mail Address	c crews@tanner.org
Mailing Street Address	705 Dixie Street
Mailing City, State, Zip	Carrollton, GA 30117

Outside Preparer:	
Name	Wilson E. Joiner, III
Title	Partner
Firm Name	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	bjoiner@draffin-tucker.com

D. General Cost Report Year Information 7/1/2021 - 6/30/2022

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:

2. Select Cost Report Year Covered by this Survey (enter "X"):

7/1/2021 through 6/30/2022		
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:

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	TANNER MEDICAL CENTER-CARROLLTON	Yes	
5. Medicaid Provider Number:	000001867A	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:	110011	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	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		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2021 - 06/30/2022)

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)	\$ 187,087	\$ 839,189	\$1,026,276
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 1,999,350	\$ 9,636,289	\$11,635,639
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	\$2,186,437	\$10,475,478	\$12,661,915
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	8.56%	8.01%	8.11%

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

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

16. Total Medicaid managed care non-claims payments (see question 13 above) received

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2021 - 06/30/2022)

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) 61,859 (See Note in Section F-3, below)

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2. Inpatient Hospital Subsidies	
3. Outpatient Hospital Subsidies	
4. Unspecified I/P and O/P Hospital Subsidies	
5. Non-Hospital Subsidies	
6. Total Hospital Subsidies	\$ -
7. Inpatient Hospital Charity Care Charges	18,329,069
8. Outpatient Hospital Charity Care Charges	12,798,975
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	\$ 31,128,044

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

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

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$181,217,354.00			\$ 127,625,957	\$ -	\$ -	\$ 53,591,397
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$0.00			\$ -	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$0.00			\$ -	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$356,728,298.00	\$442,590,596.00		\$ 251,233,059	\$ 311,703,305	\$ -	\$ 236,382,529
20. Outpatient Services		\$75,854,946.00			\$ 53,422,367	\$ -	\$ 22,432,579
21. Home Health Agency			\$7,303,162.00			\$ 5,143,398	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00			\$ -	
24. ASC	\$0.00	\$0.00				\$ -	
25. Hospice			\$1,637,517.00			\$ 1,153,254	
26. Other	\$0.00	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
27. Total	\$ 537,945,652	\$ 518,445,542	\$ 8,940,679	\$ 378,859,016	\$ 365,125,672	\$ 6,296,653	\$ 312,406,506
28. Total Hospital and Non Hospital		Total from Above	\$ 1,065,331,873		Total from Above	\$ 750,281,341	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,065,331,873	Total Contractual Adj. (G-3 Line 2)	746,831,351
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	3,449,990
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35. Adjusted Contractual Adjustments				750,281,341
36. Unreconciled Difference	Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-CARROLLTON

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col. 2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. 1, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

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

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 81,902,179	\$ -	\$ -	\$ 0.00	\$ 81,902,179	61,566	\$102,005,206.00	\$ 1,330.32
2	03100	INTENSIVE CARE UNIT	\$ 18,246,556	\$ -	\$ 24,888		\$ 18,271,444	5,116	\$19,067,097.00	\$ 3,571.43
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ 3,099,072	\$ -	\$ -		\$ 3,099,072	2,435	\$2,208,074.00	\$ 1,272.72
11	3301	NEONATAL INTENSIVE CARE UNIT	\$ 4,646,185	\$ -	\$ -		\$ 4,646,185	2,337	\$5,619,851.00	\$ 1,988.10
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 107,893,992	\$ -	\$ 24,888	\$ -	\$ 107,918,880	71,454	\$ 128,900,228	
19		Weighted Average								\$ 1,510.33

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. 1, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio	
20	09200	Observation (Non-Distinct)	9,595	-	\$ 12,764,420	\$5,832,864.00	\$17,994,712.00	\$ 23,827,576	0.535699

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. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000	OPERATING ROOM	\$34,090,252.00	\$ -	\$ -	\$ 34,090,252	\$45,442,024.00	\$116,652,702.00	\$ 162,094,726	0.210311
22	5200	DELIVERY ROOM & LABOR ROOM	\$7,215,306.00	\$ -	\$ -	\$ 7,215,306	\$5,557,886.00	\$300.00	\$ 5,558,186	1.298140
23	5400	RADIOLOGY-DIAGNOSTIC	\$13,060,499.00	\$ -	\$ -	\$ 13,060,499	\$7,663,595.00	\$22,726,685.00	\$ 30,390,280	0.429759
24	5500	RADIOLOGY-THERAPEUTIC	\$4,862,566.00	\$ -	\$ -	\$ 4,862,566	\$860,902.00	\$25,566,396.00	\$ 26,427,298	0.183998
25	5600	RADIOISOTOPE	\$1,583,954.00	\$ -	\$ -	\$ 1,583,954	\$3,496,613.00	\$16,288,422.00	\$ 19,785,035	0.080058
26	5700	CT SCAN	\$2,718,090.00	\$ -	\$ -	\$ 2,718,090	\$22,923,295.00	\$63,385,292.00	\$ 86,308,587	0.031493
27	5800	MRI	\$1,934,201.00	\$ -	\$ -	\$ 1,934,201	\$4,626,761.00	\$12,805,799.00	\$ 17,432,560	0.110953
28	5900	CARDIAC CATHETERIZATION	\$7,860,601.00	\$ -	\$ 5,244	\$ 7,865,845	\$17,535,961.00	\$16,052,841.00	\$ 33,588,802	0.234181
29	6000	LABORATORY	\$14,126,388.00	\$ -	\$ 22,850	\$ 14,149,238	\$69,078,086.00	\$39,679,641.00	\$ 108,757,727	0.130099
30	6500	RESPIRATORY THERAPY	\$20,654,897.00	\$ -	\$ 8,502	\$ 20,663,399	\$38,928,824.00	\$27,953,082.00	\$ 66,881,906	0.308954

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-CARROLLTON

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6600 PHYSICAL THERAPY	\$2,362,188.00	\$ -	\$ -	\$ 2,362,188	\$5,983,722.00	\$1,162,246.00	\$ 7,145,968	0.330562
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$6,233,870.00	\$ -	\$ -	\$ 6,233,870	\$29,575,746.00	\$20,043,232.00	\$ 49,618,978	0.125635
33	7200 IMPL. DEV. CHARGED TO PATIENTS	\$27,946,851.00	\$ -	\$ -	\$ 27,946,851	\$20,987,025.00	\$47,414,486.00	\$ 68,401,511	0.408571
34	7300 DRUGS CHARGED TO PATIENTS	\$22,171,156.00	\$ -	\$ -	\$ 22,171,156	\$102,577,369.00	\$51,429,220.00	\$ 154,006,589	0.143962
35	7600 PARTIAL HOSPITALIZATION PROGRAM	\$3,328,458.00	\$ -	\$ -	\$ 3,328,458	\$0.00	\$7,557,131.00	\$ 7,557,131	0.440439
36	7697 CARDIAC REHABILITATION	\$886,908.00	\$ -	\$ 621	\$ 887,529	\$609.00	\$694,545.00	\$ 695,154	1.276737
37	7698 HYPERBARIC OXYGEN THERAPY	\$151,782.00	\$ -	\$ -	\$ 151,782	\$0.00	\$1,325,931.00	\$ 1,325,931	0.114472
38	9000 CLINIC	\$89,164.00	\$ -	\$ -	\$ 89,164	\$0.00	\$0.00	\$ -	-
39	9002 WOUND CARE	\$953,760.00	\$ -	\$ -	\$ 953,760	\$59,015.00	\$3,812,846.00	\$ 3,871,861	0.246331
40	9100 EMERGENCY	\$17,976,567.00	\$ -	\$ -	\$ 17,976,567	\$12,839,980.00	\$48,533,587.00	\$ 61,373,567	0.292904
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-CARROLLTON

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 190,207,458	\$ -	\$ 37,217	\$ 190,244,675	\$ 393,970,277	\$ 541,079,096	\$ 935,049,373	
127	Weighted Average								0.217015
128	Sub Totals	\$ 298,101,450	\$ -	\$ 62,105	\$ 298,163,555	\$ 522,870,505	\$ 541,079,096	\$ 1,063,949,601	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	Grand Total				\$ 298,163,555				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%			

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

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

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-CARROLLTON

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-Over (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 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	\$ 1,330.32		3,615		2,128		6,513		3,910		2,880		16,166		37.43%	
2	03100 INTENSIVE CARE UNIT	\$ 3,571.43		375		97		623		191		271		1,286		31.55%	
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	\$ 1,272.72		146		1,157		-		126		37		1,429		60.37%	
11	3301 NEONATAL INTENSIVE CARE UNIT	\$ 1,988.10		140		1,203		-		121		35		1,464		64.31%	
12		\$ -															
13		\$ -															
14		\$ -															
15		\$ -															
16		\$ -															
17		\$ -															
18		\$ -															
19				Total Days		4,276		4,585		7,136		4,348		3,223		20,345	33.65%
20	Total Days per PS&R or Exhibit Detail			4,276		4,585		7,136		4,348		3,223					
21	Unreconciled Days (Explain Variance)			-		-		-		-		-		-			
21.01	Routine Charges			\$ 9,022,263		\$ 9,760,759		\$ 15,584,944		\$ 7,415,815		\$ 6,862,602		\$ 41,783,781		38.56%	
	Calculated Routine Charge Per Diem			\$ 2,109.98		\$ 2,128.85		\$ 2,183.99		\$ 1,705.57		\$ 2,129.26		\$ 2,053.76			
22	Ancillary Cost Centers (from WIS 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		
23	09200 Observation (Non-Distinct)	0.535899		398,755	933,168	251,209	540,265	603,896	2,095,958	368,175	1,072,513	260,403	1,619,586	\$ 1,622,035	\$ 4,641,904	35.62%	
24	5000 OPERATING ROOM	0.210311		2,543,402	3,093,955	2,240,876	7,091,002	4,040,429	6,946,804	2,114,275	2,402,340	2,800,033	3,946,278	\$ 10,938,982	\$ 19,534,100	23.53%	
25	5200 DELIVERY ROOM & LABOR ROOM	1.298140		197,672	1,976,723	2,510,723	9,014	1,220	-	737,140	2,183	68,231	3,446,755	\$ 3,446,755	\$ 11,197	63.53%	
26	5400 RADIOLOGY-DIAGNOSTIC	0.429759		524,173	946,368	299,357	1,693,486	899,184	1,211,243	342,046	941,523	395,192	1,546,741	\$ 2,064,760	\$ 4,792,620	29.51%	
27	5500 RADIOLOGY-THERAPEUTIC	0.183998		93,770	969,592	-	517,109	76,242	3,099,434	54,053	219,806	-	771,448	\$ 224,065	\$ 4,805,941	22.13%	
28	5600 RADIOISOTOPE	0.080058		233,358	383,034	329,822	72,811	390,004	1,474,867	180,395	307,340	220,596	893,375	\$ 876,568	\$ 2,495,063	23.25%	
29	5700 CT SCAN	0.031493		1,656,581	2,610,800	376,662	3,592,737	2,712,842	5,726,137	1,182,210	1,725,277	1,549,478	7,365,855	\$ 5,928,294	\$ 13,654,950	33.71%	
30	5800 MRI	0.110953		292,482	520,555	457,146	438,883	1,093,914	438,883	135,579	422,984	487,631	649,252	\$ 962,160	\$ 2,494,599	27.02%	
31	5900 CARDIAC CATHETERIZATION	0.234181		-	-	445,559	568,510	1,337,332	1,131,705	394,147	310,367	1,880,251	784,192	\$ 2,177,039	\$ 2,010,582	21.75%	
32	6000 LABORATORY	0.130099		5,085,816	1,937,206	2,786,038	2,740,239	7,903,695	3,061,943	3,717,414	1,525,835	3,855,430	4,020,527	\$ 19,492,962	\$ 9,265,223	34.41%	
33	6500 RESPIRATORY THERAPY	0.308954		3,164,663	1,432,272	590,894	982,782	4,847,134	2,615,588	1,907,235	651,605	1,798,303	1,598,736	\$ 10,509,926	\$ 5,682,248	29.97%	
34	6800 PHYSICAL THERAPY	0.330362		401,361	4,944	68,810	12,251	785,323	175,584	288,359	31,676	226,312	36,451	\$ 1,543,852	\$ 224,455	28.98%	
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.125635		1,430,721	504,329	1,007,793	1,492,819	2,807,600	1,467,443	1,103,352	342,339	1,329,402	531,971	\$ 6,349,467	\$ 3,806,931	24.77%	
36	7200 IMPL. DEV. CHARGED TO PATIENTS	0.408571		882,559	7,219	-	-	1,748,940	3,166,901	698,602	353,626	652,427	949,107	\$ 3,330,100	\$ 3,527,746	12.46%	
37	7300 DRUGS CHARGED TO PATIENTS	0.143962		6,579,192	4,029,940	2,327,508	-	11,698,594	5,340,485	5,241,379	1,634,167	5,090,237	4,780,349	\$ 27,549,104	\$ 11,303,465	32.42%	
38	7600 PARTIAL HOSPITALIZATION PROGRAM	0.440439		-	161,616	-	379,710	-	153,255	-	394,682	-	35,202	\$ -	\$ 1,089,263	14.88%	
39	7697 CARDIAC REHABILITATION	1.276737		-	-	-	-	-	3,247	-	7,678	-	19,354	\$ -	\$ 10,925	4.36%	
40	7698 HYPERBARIC OXYGEN THERAPY	0.114472		-	-	-	-	-	168,516	-	5,436	-	-	\$ -	\$ 173,952	13.12%	
41	9000 CLINIC	-		-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
42	9002 WOUND CARE	0.246331		7,224	38,979	3,180	24,006	328	9,859	489	255	-	339	\$ 11,201	\$ 73,099	2.30%	
43	9100 EMERGENCY	0.292904		924,940	2,802,124	353,671	8,225,058	1,614,670	3,554,048	666,313	1,675,112	852,350	8,567,105	\$ 3,559,594	\$ 16,256,341	48.44%	
44														\$ -	\$ -		
45														\$ -	\$ -		
46														\$ -	\$ -		
47														\$ -	\$ -		
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58														\$ -	\$ -		
59														\$ -	\$ -		
60														\$ -	\$ -		

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

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-CARROLLTON

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%	
61																
62																
63																
64																
65																
66																
67																
68																
69																
70																
71																
72																
73																
74																
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124																
125																
126																
127																
			\$ 24,416,668	\$ 18,347,467	\$ 15,132,738	\$ 30,983,463	\$ 41,906,316	\$ 42,496,930	\$ 19,131,143	\$ 14,026,743	\$ 21,466,277	\$ 38,115,878				

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

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-CARROLLTON

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
Totals / Payments													
128 Total Charges (includes organ acquisition from Section J)	\$ 33,438,931	\$ 18,347,467	\$ 24,893,497	\$ 30,983,463	\$ 57,491,260	\$ 42,496,930	\$ 26,546,958	\$ 14,026,743	\$ 28,328,879	\$ 38,115,878	\$ 142,370,646	\$ 105,854,603	30.25%
									(Agrees to Exhibit A)	(Agrees to Exhibit A)			
129 Total Charges per PS&R or Exhibit Detail	\$ 33,438,931	\$ 18,347,467	\$ 24,893,497	\$ 30,983,463	\$ 57,491,260	\$ 42,496,930	\$ 26,546,958	\$ 14,026,743	\$ 28,328,879	\$ 38,115,878			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 11,495,752	\$ 3,858,476	\$ 12,546,856	\$ 6,707,896	\$ 18,953,083	\$ 9,005,374	\$ 10,741,464	\$ 3,234,255	\$ 9,011,551	\$ 7,784,894	\$ 53,737,155	\$ 22,806,001	31.98%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 6,583,533	\$ 3,209,456			\$ 481,365	\$ 519,017		\$ 3,567			\$ 7,084,898	\$ 3,732,040	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 5,777,597	\$ 5,236,435							\$ 5,777,597	\$ 5,236,435	
134 Private Insurance (including primary and third party liability)	\$ 103,851	\$ 2,402	\$ 29,008	\$ 12,501	\$ 1,400	\$ 21,616	\$ 3,324,664	\$ 3,648,761			\$ 3,458,923	\$ 3,685,280	
135 Self-Pay (including Co-Pay and Spend-Down)			\$ 13	\$ 3				\$ 75			\$ 13	\$ 75	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 6,687,384	\$ 3,211,858	\$ 5,806,618	\$ 5,248,939									
137 Medicaid Cost Settlement Payments (See Note B)		\$ 139,441										\$ 139,441	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)													
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 11,283,387	\$ 5,538,538	\$ 2,312,114	\$ 204,577			\$ 13,595,501	\$ 5,743,115	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 1,707,824	\$ 611,473			\$ 1,707,824	\$ 611,473	
141 Medicare Cross-Over Bad Debt Payments					\$ 10,736	\$ 17,863					\$ 10,736	\$ 17,863	
142 Other Medicare Cross-Over Payments (See Note D)					\$ 445,580	\$ 1,193	\$ 68,744	\$ 29	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	\$ 514,324	\$ 1,222	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 187,087	\$ 839,189			
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)	\$ 4,808,368	\$ 507,177	\$ 6,740,238	\$ 1,458,957	\$ 6,730,615	\$ 2,907,147	\$ 3,328,118	\$ (1,234,227)	\$ 8,624,464	\$ 6,945,705	\$ 21,607,339	\$ 3,639,054	
146 Calculated Payments as a Percentage of Cost	58%	87%	46%	78%	64%	68%	69%	138%	2%	11%	60%	84%	
147 Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					34,656								
148 Percent of cross-over days to total Medicare days from the cost report					21%								

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-CARROLLTON

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 PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
		From Section G	From Section G										
Routine Cost Centers (list below):					Days		Days		Days		Days		Days
1	03000 ADULTS & PEDIATRICS	\$ 1,330.32			408							408	
2	03100 INTENSIVE CARE UNIT	\$ 3,571.43			57							57	
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	\$ 1,272.72			4							4	
11	3301 NEONATAL INTENSIVE CARE UNIT	\$ 1,988.10			4							4	
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
					Total Days							473	
19	Total Days per PS&R or Exhibit Detail				473								
20	Unreconciled Days (Explain Variance)												
21					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges
21.01	Routine Charges				\$ 1,058,793		\$ -		\$ -		\$ -		\$ 1,058,793
	Calculated Routine Charge Per Diem				\$ 2,238.46		\$ -		\$ -		\$ -		\$ 2,238.46
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
22	09200 Observation (Non-Distinct)		0.535699		46,308	297,290						\$ 46,308	\$ 297,290
23	5000 OPERATING ROOM		0.210311		532,239	424,136						\$ 532,239	\$ 424,136
24	5200 DELIVERY ROOM & LABOR ROOM		1.298140		4,739	-						\$ 4,739	\$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.429759		68,851	99,913						\$ 68,851	\$ 99,913
26	5500 RADIOLOGY-THERAPEUTIC		0.183998		-	47,586						\$ -	\$ 47,586
27	5600 RADIOISOTOPE		0.080058		24,831	88,937						\$ 24,831	\$ 88,937
28	5700 CT SCAN		0.031493		227,729	366,579						\$ 227,729	\$ 366,579
29	5800 MRI		0.110953		38,425	78,112						\$ 38,425	\$ 78,112
30	5900 CARDIAC CATHETERIZATION		0.234181		255,397	196,631						\$ 255,397	\$ 196,631
31	6000 LABORATORY		0.130099		510,254	280,140						\$ 510,254	\$ 280,140
32	6500 RESPIRATORY THERAPY		0.308954		299,529	152,686						\$ 299,529	\$ 152,686
33	6600 PHYSICAL THERAPY		0.330562		36,938	2,789						\$ 36,938	\$ 2,789
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.125635		188,993	84,369						\$ 188,993	\$ 84,369
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.408571		49,574	16,618						\$ 49,574	\$ 16,618
36	7300 DRUGS CHARGED TO PATIENTS		0.143962		733,163	468,271						\$ 733,163	\$ 468,271
37	7600 PARTIAL HOSPITALIZATION PROGRAM		0.440439		-	-						\$ -	\$ -
38	7697 CARDIAC REHABILITATION		-		-	-						\$ -	\$ -
39	7698 HYPERBARIC OXYGEN THERAPY		0.114472		-	-						\$ -	\$ -
40	9000 CLINIC		-		-	-						\$ -	\$ -
41	9002 WOUND CARE		0.246331		-	4,503						\$ -	\$ 4,503
42	9100 EMERGENCY		0.292904		98,937	394,171						\$ 98,937	\$ 394,171
43												\$ -	\$ -
44												\$ -	\$ -
45												\$ -	\$ -
46												\$ -	\$ -
47												\$ -	\$ -
48												\$ -	\$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-CARROLLTON

		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	
112										\$ -	\$ -
113										\$ -	\$ -
114										\$ -	\$ -
115										\$ -	\$ -
116										\$ -	\$ -
117										\$ -	\$ -
118										\$ -	\$ -
119										\$ -	\$ -
120										\$ -	\$ -
121										\$ -	\$ -
122										\$ -	\$ -
123										\$ -	\$ -
124										\$ -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
		\$ 3,115,907	\$ 3,002,731	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Totals / Payments											
128	Total Charges (includes organ acquisition from Section K)	\$ 4,174,700	\$ 3,002,731	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,174,700	\$ 3,002,731
129	Total Charges per PS&R or Exhibit Detail	\$ 4,174,700	\$ 3,002,731	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
130	Unreconciled Charges (Explain Variance)										
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 1,354,761	\$ 659,438	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,354,761	\$ 659,438
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 548,552	\$ 128,879							\$ 548,552	\$ 128,879
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)		\$ 62							\$ -	\$ 62
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 548,552	\$ 128,941	\$ -	\$ -						
137	Medicaid Cost Settlement Payments (See Note B)									\$ -	\$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									\$ -	\$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									\$ -	\$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									\$ -	\$ -
141	Medicare Cross-Over Bad Debt Payments									\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)									\$ -	\$ -
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 806,209	\$ 530,497	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 806,209	\$ 530,497
144	Calculated Payments as a Percentage of Cost	40%	20%	0%	0%	0%	0%	0%	0%	40%	20%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).

Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.

Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).

Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-CARROLLTON

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 4,381,822	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	9900.85 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 4,381,822	5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
8 Reason for adjustment		(Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
12 Reason for adjustment		
13 Reason for adjustment		
14 Reason for adjustment		
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ 4,381,822	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:	
18 Medicaid Hospital Charges Sec. G	255,402,680
19 Uninsured Hospital Charges Sec. G	66,444,757
20 Total Hospital Charges Sec. G	1,063,949,601
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	24.01%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	6.25%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider 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.