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

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2024	06/30/2025

2. Select Your Facility from the Drop-Down Menu Provided: TANNER MEDICAL CENTER-CARROLLTON

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	07/01/2022	06/30/2023
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:	DSH Examination Year (07/01/24 - 06/30/25)
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.)	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?	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?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	11/1/1949

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025** $ 3,271,109
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2024 - 06/30/2025** $ 3,868,460
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2024 - 06/30/2025** $ 7,139,569

Certification:

	Answer
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.**	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

CFO — Title

2-28-25 — Date

Carol S. Crews — Hospital CEO or CFO Printed Name

770-836-9745 — Hospital CEO or CFO Telephone Number

ccrews@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	ccrews@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

DSH Version 9.00 9/11/2024

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

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

1. Select Your Facility from the Drop-Down Menu Provided: TANNER MEDICAL CENTER-CARROLLTON

	7/1/2022 through 6/30/2023		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

3. Status of Cost Report Used for this Survey (Should be audited if available): 5 - Amended

3a. Date CMS processed the HCRIS file into the HCRIS database: 5/9/2024

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

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 4,328	$ 722,683	$727,011
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 142,114	$ 8,902,735	$9,044,849
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)	$146,442	$9,625,418	$9,771,860
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	2.96%	7.51%	7.44%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** Yes
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	$ 3,868,460	***<--These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.***
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	$3,868,460	

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2022 - 06/30/2023)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	54,340 **(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	14,738,126
8.	Outpatient Hospital Charity Care Charges	15,182,748
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 29,920,874

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)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$188,493,957.00			$ 137,412,919	$ -	$ -	$ 51,081,038
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	$333,217,864.00	$497,448,906.00		$ 242,917,281	$ 362,642,429	$ -	$ 225,107,060
20.	Outpatient Services		$93,315,036.00			$ 68,027,070	$ -	$ 25,287,966
21.	Home Health Agency			$7,642,145.00			$ 5,571,157	
22.	Ambulance	-		$ -	-		$ -	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$1,384,774.00			$ 1,009,506	
26.	Other	$0.00	$0.00	$0.00	$ -	$ -	$ -	$ -
27.	Total	$ 521,711,821	$ 590,763,942	$ 9,026,919	$ 380,330,200	$ 430,669,498	$ 6,580,663	$ 301,476,064
28.	Total Hospital and Non Hospital		Total from Above	$ 1,121,502,682		Total from Above	$ 817,580,362	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,121,502,682	Total Contractual Adj. (G-3 Line 2)		814,049,667
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)			-	+	3,530,695
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"				-	
36.	Adjusted Contractual Adjustments					817,580,362
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) TANNER MEDICAL CENTER-CARROLLTON

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.

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
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 69,597,061	$ -	$ -	$0.00	$ 69,597,061	61,342	$90,005,788.00		$ 1,134.57
2	03100 INTENSIVE CARE UNIT	$ 18,182,806	$ -	$ -		$ 18,182,806	2,808	$16,680,254.00		$ 6,475.36
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	$ 3,489,871	$ -	$ -		$ 3,489,871	2,198	$2,406,699.00		$ 1,587.75
11	3301 NEONATAL INTENSIVE CARE UNIT	$ 4,609,052	$ -	$ -		$ 4,609,052	2,575	$5,546,087.00		$ 1,789.92
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 95,878,790	$ -	$ -	$ -	$ 95,878,790	68,923	$ 114,638,828		
19	Weighted Average									$ 1,391.10

		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	14,583	-	-	$ 16,545,434	$11,152,827.00	$25,836,063.00	$ 36,988,890	0.447308

		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below)									
21	5000 OPERATING ROOM	$40,698,384.00	$ -	$ 1,518		$ 40,699,902	$55,083,048.00	$127,631,229.00	$ 182,714,277	0.222752
22	5200 DELIVERY ROOM & LABOR ROOM	$7,689,314.00	$ -	$ -		$ 7,689,314	$6,592,140.00	$0.00	$ 6,592,140	1.166437
23	5400 RADIOLOGY-DIAGNOSTIC	$14,540,193.00	$ -	$ -		$ 14,540,193	$8,333,136.00	$27,064,170.00	$ 35,397,306	0.410771
24	5500 RADIOLOGY-THERAPEUTIC	$4,822,591.00	$ -	$ -		$ 4,822,591	$1,134,661.00	$36,105,567.00	$ 37,240,228	0.129500
25	5600 RADIOISOTOPE	$1,817,096.00	$ -	$ -		$ 1,817,096	$3,741,184.00	$16,838,455.00	$ 20,579,639	0.088296
26	5700 CT SCAN	$3,053,505.00	$ -	$ -		$ 3,053,505	$25,463,518.00	$78,053,729.00	$ 103,517,247	0.029498
27	5800 MRI	$2,021,139.00	$ -	$ -		$ 2,021,139	$5,143,964.00	$16,132,141.00	$ 21,276,105	0.094996
28	5900 CARDIAC CATHETERIZATION	$7,800,415.00	$ -	$ 5,244		$ 7,805,659	$19,479,927.00	$18,086,632.00	$ 37,566,559	0.207782
29	6000 LABORATORY	$15,298,069.00	$ -	$ 8,199		$ 15,306,268	$66,071,060.00	$45,971,291.00	$ 112,042,351	0.136611
30	6500 RESPIRATORY THERAPY	$13,577,979.00	$ -	$ 4,601		$ 13,582,580	$33,739,778.00	$31,953,572.00	$ 65,693,350	0.206757
31	6600 PHYSICAL THERAPY	$2,577,487.00	$ -	$ -		$ 2,577,487	$5,766,469.00	$1,478,513.00	$ 7,244,982	0.355762

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) 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
32	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$7,625,142.00	$ -	$ -		$ 7,625,142	$28,982,363.00	$24,485,002.00	$ 53,467,365	0.142613
33	7200	IMPL. DEV. CHARGED TO PATIENTS	$24,885,955.00	$ -	$ -		$ 24,885,955	$18,207,401.00	$40,138,752.00	$ 58,346,153	0.426523
34	7300	DRUGS CHARGED TO PATIENTS	$19,549,107.00	$ -	$ -		$ 19,549,107	$76,301,040.00	$60,917,730.00	$ 137,218,770	0.142467
35	7600	PARTIAL HOSPITALIZATION PROGRAM	$3,324,543.00	$ -	$ -		$ 3,324,543	$56.00	$8,426,769.00	$ 8,426,825	0.394519
36	7697	CARDIAC REHABILITATION	$926,081.00	$ -	$ 746		$ 926,827	$437.00	$969,173.00	$ 969,610	0.955876
37	7698	HYPERBARIC OXYGEN THERAPY	$147,740.00	$ -	$ -		$ 147,740	$1,359.00	$374,631.00	$ 375,990	0.392936
38	9002	WOUND CARE	$954,628.00	$ -	$ -		$ 954,628	$30,326.00	$3,523,423.00	$ 3,553,749	0.268626
39	9100	EMERGENCY	$19,911,297.00	$ -	$ -		$ 19,911,297	$12,902,739.00	$64,149,530.00	$ 77,052,269	0.258413
40			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
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	$ -	-
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) 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
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**	$ 191,220,665	$ -	$ 20,308		$ 191,240,973	$ 378,127,433	$ 628,136,372	$ 1,006,263,805	
127		**Weighted Average**									0.206493
128		**Sub Totals**	$ 287,099,455	$ -	$ 20,308		$ 287,119,763	$ 492,766,261	$ 628,136,372	$ 1,120,902,633	
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**					$ 287,119,763				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%				

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

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

Cost Report Year (07/01/2022-06/30/2023) | TANNER MEDICAL CENTER-CARROLLTON

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)		From PS&R Summary (Note A)		From PS&R Summary (Note A)		From PS&R Summary (Note A)		From PS&R Summary (Note A)		From Hospital's Own Internal	From Hospital's Own Internal			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,134.57		2,561		2,053		3,488		5,769				2,809		13,871		37.93%
2	03100 INTENSIVE CARE UNIT	$ 6,475.36		267		58		170		415				346		910		46.94%
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	$ 1,587.75		167		1,285				84				29		1,536		71.84%
11	3301 NEONATAL INTENSIVE CARE UNIT	$ 1,789.92		196		1,113				220				97		1,529		63.42%
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	3,191		4,509		3,658		6,488				3,281		17,846		32.31%
19	Total Days per PS&R or Exhibit Detail			3,191		4,509		3,658		6,488				3,281				
20	Unreconciled Days (Explain Variance)			-														
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 7,090,768		$ 7,847,517		$ 7,962,664		$ 13,965,223				$ 7,100,029		$ 36,866,172		40.56%
21.01	Calculated Routine Charge Per Diem			$ 2,222.11		$ 1,740.41		$ 2,176.78		$ 2,152.47		$ -		$ 2,163.98		$ 2,065.79		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.447308	530,856	840,681	299,371	1,022,806	698,430	974,010	1,522,515	3,207,153			581,703	2,552,584	$ 3,051,172	$ 6,044,650	35.58%
23	5000 OPERATING ROOM		0.222752	2,292,212	3,318,629	2,620,040	10,257,817	2,284,185	2,142,177	4,956,619	7,811,598			3,294,955	3,826,491	$ 12,153,056	$ 23,530,220	
24	5200 DELIVERY ROOM & LABOR ROOM		1.166437	260,522		2,712,076	8,185	4,739		844,809	6,150			157,454		$ 3,822,146	$ 14,335	
25	5400 RADIOLOGY-DIAGNOSTIC		0.410771	440,662	1,077,026	449,263	2,497,046	538,193	540,792	831,764	2,010,493			471,599	1,888,374	$ 2,259,882	$ 6,125,357	
26	5500 RADIOLOGY-THERAPEUTIC		0.129500	140,859	1,548,462	27,686	518,005	47,805	945,279	40,122	1,935,898			22,886	1,818,005	$ 256,472	$ 4,947,644	4.01%
27	5600 RADIOISOTOPE		0.088296	175,162	342,879	45,722	305,201	184,875	328,756	430,309	1,261,144			211,824	672,149	$ 836,068	$ 2,237,980	64.43%
28	5700 CT SCAN		0.029498	1,486,202	2,766,788	523,814	5,237,646	2,072,152	2,507,157	2,871,737	6,573,200			1,675,915	8,582,705	$ 6,953,905	$ 17,084,792	100.80%
29	5800 MRI		0.094996	232,197	589,388	84,084	571,438	306,618	382,465	519,692	1,331,262			369,342	811,122	$ 1,142,592	$ 2,874,553	15.04%
30	5900 CARDIAC CATHETERIZATION		0.207782	-		232,609	162,120	702,393	365,631	1,771,221	667,456			1,550,379	744,507	$ 2,706,223	$ 1,195,207	33.21%
31	6000 LABORATORY		0.136611	4,326,584	2,038,032	3,001,417	4,214,111	4,537,894	1,204,078	7,346,121	3,808,260			4,216,811	5,149,165	$ 19,212,016	$ 11,264,481	40.30%
32	6500 RESPIRATORY THERAPY		0.206757	2,749,237	1,651,395	1,221,046	1,544,098	2,517,240	768,872	4,401,874	2,460,447			1,847,864	1,731,476	$ 10,889,397	$ 6,424,812	103.00%
33	6600 PHYSICAL THERAPY		0.355762	285,450	1,465	96,469	19,068	346,250	41,042	689,524	145,507			263,326	78,485	$ 1,417,693	$ 207,082	5.54%
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.142613	1,221,403	437,694	795,297	684,223	1,259,905	396,925	2,900,952	1,341,026			1,112,013	854,770	$ 6,177,557	$ 2,859,868	10.24%
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.426523	561,789	182,435	228,598	1,014,223	821,116	504,276	- 1,486,031	2,250,497			543,238	1,365,402	$ 3,097,534	$ 3,951,431	14.10%
36	7300 DRUGS CHARGED TO PATIENTS		0.142467	4,614,512	2,148,993	3,326,017	4,079,380	5,519,988	1,917,539	9,087,137	5,172,921	-		4,907,126	5,584,375	$ 22,547,654	$ 13,318,834	674.37%
37	7600 PARTIAL HOSPITALIZATION PROGRAM		0.394519	-	283,800		5,119,351		52,161	-	761,087			-	105,843	$ -	$ 6,216,399	11.83%
38	7697 CARDIAC REHABILITATION		0.955876	- -				- 203	11,063		20,209			- -	27,366	$ 203	$ 31,272	0.10%
39	7698 HYPERBARIC OXYGEN THERAPY		0.392936	-					453		7,248			-	20,838	$ -	$ 7,701	0.02%
40	9002 WOUND CARE		0.268626	6,313	4,777	435	255	719	5,518	2,288	6,858			464	3,505	$ 9,755	$ 17,408	0.53%
41	9100 EMERGENCY		0.258413	838,736	3,240,895	359,091	12,183,624	1,066,607	1,714,827	1,450,572	5,427,725			843,423	10,218,917	$ 3,715,006	$ 22,567,071	3959.98%
42			-													$ -	$ -	0.00%
43			-													$ -	$ -	0.00%
44			-	-												$ -	$ -	0.00%
45			-													$ -	$ -	
46			-													$ -	$ -	
47			-													$ -	$ -	
48			-													$ -	$ -	
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51			-		-		-		-							$ -	$ -	
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73			-													$ -	$ -	

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

Cost Report Year (07/01/2022-06/30/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report
74				-													$ -	$ -	
75				-													$ -	$ -	
76				-													$ -	$ -	
77				-													$ -	$ -	
78				-													$ -	$ -	
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124				-													$ -	$ -	
125				-													$ -	$ -	
126				-													$ -	$ -	
127				-													$ -	$ -	
					$ 20,162,696	$ 20,473,340	$ 16,023,035	$ 49,438,598	$ 22,909,313	$ 14,803,019	$ 41,153,287	$ 46,206,140	$ -	$ -	$ 22,070,321	$ 46,036,080			

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

Cost Report Year (07/01/2022-06/30/2023) TANNER MEDICAL CENTER-CARROLLTON

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 27,253,464	$ 20,473,340	$ 23,870,552	$ 49,438,598	$ 30,871,977	$ 14,803,019	$ 55,118,510	$ 46,206,140	$ -	$ -	$ 29,170,350 (Agrees to Exhibit A)	$ 46,036,080 (Agrees to Exhibit A)	$ 137,114,503	$ 130,921,097	32.05%
129	Total Charges per PS&R or Exhibit Detail	$ 27,253,464	$ 20,473,340	$ 23,870,552	$ 49,438,598	$ 30,871,977	$ 14,803,019	$ 55,118,510	$ 46,206,140	$ -	$ -	$ 29,170,350	$ 46,036,080			
130	Unreconciled Charges (Explain Variance)	-														
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 9,133,774	$ 3,943,598	$ 12,356,703	$ 11,295,453	$ 9,220,622	$ 2,831,586	$ 18,293,874	$ 9,524,462	$ -	$ -	$ 9,806,289	$ 8,856,501	$ 49,004,973	$ 27,595,099	34.67%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 5,821,770	$ 3,471,136											$ 5,821,770	$ 3,471,136	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 6,154,832	$ 9,224,924									$ 6,154,832	$ 9,224,924	
134	Private Insurance (including primary and third party liability)	$ 32,610	$ 4,996					$ 4,643,040	$ 5,031,807					$ 4,675,650	$ 5,036,803	
135	Self-Pay (including Co-Pay and Spend-Down)			$ 52	$ 11,014	$ 1,556	$ 348	$ 2,387	$ 21,242					$ 3,995	$ 32,604	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 5,854,380	$ 3,476,132	$ 6,154,884	$ 9,235,938											
137	Medicaid Cost Settlement Payments (See Note B)		$ (133,748)											$ -	$ (133,748)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)					$ 6,411,612	$ 1,974,208	$ 261,414	$ 90,418					$ 6,673,026	$ 2,064,626	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 8,053,096	$ 4,719,706					$ 8,053,096	$ 4,719,706	
141	Medicare Cross-Over Bad Debt Payments					$ -	$ 17,764							$ -	$ 17,764	
142	Other Medicare Cross-Over Payments (See Note D)	-	-	-	-	$ 1,125,320	$ 240,453	$ 124,834	$ 16,486	-	-	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 1,250,154	$ 256,939	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 4,328	$ 722,683			
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)**	$ 3,279,394	$ 601,214	$ 6,201,819	$ 2,059,515	$ 1,682,134	$ 598,813	$ 5,209,103	$ (355,197)	$ -	$ -	$ 9,801,961	$ 8,133,818	$ 16,372,450	$ 2,904,345	
146	**Calculated Payments as a Percentage of Cost**	64%	85%	50%	82%	82%	79%	72%	104%	0%	0%	0%	8%	67%	89%	
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**					31,647										
148	**Percent of cross-over days to total Medicare days from the cost report**					12%										

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 surve
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payment
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) TANNER MEDICAL CENTER-CARROLLTON

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,134.57		578						478		1,056	
2	03100 INTENSIVE CARE UNIT	$ 6,475.36		39						23		62	
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	$ 1,587.75		14								14	
11	3301 NEONATAL INTENSIVE CARE UNIT	$ 1,789.92		5						2		7	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	636						503		1,139	
19	Total Days per PS&R or Exhibit Detail			636						503			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 1,371,152						$ 1,155,273		$ 2,526,425	
21.01	Calculated Routine Charge Per Diem			$ 2,155.90		$ -		$ -		$ 2,296.77		$ 2,218.11	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.447308	192,020	326,252					103,308	309,859	$ 295,328	$ 636,111
23	5000 OPERATING ROOM		0.222752	469,317	450,484					373,054	466,456	$ 842,371	$ 916,940
24	5200 DELIVERY ROOM & LABOR ROOM		1.166437	14,078						34,845		$ 48,923	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.410771	71,005	132,358					64,433	129,034	$ 135,438	$ 261,392
26	5500 RADIOLOGY-THERAPEUTIC		0.129500	1,994	137,293					-	144,440	$ 1,994	$ 281,733
27	5600 RADIOISOTOPE		0.088296	38,530	100,548					50,058	100,289	$ 88,588	$ 200,837
28	5700 CT SCAN		0.029498	302,906	443,374					218,531	417,620	$ 521,438	$ 860,994
29	5800 MRI		0.094996	104,775	96,430					46,261	154,199	$ 151,036	$ 250,629
30	5900 CARDIAC CATHETERIZATION		0.207782	154,510	141,282					139,464	203,112	$ 293,974	$ 344,394
31	6000 LABORATORY		0.136611	688,961	306,004					611,455	270,167	$ 1,300,416	$ 576,171
32	6500 RESPIRATORY THERAPY		0.206757	342,602	189,429					289,579	199,485	$ 632,181	$ 388,914
33	6600 PHYSICAL THERAPY		0.355762	48,198	5,064					52,075	9,973	$ 100,273	$ 15,037
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.142613	154,602	61,149					188,528	68,821	$ 343,130	$ 129,970
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.426523	72,429	47,220					114,068	70,210	$ 186,497	$ 117,430
36	7300 DRUGS CHARGED TO PATIENTS		0.142467	687,923	659,187					721,558	431,242	$ 1,409,480	$ 1,090,429
37	7600 PARTIAL HOSPITALIZATION PROGRAM		0.394519	-	800					-		$ -	$ 800
38	7697 CARDIAC REHABILITATION		0.955876	-						-		$ -	$ -
39	7698 HYPERBARIC OXYGEN THERAPY		0.392936	-						-		$ -	$ -
40	9002 WOUND CARE		0.268626	265	9,822					-	3,743	$ 265	$ 13,565
41	9100 EMERGENCY		0.258413	88,885	562,936					74,902	325,256	$ 163,787	$ 888,192
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
				-						-			
				-						-			

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
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61			-									$ -	$ -
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109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 3,433,000	$ 3,669,633	$ -	$ -	$ -	$ -	$ 3,082,119	$ 3,303,905		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ 4,804,152	$ 3,669,633	$ -	$ -	$ -	$ -	$ 4,237,392	$ 3,303,905	$ 9,041,543	$ 6,973,538
129	Total Charges per PS&R or Exhibit Detail			$ 4,804,152	$ 3,669,633	$ -	$ -	$ -	$ -	$ 4,237,392	$ 3,303,905		
130	Unreconciled Charges (Explain Variance)			-									
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 1,586,262	$ 732,871	$ -	$ -	$ -	$ -	$ 1,295,120	$ 660,195	$ 2,881,382	$ 1,393,066
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 880,818	$ 188,216							$ 880,818	$ 188,216
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)									$ 135,811	$ 340,287	$ 135,811	$ 340,287
135	Self-Pay (including Co-Pay and Spend-Down)				$ 47						$ 787	$ -	$ 834
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 880,818	$ 188,263	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)									$ 455,713	$ 99,500	$ 455,713	$ 99,500
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 385,872	$ 216,097	$ 385,872	$ 216,097
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)**			$ 705,444	$ 544,608	$ -	$ -	$ -	$ -	$ 317,724	$ 3,524	$ 1,023,168	$ 548,132
144	**Calculated Payments as a Percentage of Cost**			56%	26%	0%	0%	0%	0%	75%	99%	64%	61%

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (07/01/2022-06/30/2023) 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)*		$ 4,070,712		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	01.9900.8510	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 4,070,712	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		$ 4,070,712		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	284,050,681
19	Uninsured Hospital	**Charges Sec. G**	75,206,429
20	Total Hospital	**Charges Sec. G**	1,120,902,633
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		25.34%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.71%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$** -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	129,509,738
27	Uninsured Hospital	**Charges Sec. G**	75,206,429
28	Total Hospital	**Charges Sec. G**	1,120,902,633
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		11.55%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.71%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ -
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$** -

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

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

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