

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2026

DSH Version 6.02

2/10/2023

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2025	06/30/2026

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

TANNER MEDICAL CENTER-CARROLLTON

Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1
4. Cost Report Year 2 (if applicable)
5. Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
07/01/2023	06/30/2024

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

6. Medicaid Provider Number:

7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

9. Medicare Provider Number:

Data
000001867A
0
0
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.)
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

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

3b. What date did the hospital open?

DSH Examination
Year (07/01/25 -
06/30/26)

Yes

No

No

Yes

11/1/1949

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026

(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

\$ 4,806,120

2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2025 - 06/30/2026

(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.

\$ 3,987,953

3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2025 - 06/30/2026

\$ 8,794,073

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

CFO
Title

11/30/2025
Date

Carol S. Crews
Hospital CEO or CFO Printed Name

770-836-9745
Hospital CEO or CFO Telephone Number

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 229-883-7676
E-Mail Address bjoiner@draffin-tucker.com

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4/22/2025

D. General Cost Report Year Information 7/1/2023 - 6/30/2024

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

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):

1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database:

12/4/2024

4. Hospital Name:

TANNER MEDICAL CENTER-CARROLLTON

5. Medicaid Provider Number:

000001867A

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

0

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

0

8. Medicare Provider Number:

110011

9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):

Non-State Govt.

10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)

Pool 2

11. Rural Referral Center (Yes or No)

No

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

12. State Name & Number

13. State Name & Number

14. State Name & Number

15. State Name & Number

16. State Name & Number

17. State Name & Number

18. State Name & Number

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2023 - 06/30/2024)

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)**

9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)

10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)

11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)

12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

\$-

\$-

Inpatient

\$ 121,996

\$ 1,763,036

\$ 1,885,032

6.47%

Outpatient

\$ 483,984

\$ 7,148,822

\$ 7,632,806

6.34%

Total

\$605,980

\$8,911,858

\$9,517,838

6.37%

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

\$ 4,865,064

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

\$4,865,064

<-- 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.

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 (07/01/2023 - 06/30/2024)**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)

54,852

(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
8. Outpatient Hospital Charity Care Charges
9. Non-Hospital Charity Care Charges
10. Total Charity Care Charges

16,207,542

22,328,970

\$ 38,536,512

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	\$193,285,173.00			\$ 138,829,675	\$ -	\$ -	\$ 54,455,498
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	\$384,781,421.00	\$512,238,098.00		\$ 276,374,430	\$ 367,921,902	\$ -	\$ 252,723,187
20. Outpatient Services		\$108,291,962.00			\$ 77,782,158	\$ -	\$ 30,509,804
21. Home Health Agency			\$9,145,714.00			\$ 6,569,032	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$2,374,120.00			\$ 1,705,244	
26. Other	\$0.00	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
27. Total	\$ 578,066,594	\$ 620,530,060	\$ 11,519,834	\$ 415,204,104	\$ 445,704,060	\$ 8,274,276	\$ 337,688,490
28. Total Hospital and Non Hospital		Total from Above	\$ 1,210,116,488		Total from Above	\$ 869,182,440	
29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)			Total Contractual Adj. (G-3 Line 2)			
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)	1,210,116,488			862,643,072			
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)							+
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)				6,539,368			+
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				869,182,440			-
37. Unreconciled Difference	Unreconciled Difference (Should be \$0)			Unreconciled Difference (Should be \$0)			
	\$ -			\$ -			

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) 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
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.		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. 1, 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	\$ 71,335,334	\$ -	\$ -	\$0.00	\$ 71,335,334	58,501	\$97,654,200.00	\$ 1,219.39
2	03100 INTENSIVE CARE UNIT	\$ 14,791,118	\$ -	\$ -		\$ 14,791,118	5,022	\$15,726,623.00	\$ 2,945.26
3	03200 CORONARY CARE UNIT	\$ 4,061,552	\$ -	\$ -		\$ 4,061,552	228	\$781,472.00	\$ 17,813.82
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	\$ 3,492,435	\$ -	\$ -		\$ 3,492,435	2,415	\$2,412,628.00	\$ 1,446.14
11	3301 NEONATAL INTENSIVE CARE UNIT	\$ 5,220,800	\$ -	\$ -		\$ 5,220,800	2,312	\$5,879,769.00	\$ 2,258.13
12		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18	Total Routine	\$ 98,901,239	\$ -	\$ -	\$ -	\$ 98,901,239	68,478	\$ 122,454,692	
19	Weighted Average								\$ 1,444.28

Observation Data (Non-Distinct)

20	09200 Observation (Non-Distinct)		13.626	-	-	\$ 16,615,408	\$11,610,166.00	\$21,298,442.00	\$ 32,908,608	0.504895
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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
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000 OPERATING ROOM	\$45,533,815.00	\$ -		\$ 45,533,815	\$71,664,178.00	\$126,222,414.00	\$ 197,886,592	0.230101
22	5200 DELIVERY ROOM & LABOR ROOM	\$7,962,381.00	\$ -		\$ 7,962,381	\$6,485,842.00	\$61,941.00	\$ 6,547,783	1.216042
23	5400 RADIOLOGY-DIAGNOSTIC	\$15,380,408.00	\$ -		\$ 15,380,408	\$9,033,248.00	\$31,102,592.00	\$ 40,135,840	0.383209
24	5500 RADIOLOGY-THERAPEUTIC	\$4,929,963.00	\$ -		\$ 4,929,963	\$940,863.00	\$36,153,103.00	\$ 37,093,966	0.132905
25	5600 RADIOISOTOPE	\$2,146,384.00	\$ -		\$ 2,146,384	\$3,795,824.00	\$17,483,002.00	\$ 21,278,826	0.100869
26	5700 CT SCAN	\$4,325,188.00	\$ -		\$ 4,325,188	\$29,979,917.00	\$97,294,369.00	\$ 127,274,286	0.033983
27	5800 MRI	\$2,312,687.00	\$ -		\$ 2,312,687	\$7,214,517.00	\$21,299,794.00	\$ 28,514,311	0.081106
28	5900 CARDIAC CATHETERIZATION	\$9,930,358.00	\$ -		\$ 9,930,358	\$25,675,916.00	\$18,898,667.00	\$ 44,574,583	0.222781
29	6000 LABORATORY	\$16,638,481.00	\$ -		\$ 16,638,481	\$74,019,103.00	\$48,971,854.00	\$ 122,990,957	0.135282

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) 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
30	6500 RESPIRATORY THERAPY	\$11,637,631.00	\$ -	-	\$ 11,637,631	\$37,043,013.00	\$33,449,466.00	\$ 70,492,479	0.165090
31	6600 PHYSICAL THERAPY	\$3,968,761.00	\$ -	-	\$ 3,968,761	\$7,479,940.00	\$1,438,340.00	\$ 8,918,280	0.445014
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$8,762,342.00	\$ -	-	\$ 8,762,342	\$31,171,151.00	\$16,687,152.00	\$ 47,858,303	0.183089
33	7200 IMPL. DEV. CHARGED TO PATIENTS	\$18,246,122.00	\$ -	-	\$ 18,246,122	\$18,721,093.00	\$29,991,259.00	\$ 48,712,352	0.374569
34	7300 DRUGS CHARGED TO PATIENTS	\$19,460,956.00	\$ -	-	\$ 19,460,956	\$86,059,653.00	\$61,035,286.00	\$ 147,094,939	0.132302
35	7600 PARTIAL HOSPITALIZATION PROGRAM	\$3,824,631.00	\$ -	-	\$ 3,824,631	\$160.00	\$8,279,042.00	\$ 8,279,202	0.461956
36	7697 CARDIAC REHABILITATION	\$1,009,442.00	\$ -	-	\$ 1,009,442	\$2,502.00	\$1,054,142.00	\$ 1,056,644	0.955328
37	7698 HYPERBARIC OXYGEN THERAPY	\$156,768.00	\$ -	\$ -	\$ 156,768	\$0.00	\$828,537.00	\$ 828,537	0.189211
38	9002 WOUND CARE	\$958,323.00	\$ -	\$ -	\$ 958,323	\$17,236.00	\$3,680,091.00	\$ 3,697,327	0.259193
39	9100 EMERGENCY	\$22,453,349.00	\$ -	\$ -	\$ 22,453,349	\$14,524,575.00	\$73,752,616.00	\$ 88,277,191	0.254351
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	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) 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
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
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	\$ 199,637,990	\$ -	\$ -	\$ 199,637,990	\$ 435,438,897	\$ 648,982,109	\$ 1,084,421,006	
127	Weighted Average								0.199418
128	Sub Totals	\$ 298,539,229	\$ -	\$ -	\$ 298,539,229	\$ 557,893,589	\$ 648,982,109	\$ 1,206,875,698	
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				\$ 298,539,229				
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 (07/01/2023-06/30/2024)

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 & 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 PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
			From Section G	From Section G															
					Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	
1		03000 ADULTS & PEDIATRICS	\$ 1,219.39		2,312	1,793			2,415		5,108		248		1,705		11,876		32.41%
2		03100 INTENSIVE CARE UNIT	\$ 2,945.26		140	96			84		231		6		187		559		16.65%
3		03200 CORONARY CARE UNIT	\$ 17,813.82			5			4		10				8		19		13.60%
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	\$ 1,446.14		138	933					221		43		125		1,335		61.24%
11		3301 NEONATAL INTENSIVE CARE UNIT	\$ 2,258.13		438	988					102		45		48		1,573		72.75%
12			\$ -														-		
13			\$ -														-		
14			\$ -														-		
15			\$ -														-		
16			\$ -														-		
17			\$ -														-		
18			\$ -														-		
19		Total Days			3,028	3,817			2,503		5,672		342		2,073		15,362		27.12%
20		Total Days per PS&R or Exhibit Detail			3,028	3,817			2,503		5,672		342		2,073				
20		Unreconciled Days (Explain Variance)			-	-			-		-		-		-				
21		Routine Charges	\$ 6,875,431		\$ 7,280,770		\$ 5,917,006		\$ 12,709,722		\$ 677,691		\$ 4,785,390		\$ 32,782,929		\$ 2,134.03		32.94%
21.01		Calculated Routine Charge Per Diem	\$ 2,270.62		\$ 1,907.46		\$ 2,363.97		\$ 2,240.78		\$ 1,981.55		\$ 2,308.44						
		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	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22		09200 Observation (Non-Distinct)	0.504895		612,272	581,202	380,793	696,665	556,039	466,913	1,324,873	2,610,433	54,886	35,153	555,071	1,753,045	\$ 2,873,977	\$ 4,355,213	30.88%
23		5000 OPERATING ROOM	0.230101		2,445,398	2,363,219	2,190,184	8,933,176	1,764,882	1,450,271	5,635,432	6,466,857	243,489	247,444	2,788,230	4,036,171	\$ 12,035,896	\$ 19,213,523	20.40%
24		5200 DELIVERY ROOM & LABOR ROOM	1.216042		220,373	2,062	2,593,068	7,146	6,591	-	935,108	92,622	92,622	3,395	232,774	3,395	\$ 3,755,140	\$ 9,208	63.54%
25		5400 RADIOLOGY-DIAGNOSTIC	0.383209		465,409	1,075,000	476,270	2,492,217	387,756	413,245	838,402	1,867,633	60,840	107,179	358,089	1,920,794	\$ 2,167,637	\$ 5,848,116	27.20%
26		5500 RADIOLOGY-THERAPEUTIC	0.132905		43,460	836,594	-	494,774	43,815	696,543	137,402	2,303,389	-	43,628	48,169	1,149,496	\$ 224,677	\$ 4,331,300	16.31%
27		5600 RADIOISOTOPE	0.100869		164,654	346,127	55,116	255,478	205,318	182,764	305,765	1,194,301	9,829	28,894	185,281	491,059	\$ 730,853	\$ 1,978,671	17.43%
28		5700 CT SCAN	0.033983		1,737,184	2,986,792	492,445	5,038,141	1,919,854	2,962,340	7,047,262	116,034	338,348	1,596,520	9,616,941	6,728,632	\$ 16,992,030	\$ 28,909	28.90%
29		5800 MRI	0.081106		329,761	697,613	109,876	582,304	244,613	640,950	1,173,105	31,428	165,540	-	38,181	839,789	\$ 1,324,201	\$ 2,734,663	26.54%
30		5900 CARDIAC CATHETERIZATION	0.222781		-	169,220	669,942	163,183	669,942	209,010	1,761,869	1,006,292	35,737	-	2,103,115	505,168	\$ 2,601,031	\$ 1,378,485	16.87%
31		6000 LABORATORY	0.135282		3,942,174	1,904,677	3,053,581	3,751,072	3,293,329	881,142	7,017,461	3,598,967	304,619	182,913	3,230,687	4,042,517	\$ 17,306,545	\$ 10,135,858	30.33%
32		6500 RESPIRATORY THERAPY	0.165090		2,583,124	1,101,678	1,732,175	1,210,473	1,564,312	549,671	3,562,343	2,297,838	96,389	133,131	1,587,469	1,402,133	\$ 9,441,547	\$ 5,150,660	27.16%
33		6600 PHYSICAL THERAPY	0.445014		327,332	5,567	102,336	17,720	372,609	26,171	760,157	124,289	968	49,265	164,531	49,265	\$ 1,562,433	\$ 176,747	29.91%
34		7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.183089		1,058,864	352,996	794,141	422,252	878,161	261,829	2,734,279	1,051,500	59,407	11,948	1,012,339	425,025	\$ 5,465,445	\$ 2,089,576	26.42%
35		7200 IMPL. DEV. CHARGED TO PATIENTS	0.374569		613,792	693,092	258,463	912,848	436,307	447,546	1,682,066	1,613,320	78,342	8,014	534,045	545,422	\$ 2,990,628	\$ 3,666,806	16.67%
36		7300 DRUGS CHARGED TO PATIENTS	0.132302		4,118,065	1,685,575	3,420,359	3,639,218	3,470,571	1,039,808	8,891,204	4,835,348	292,898	234,563	3,785,374	5,572,741	\$ 19,900,199	\$ 11,199,948	28.60%
37		7600 PARTIAL HOSPITALIZATION PROGRAM	0.461866		-	206,406	-	2,302,181	600	-	2,854,655	-	157,560	-	70,049	-	\$ 5,163,844	\$ 16,229	16.22%
38		7697 CARDIAC REHABILITATION	0.955328		-	-	-	2,387	-	12,978	-	21,304	-	3,678	-	29,722	\$ -	\$ 36,669	6.63%
39		7698 HYPERBARIC OXYGEN THERAPY	0.189211		-	-	-	-	-	-	-	23,556	-	3,624	-	-	\$ -	\$ 23,556	3.28%
40		8002 WOUND CARE	0.259193		10,394	4,905	-	1,530	474	1,314	435	8,187	-	-	-	-	\$ 11,303	\$ 15,936	0.79%
41		9100 EMERGENCY	0.254351		863,780	3,510,032	375,294	11,227,351	827,633	1,409,438	1,580,202	5,052,833	80,679	484,841	778,007	11,185,085	\$ 3,667,019	\$ 21,199,654	43.75%
42			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
43			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
44			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
45			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
46			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
47			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
48			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
49			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
50			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
51			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
52			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
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58			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
59			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
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61			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
62			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
63			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
64			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
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66			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
67			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
68			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
69			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-
70			-		-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-

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

Cost Report Year (07/01/2023-06/30/2024) 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									
71				-													\$	-	-								
72				-													\$	-	-								
73				-													\$	-	-								
74				-													\$	-	-								
75				-													\$	-	-								
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123				-													\$	-	-								
124				-													\$	-	-								
125				-													\$	-	-								
126				-													\$	-	-								
127				-													\$	-	-								
				\$	19,556,035	\$	18,356,558	\$	16,202,231	\$	42,150,117	\$	16,269,215	\$	10,250,717	\$	40,760,288	\$	44,951,069	\$	1,586,879	\$	2,207,424	\$	19,327,882	\$	43,727,815

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

Cost Report Year (07/01/2023-06/30/2024) 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 & 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				
Totals / Payments																																	
128	Total Charges (includes organ acquisition from Section J)																	\$ 26,431,466	\$ 18,356,558	\$ 23,483,001	\$ 42,150,117	\$ 22,186,221	\$ 10,250,717	\$ 53,470,010	\$ 44,951,069	\$ 2,284,570	\$ 2,207,424	\$ 24,113,272 (Agrees to Exhibit A)	\$ 43,727,815 (Agrees to Exhibit A)	\$ 125,570,699	\$ 115,708,461	27.04%	
129	Total Charges per PS&R or Exhibit Detail																	\$ 26,431,466	\$ 18,356,558	\$ 23,483,001	\$ 42,150,117	\$ 22,186,221	\$ 10,250,717	\$ 53,470,010	\$ 44,951,069	\$ 2,284,570	\$ 2,207,424	\$ 24,113,272	\$ 43,727,815				
130	Unreconciled Charges (Explain Variance)																																
131	Total Calculated Cost (includes organ acquisition from Section J)																	\$ 8,148,019	\$ 3,535,877	\$ 11,779,955	\$ 9,255,083	\$ 6,222,261	\$ 1,919,713	\$ 16,236,307	\$ 9,403,672	\$ 888,834	\$ 434,697	\$ 6,836,098	\$ 8,004,029	\$ 42,386,542	\$ 24,114,345	28.73%	
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)																	\$ 5,397,035	\$ 3,271,612			\$ 555,365	\$ 160,806	\$ 405,983	\$ 444,056					\$ 6,358,383	\$ 3,876,474		
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)																			\$ 5,884,995	\$ 7,494,616			\$ 16,803	\$ 98,523					\$ 5,901,798	\$ 7,593,139		
134	Private Insurance (including primary and third party liability)																	\$ 117,808	\$ 6,668					\$ 5,411,107	\$ 5,477,227					\$ 5,528,915	\$ 5,483,895		
135	Self-Pay (including Co-Pay and Spend-Down)																	\$ 38	\$ 1,545	\$ 84	\$ 8,326		\$ 302	\$ 10,960	\$ 13,303	\$ 4,530	\$ 2,840			\$ 11,082	\$ 23,476		
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)																	\$ 5,514,881	\$ 3,279,825	\$ 5,885,079	\$ 7,502,942												
137	Medicaid Cost Settlement Payments (See Note B)																		\$ (413,143)												\$ -	\$ (413,143)	
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)																					\$ 4,309,987	\$ 1,249,928	\$ 333,087	\$ 196,837					\$ 4,643,074	\$ 1,446,765		
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)																							\$ 8,324,565	\$ 4,081,053					\$ 8,324,565	\$ 4,081,053		
141	Medicare Cross-Over Bad Debt Payments																					\$ 75,117	\$ 15,648							\$ 75,117	\$ 15,648		
142	Other Medicare Cross-Over Payments (See Note D)																					\$ 386,908	\$ 211,661	\$ (20,229)	\$ 34,936					\$ 366,679	\$ 246,597		
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)																											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)				
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)																											\$ 121,996	\$ 483,984				
																												\$ -	\$ -				
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)																	\$ 2,633,138	\$ 669,195	\$ 5,894,876	\$ 1,752,141	\$ 894,884	\$ 281,368	\$ 1,754,031	\$ (942,263)	\$ 884,304	\$ 431,857	\$ 6,714,102	\$ 7,520,045	\$ 11,176,929	\$ 1,760,441		
146	Calculated Payments as a Percentage of Cost																	68%	81%	50%	81%	86%	85%	89%	110%	1%	1%	2%	6%	74%	93%		
147	Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)																						30,589										
148	Percent of cross-over days to total Medicare days from the cost report																						9%										

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 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 payment.
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 (07/01/2023-06/30/2024) TANNER MEDICAL CENTER-CARROLLTON

		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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
Line #	Cost Center Description			Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
Routine Cost Centers (list below):				Days	Days	Days	Days	Days	Days	Days	Days		
03000	ADULTS & PEDIATRICS	\$ 1,219.39		377				282		305		964	
03100	INTENSIVE CARE UNIT	\$ 2,945.26		46				25		19		90	
03200	CORONARY CARE UNIT	\$ 17,813.82		2				1		1		4	
03300	BURN INTENSIVE CARE UNIT	\$ -										-	
03400	SURGICAL INTENSIVE CARE UNIT	\$ -										-	
03500	OTHER SPECIAL CARE UNIT	\$ -										-	
04000	SUBPROVIDER I	\$ -										-	
04100	SUBPROVIDER II	\$ -										-	
04200	OTHER SUBPROVIDER	\$ -										-	
04300	NURSERY	\$ 1,446.14		6						13		19	
3301	NEONATAL INTENSIVE CARE UNIT	\$ 2,258.13		43						18		61	
		\$ -										-	
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Cost Report Year (07/01/2023-06/30/2024)	TANNER MEDICAL CENTER-CARROLLTON
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Cost Report Year (07/01/2023-06/30/2024)	TANNER MEDICAL CENTER-CARROLLTON
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Totals / Payments

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 (07/01/2023-06/30/2024) 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)*	\$ 4,764,517	
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)	\$ 4,764,517	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	\$ 4,764,517	

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	263,002,159
19 Uninsured Hospital Charges Sec. G	67,841,086
20 Total Hospital Charges Sec. G	1,206,875,698
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	21.79%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	5.62%
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	118,380,370
27 Uninsured Hospital Charges Sec. G	72,313,081
28 Total Hospital Charges Sec. G	1,206,875,698
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	9.81%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	5.99%
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.