

**EXAMINER ADJUSTED SURVEY**

Workpaper #:		Reviewer:
Examiner:		
Date:		

DSH Version 8.00 1/28/2021

**D. General Cost Report Year Information 7/1/2019 - 6/30/2020**

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:

AU MEDICAL CENTER

2. Select Cost Report Year Covered by this Survey:

7/1/2019 through 6/30/2020		
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:

8/31/2021

4. Hospital Name:

Data	Correct?	If Incorrect, Proper Information
AU MEDICAL CENTER	Yes	
000000723A	Yes	
0	-	
0	-	
110034	Yes	

5. Medicaid Provider Number:

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

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

8. Medicare Provider Number:

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

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)

State Name	Provider No.
South Carolina	315846
South Carolina	358127

**E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2019 - 06/30/2020)**

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)

Inpatient	Outpatient	Total
\$ 173,370	\$ 995,214	\$1,168,584
\$ 1,541,415	\$ 10,529,818	\$12,071,233
\$1,714,785	\$11,525,032	\$13,239,817
10.11%	8.64%	8.83%

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)

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

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?

No

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

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

\$ -

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

\$ -

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

\$ -

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

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

## F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2019 - 06/30/2020)

### 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) 121,536

### 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	2,334,343
3. Outpatient Hospital Subsidies	-
4. Unspecified I/P and O/P Hospital Subsidies	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	\$ 2,334,343
7. Inpatient Hospital Charity Care Charges	116,039,040
8. Outpatient Hospital Charity Care Charges	104,300,168
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 220,339,208

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

	Total Patient Revenues (Charges)			Contractual Adjustments			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$ 182,592,997	\$ -	\$ -	\$ 143,632,704	\$ -	\$ -	\$ 38,960,293
12. Psych Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13. Rehab. Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$ -			\$ -	
15. Swing Bed - NF			\$ -			\$ -	
16. Skilled Nursing Facility			\$ -			\$ -	
17. Nursing Facility			\$ -			\$ -	
18. Other Long-Term Care			\$ -			\$ -	
19. Ancillary Services	\$ 1,187,798,178	\$ 1,703,216,751	\$ -	\$ 934,354,911	\$ 1,339,797,422	\$ -	\$ 616,862,596
20. Outpatient Services	\$ 130,150,665	\$ -	\$ -	\$ 102,380,114	\$ -	\$ -	\$ 27,770,551
21. Home Health Agency			\$ -			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
24. ASC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
25. Hospice			\$ -			\$ -	
26. Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
28. Total Hospital and Non Hospital	Total from Above		\$ 3,203,758,591	Total from Above		\$ 2,520,165,151	
29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)		\$ 3,203,758,591	Total Contractual Adj. (G-3 Line 2)		\$ 2,520,165,151	
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)						\$ -	
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						\$ -	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)						\$ -	
35. Adjusted Contractual Adjustments						2,520,165,151	
36. Unreconciled Difference	Unreconciled Difference (Should be \$0)		\$ -	Unreconciled Difference (Should be \$0)		\$ -	

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (07/01/2019-06/30/2020) AU MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col. 2 and Col. 4	Swing-Bed Curve 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):**

03000	ADULTS & PEDIATRICS	\$ 117,872,749	\$ 25,429,409	\$ 413,075	\$ -	\$ 143,715,233	95,469	\$ 86,684,490	\$ 1,505.36
03100	INTENSIVE CARE UNIT	\$ 22,317,193	\$ -	\$ -	\$ -	\$ 22,317,193	13,837	\$ 36,601,001	\$ 1,612.86
03200	CORONARY CARE UNIT	\$ 3,657,527	\$ -	\$ -	\$ -	\$ 3,657,527	3,263	\$ 3,508,578	\$ 1,120.91
03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
03400	SURGICAL INTENSIVE CARE UNIT	\$ 6,787,434	\$ -	\$ -	\$ -	\$ 6,787,434	3,485	\$ 9,444,585	\$ 1,947.61
03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
04300	NURSERY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
3101	PEDIATRIC INTENSIVE CARE UNIT	\$ 7,655,618	\$ -	\$ -	\$ -	\$ 7,655,618	3,203	\$ 15,647,744	\$ 2,390.14
3401	TRAUMA INTENSIVE CARE UNIT	\$ 6,495,723	\$ -	\$ -	\$ -	\$ 6,495,723	3,641	\$ 15,243,421	\$ 1,784.05
3402	NEONATAL INTENSIVE CARE UNIT	\$ 17,154,926	\$ 548,047	\$ -	\$ -	\$ 17,702,973	8,201	\$ 38,160,706	\$ 2,158.64
Total Routine		\$ 181,941,170	\$ 25,977,456	\$ 413,075	\$ -	\$ 208,331,701	131,099	\$ 205,290,525	
Weighted Average									\$ 1,589.12

**Observation Data (Non-Distinct)**

09200	Observation (Non-Distinct)		9,563	-	-	\$ 14,395,758	\$ 1,292,152	\$ 12,478,581	\$ 13,770,733	1.045388
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**Ancillary Cost Centers (from W/S C excluding Observation) (list below):**

5000	OPERATING ROOM	\$ 97,337,194	\$ 4,603,600	\$ 55,854	\$ -	\$ 101,996,648	\$ 92,347,798	\$ 123,004,253	\$ 215,352,051	0.473627
5200	DELIVERY ROOM & LABOR ROOM	\$ 6,650,770	\$ 2,192,190	\$ 25,219	\$ -	\$ 8,868,179	\$ 6,872,658	\$ 116,495	\$ 6,989,153	1.268849
5300	ANESTHESIOLOGY	\$ 3,342,300	\$ 5,370,867	\$ 19,381	\$ -	\$ 8,732,548	\$ 38,273,460	\$ 40,574,399	\$ 78,847,859	0.110752
5400	RADIOLOGY-DIAGNOSTIC	\$ 27,308,621	\$ 2,630,628	\$ 11,510	\$ -	\$ 29,950,759	\$ 80,605,284	\$ 80,467,854	\$ 161,073,138	0.185945
5500	RADIOLOGY-THERAPEUTIC	\$ 12,172,663	\$ -	\$ 959	\$ -	\$ 12,173,622	\$ 1,610,350	\$ 71,007,560	\$ 72,617,910	0.167639
5600	RADIOISOTOPE	\$ 3,877,954	\$ -	\$ -	\$ -	\$ 3,877,954	\$ 2,240,509	\$ 29,629,366	\$ 31,869,875	0.121681
5700	CT SCAN	\$ 3,006,225	\$ -	\$ -	\$ -	\$ 3,006,225	\$ 46,282,682	\$ 75,207,923	\$ 121,490,605	0.024745
5800	MRI	\$ 2,840,884	\$ -	\$ -	\$ -	\$ 2,840,884	\$ 13,544,407	\$ 43,531,580	\$ 57,075,987	0.049774
5900	CARDIAC CATHETERIZATION	\$ 6,670,224	\$ -	\$ -	\$ -	\$ 6,670,224	\$ 23,309,588	\$ 24,600,962	\$ 47,910,550	0.139222
6000	LABORATORY	\$ 43,413,100	\$ 1,096,095	\$ 6,157	\$ -	\$ 44,515,352	\$ 218,534,781	\$ 170,974,227	\$ 389,509,008	0.114286

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (07/01/2019-06/30/2020) AU MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	\$ 5,089,926	\$ -	\$ -	\$ 5,089,926	\$ 13,983,172	\$ 3,116,117	\$ 17,099,289	0.297669
32	6500 RESPIRATORY THERAPY	\$ 14,488,096	\$ -	\$ -	\$ 14,488,096	\$ 105,310,845	\$ 8,208,124	\$ 113,518,969	0.127627
33	6600 PHYSICAL THERAPY	\$ 5,678,322	\$ -	\$ -	\$ 5,678,322	\$ 5,862,399	\$ 9,130,088	\$ 14,992,487	0.378745
34	6700 OCCUPATIONAL THERAPY	\$ 3,423,712	\$ -	\$ -	\$ 3,423,712	\$ 4,597,688	\$ 1,872,942	\$ 6,470,630	0.529116
35	6800 SPEECH PATHOLOGY	\$ 1,651,069	\$ -	\$ -	\$ 1,651,069	\$ 3,587,273	\$ 1,708,471	\$ 5,295,744	0.311773
36	6900 ELECTROCARDIOLOGY	\$ 16,914,091	\$ 1,205,705	\$ -	\$ 18,119,796	\$ 22,087,558	\$ 45,404,871	\$ 67,492,429	0.268472
37	7000 ELECTROENCEPHALOGRAPHY	\$ 2,021,274	\$ -	\$ -	\$ 2,021,274	\$ 8,419,942	\$ 14,116,096	\$ 22,536,038	0.089691
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 20,416,926	\$ -	\$ -	\$ 20,416,926	\$ 80,012,446	\$ 57,021,003	\$ 137,033,449	0.148992
39	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 47,379,297	\$ -	\$ -	\$ 47,379,297	\$ 116,419,069	\$ 84,189,625	\$ 200,608,694	0.236178
40	7300 DRUGS CHARGED TO PATIENTS	\$ 144,457,158	\$ -	\$ -	\$ 144,457,158	\$ 221,104,289	\$ 671,569,479	\$ 892,673,768	0.161825
41	7400 RENAL DIALYSIS	\$ 2,533,951	\$ -	\$ -	\$ 2,533,951	\$ 3,159,039	\$ 366,346	\$ 3,525,385	0.718773
42	9000 CLINIC	\$ 52,500,462	\$ 1,863,362	\$ 11,208	\$ 54,375,032	\$ 687,032	\$ 134,078,506	\$ 134,765,538	0.403479
43	9100 EMERGENCY	\$ 35,183,539	\$ 4,055,553	\$ 106,479	\$ 39,345,571	\$ 49,365,805	\$ 101,655,744	\$ 151,021,549	0.260530
44	10500 KIDNEY ACQUISITION	\$ 7,048,553	\$ -	\$ -	\$ 7,048,553	\$ 12,324,490	\$ 298,663	\$ 12,623,153	-
45	10900 PANCREAS ACQUISITION	\$ 78,710	\$ -	\$ -	\$ 78,710	\$ 166,454	\$ -	\$ 166,454	-
126	<b>Total Ancillary</b>	\$ 565,485,021	\$ 23,018,000	\$ 236,767	\$ 588,739,788	\$ 1,172,001,170	\$ 1,804,329,275	\$ 2,976,330,445	
127	<b>Weighted Average</b>								<b>0.201114</b>
128	<b>Sub Totals</b>	\$ 747,426,191	\$ 48,995,456	\$ 649,842	\$ 797,071,489	\$ 1,377,291,695	\$ 1,804,329,275	\$ 3,181,620,970	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$ -				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$ -				
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	<b>Grand Total</b>				\$ 797,071,489				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				<b>6.55%</b>				

\* 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 (07/01/2019-06/30/2020) AU MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
		From Section G	From Section G													
	<b>Routine Cost Centers (from Section G):</b>			<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>			
1	03000 ADULTS & PEDIATRICS	\$ 1,505.36		10,314	4,446			5,806		734		6,141		21,300		38.08%
2	03100 INTENSIVE CARE UNIT	\$ 1,612.86		2,093	121			1,309		65		4,188		983		43.90%
3	03200 CORONARY CARE UNIT	\$ 1,120.91		228	30			630		18		906		386		43.09%
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-	-			-		-		-		-		
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ 1,947.61		-	10			369		9		185		388		20.14%
6	03500 OTHER SPECIAL CARE UNIT	\$ -		-	-			-		-		-		-		
7	04000 SUBPROVIDER I	\$ -		-	-			-		-		-		-		
8	04100 SUBPROVIDER II	\$ -		-	-			-		-		-		-		
9	04200 OTHER SUBPROVIDER	\$ -		-	-			-		-		-		-		
10	04300 NURSERY	\$ -		-	-			-		-		-		-		
11	3101 PEDIATRIC INTENSIVE CARE UNIT	\$ 2,390.14		788	549			18		187		23		1,542		61.50%
12	3401 TRAUMA INTENSIVE CARE UNIT	\$ 1,784.05		366	39			167		42		364		614		31.78%
13	3402 NEONATAL INTENSIVE CARE UNIT	\$ 2,158.64		36	4,759			-		348		69		5,143		83.15%
18			<b>Total Days</b>	14,425	9,954			8,299		1,403		8,151		34,081		41.83%
19	Total Days per PS&R or Exhibit Detail			14,425	9,954			8,299		1,403		8,151				
20	Unreconciled Days (Explain Variance)			-	-			-		-		-				
21	Routine Charges	\$ 24,631,044		\$ 24,631,044	\$ 21,875,781			\$ 12,333,912		\$ 3,136,431		\$ 11,890,954		\$ 61,977,168		43.93%
21.01	Calculated Routine Charge Per Diem	\$ 1,707.52		\$ 1,707.52	\$ 2,197.69			\$ 1,486.19		\$ 2,235.52		\$ 1,458.83		\$ 1,818.53		
	<b>Ancillary Cost Centers (from WIS C) (from Section G):</b>			<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	
22	09200 Observation (Non-Distinct)		1.045388	\$ 478,710	\$ 1,156,999	\$ 74,820	\$ 1,234,126	\$ 155,772	\$ 928,586	\$ 16,096	\$ 177,636	\$ 113,408	\$ 1,362,669	\$ 725,398	\$ 3,497,347	48.49%
23	5000 OPERATING ROOM		0.473627	\$ 10,464,662	\$ 7,591,085	\$ 4,616,103	\$ 9,170,983	\$ 4,503,403	\$ 4,079,338	\$ 1,118,762	\$ 796,311	\$ 6,555,829	\$ 5,710,085	\$ 20,702,930	\$ 21,637,717	29.97%
24	5200 DELIVERY ROOM & LABOR ROOM		1.268849	\$ 33,599	\$ 10,117	\$ 1,993,534	\$ 15,999	\$ 38,069	\$ -	\$ 322,352	\$ 717	\$ 115,440	\$ 717	\$ 2,437,584	\$ 26,116	45.15%
25	5300 ANESTHESIOLOGY		0.110752	\$ 3,128,160	\$ 1,972,218	\$ 1,462,484	\$ 2,322,365	\$ 2,028,511	\$ 1,990,372	\$ 461,455	\$ 325,603	\$ 2,789,065	\$ 2,086,852	\$ 7,080,610	\$ 7,110,558	29.07%
26	5400 RADIOLOGY-DIAGNOSTIC		0.185945	\$ 4,056,892	\$ 3,411,761	\$ 2,933,807	\$ 5,923,367	\$ 5,789,355	\$ 3,687,040	\$ 1,243,974	\$ 854,504	\$ 7,502,294	\$ 7,414,958	\$ 14,024,091	\$ 13,876,672	15.65%
27	5500 RADIOLOGY-THERAPEUTIC		0.167639	\$ 249,836	\$ 4,541,787	\$ 109,698	\$ 2,062,985	\$ 34,035	\$ 2,854,392	\$ 2,985	\$ 143,419	\$ 44,878	\$ 2,788,325	\$ 396,554	\$ 9,602,583	21.67%
28	5600 RADIOISOTOPE		0.121681	\$ 150,647	\$ 416,090	\$ 35,480	\$ 455,785	\$ 214,341	\$ 1,420,864	\$ 1,582	\$ 59,656	\$ 177,814	\$ 1,056,921	\$ 402,050	\$ 2,352,395	15.43%
29	5700 CT SCAN		0.024745	\$ 3,992,724	\$ 3,655,066	\$ 942,045	\$ 1,981,413	\$ 3,302,212	\$ 3,820,663	\$ 276,979	\$ 412,245	\$ 5,074,671	\$ 10,239,479	\$ 8,513,960	\$ 9,869,387	32.18%
30	5800 MRI		0.049774	\$ 1,184,451	\$ 2,103,210	\$ 483,954	\$ 2,376,394	\$ 776,818	\$ 1,684,229	\$ 49,910	\$ 257,341	\$ 1,136,200	\$ 2,065,541	\$ 2,495,133	\$ 6,421,174	26.40%
31	5900 CARDIAC CATHETERIZATION		0.139222	\$ 1,130,288	\$ 407,117	\$ 277,776	\$ 408,476	\$ 2,278,496	\$ 1,271,380	\$ 107,512	\$ 143,296	\$ 1,291,868	\$ 638,506	\$ 3,794,072	\$ 2,230,269	19.48%
32	6000 LABORATORY		0.114286	\$ 22,847,590	\$ 10,868,317	\$ 8,685,490	\$ 9,420,665	\$ 16,949,107	\$ 7,555,431	\$ 1,875,958	\$ 1,108,147	\$ 14,874,735	\$ 13,675,394	\$ 50,358,145	\$ 28,752,560	32.80%
33	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.297669	\$ 1,379,415	\$ 731,591	\$ 745,136	\$ 197,848	\$ 596,042	\$ 177,595	\$ 229,920	\$ 706,595	\$ 295,395	\$ 2,950,513	\$ 2,950,513	\$ 1,127,662	36.04%
34	6500 RESPIRATORY THERAPY		0.127627	\$ 13,100,819	\$ 861,323	\$ 7,492,001	\$ 987,595	\$ 7,933,295	\$ 470,050	\$ 1,489,511	\$ 147,963	\$ 4,984,729	\$ 543,275	\$ 30,015,626	\$ 2,466,931	41.14%
35	6600 PHYSICAL THERAPY		0.378745	\$ 652,672	\$ 114,866	\$ 427,965	\$ 76,570	\$ 409,178	\$ 150,321	\$ 59,362	\$ 28,362	\$ 328,492	\$ 123,234	\$ 1,549,177	\$ 370,119	22.39%
36	6700 OCCUPATIONAL THERAPY		0.529116	\$ 502,289	\$ 15,108	\$ 366,351	\$ 17,253	\$ 281,829	\$ 39,841	\$ 42,686	\$ 3,672	\$ 266,679	\$ 36,930	\$ 1,193,255	\$ 75,874	30.30%
37	6800 SPEECH PATHOLOGY		0.311773	\$ 383,632	\$ 20,538	\$ 410,159	\$ 94,405	\$ 220,012	\$ 36,947	\$ 34,901	\$ 11,702	\$ 175,566	\$ 24,764	\$ 1,048,704	\$ 163,592	34.05%
38	6900 ELECTROCARDIOLOGY		0.268472	\$ 4,334,870	\$ 1,892,817	\$ 735,409	\$ 2,043,887	\$ 1,795,008	\$ 2,189,069	\$ 203,757	\$ 302,864	\$ 1,662,030	\$ 1,391,711	\$ 7,069,044	\$ 6,428,637	28.38%
39	7000 ELECTROENCEPHALOGRAPHY		0.089691	\$ 1,615,342	\$ 846,346	\$ 250,406	\$ 1,960,002	\$ 587,352	\$ 863,870	\$ 236,604	\$ 200,705	\$ 488,109	\$ 433,318	\$ 2,691,764	\$ 3,670,923	38.18%
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.148992	\$ 6,609,824	\$ 2,174,138	\$ 2,767,804	\$ 2,362,895	\$ 4,465,517	\$ 2,628,349	\$ 737,852	\$ 351,243	\$ 5,517,289	\$ 2,674,749	\$ 14,580,997	\$ 7,516,625	26.26%
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.236178	\$ 8,008,552	\$ 3,851,546	\$ 3,045,428	\$ 1,824,393	\$ 6,076,026	\$ 4,578,644	\$ 623,206	\$ 501,382	\$ 6,514,338	\$ 2,657,551	\$ 17,753,212	\$ 10,755,965	22.57%
42	7300 DRUGS CHARGED TO PATIENTS		0.161825	\$ 26,439,431	\$ 36,002,293	\$ 9,264,010	\$ 14,878,849	\$ 13,939,775	\$ 28,732,340	\$ 2,067,476	\$ 2,365,203	\$ 13,051,785	\$ 14,460,743	\$ 51,710,692	\$ 81,978,685	22.05%
43	7400 RENAL DIALYSIS		0.718773	\$ 405,432	\$ -	\$ 14,337	\$ 7,913	\$ 523,026	\$ 76,273	\$ 7,176	\$ 2,478	\$ 50,640	\$ 15,975	\$ 949,971	\$ 86,664	38.16%
44	9000 CLINIC		0.403479	\$ 20,372	\$ 6,111,498	\$ 74,247	\$ 8,328,916	\$ 64,476	\$ 6,189,285	\$ 13,101	\$ 716,962	\$ 23,488	\$ 7,672,968	\$ 172,196	\$ 21,346,661	26.11%
45	9100 EMERGENCY		0.260530	\$ 4,085,796	\$ 7,334,145	\$ 1,426,291	\$ 9,558,241	\$ 3,163,472	\$ 4,533,448	\$ 299,781	\$ 1,105,031	\$ 6,321,408	\$ 20,952,670	\$ 8,975,340	\$ 22,530,865	43.95%
46	10500 KIDNEY ACQUISITION		-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
47	10900 PANCREAS ACQUISITION		-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
				115,306,005	95,889,976	48,634,858	78,611,325	76,125,227	79,358,327	11,524,928	10,036,353	79,763,350	98,322,730			
	<b>Totals / Payments</b>															
128	Total Charges (includes organ acquisition from Section J)			\$ 140,098,514	\$ 95,889,976	\$ 70,510,639	\$ 78,611,325	\$ 91,028,225	\$ 79,358,327	\$ 15,089,540	\$ 10,036,353	\$ 91,654,304	\$ 98,322,730	\$ 316,726,918	\$ 263,895,981	29.04%
129	Total Charges per PS&R or Exhibit Detail			\$ 140,098,514	\$ 95,889,976	\$ 70,510,639	\$ 78,611,325	\$ 91,028,227	\$ 79,358,327	\$ 15,089,540	\$ 10,036,353	\$ 91,654,304	\$ 98,322,730			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	(2)	-	-	-	-	-			
131.01	Sampling Cost Adjustment (if applicable)															
131.02	Total Calculated Cost (includes organ acquisition from Section J)			\$ 45,016,478	\$ 20,359,536	\$ 30,123,104	\$ 18,838,661	\$ 27,862,937	\$ 16,340,191	\$ 5,321,398	\$ 2,231,832	\$ 27,463,013	\$ 20,919,947	\$ 108,323,917	\$ 57,770,220	32.30%
132	Total Medicaid Paid Amount (excludes TPL Co-Pay and Spend-Down)			\$ 30,418,900	\$ 16,433,535	\$ -	\$ -	\$ 557,764	\$ 734,398	\$ 200,434	\$ 223,950			\$ 31,176,998	\$ 17,391,883	
133	Total Medicaid Managed Care Paid Amount (excludes TPL Co-Pay and Spend-Down) (See Note E)			\$ -	\$ -	\$ 12,771,381	\$ 11,793,799	\$ -	\$ -	\$ -	\$ -			\$ 12,771,381	\$ 11,793,799	
134	Private Insurance (including primary and third party liability)			\$ 193,939	\$ 53,982	\$ 140,417	\$ 3,765	\$ -	\$ -	\$ 2,845,283	\$ 1,962,043			\$ 3,179,639	\$ 2,019,790	

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

Cost Report Year (07/01/2019-06/30/2020) AU MEDICAL CENTER

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 1,888	\$ 44,356	\$ 2,659	\$ 22,285	\$ 2,057	\$ 15,659	\$ 104,509	\$ 218,163			\$ 111,113	\$ 300,463	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 30,614,627	\$ 16,531,873	\$ 12,914,457	\$ 11,819,849									
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)					\$ 8,963,655	\$ 3,924,023	\$ -	\$ -			\$ 8,963,655	\$ 3,924,023	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 8,759,112	\$ 4,330,052	\$ -	\$ -			\$ 8,759,112	\$ 4,330,052	
141 Medicare Cross-Over Bad Debt Payments					\$ 495,782	\$ 500,989	\$ -	\$ -			\$ 495,782	\$ 500,989	
142 Other Medicare Cross-Over Payments (See Note D)					\$ 2,403,987	\$ 850,331	\$ -	\$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	\$ 2,403,987	\$ 850,331	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 173,370	\$ 995,214			
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									\$ -	\$ -			
145 <b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 14,401,851	\$ 3,827,663	\$ 17,208,647	\$ 7,018,812	\$ 6,680,580	\$ 5,984,739	\$ 2,171,172	\$ (172,324)	\$ 27,289,643	\$ 19,924,733	\$ 40,462,250	\$ 16,658,890	
146 <b>Calculated Payments as a Percentage of Cost</b>	68%	81%	43%	63%	76%	63%	59%	108%	1%	5%	63%	71%	
147 <b>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 &amp; 6)</b>					39,517								
148 <b>Percent of cross-over days to total Medicare days from the cost report</b>					27%								

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.

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

## I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2019-06/30/2020) AU MEDICAL CENTER

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-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		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):													
1	03000 ADULTS & PEDIATRICS	\$ 1,505.36		Days 1,600		Days 1,553		Days 1,942		Days 179		Days 5,274	
2	03100 INTENSIVE CARE UNIT	\$ 1,612.86		327		260		302		15		904	
3	03200 CORONARY CARE UNIT	\$ 1,120.91		12		34		65		3		114	
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ 1,947.61		19		18		92		-		129	
6	03500 OTHER SPECIAL CARE UNIT	\$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	\$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	\$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	\$ -		-		-		-		-		-	
10	04300 NURSERY	\$ -		-		-		-		-		-	
11	3101 PEDIATRIC INTENSIVE CARE UNIT	\$ 2,390.14		67		233		9		96		405	
12	3401 TRAUMA INTENSIVE CARE UNIT	\$ 1,784.05		119		24		24		12		179	
13	3402 NEONATAL INTENSIVE CARE UNIT	\$ 2,158.64		460		1,064		-		83		1,607	
18	Total Days		2,604			3,186		2,434		388		8,612	
19	Total Days per PS&R or Exhibit Detail		2,604			3,186		2,434		388			
20	Unreconciled Days (Explain Variance)		-			-		-		-			
21	Routine Charges		\$ 4,960,365			\$ 6,869,706		\$ 3,484,654		\$ 999,413		\$ 16,314,138	
21.01	Calculated Routine Charge Per Diem		\$ 1,904.90			\$ 2,156.22		\$ 1,431.66		\$ 2,575.81		\$ 1,894.35	
Ancillary Cost Centers (from W/S C) (list below):													
22	09200 Observation (Non-Distinct)	1.045388	17,940	188,816	41,608	382,048	51,460	237,152	3,900	56,220	\$ 114,908	\$ 864,236	
23	5000 OPERATING ROOM	0.473627	1,357,207	1,011,751	1,708,939	2,652,409	1,215,205	1,247,343	286,089	464,073	\$ 4,567,440	\$ 5,375,576	
24	5200 DELIVERY ROOM & LABOR ROOM	1.268849	146,928	1,272	353,724	623			73,522		\$ 574,174	\$ 1,895	
25	5300 ANESTHESIOLOGY	0.110752	524,231	395,429	618,270	1,003,442	511,970	504,635	132,778	170,994	\$ 1,787,249	\$ 2,074,500	
26	5400 RADIOLOGY-DIAGNOSTIC	0.185945	1,109,266	728,110	1,256,799	2,010,498	1,464,891	1,133,193	144,926	310,439	\$ 3,975,882	\$ 4,182,240	
27	5500 RADIOLOGY-THERAPEUTIC	0.167639	43,581	734,845	69,859	1,101,275	47,578	861,000	-	49,193	\$ 161,018	\$ 2,746,313	
28	5600 RADIOISOTOPE	0.121681	25,128	139,594	18,144	205,496	56,337	451,162	7,523	25,497	\$ 107,132	\$ 821,749	
29	5700 CT SCAN	0.024745	702,194	571,908	585,885	1,170,218	978,397	1,096,390	102,951	185,682	\$ 2,369,427	\$ 3,024,198	
30	5800 MRI	0.049774	320,042	291,366	270,785	1,012,369	221,825	603,630	66,151	162,540	\$ 878,803	\$ 2,069,905	
31	5900 CARDIAC CATHETERIZATION	0.139222	112,728	114,056	175,609	171,046	409,750	361,478	-	33,156	\$ 698,087	\$ 679,736	
32	6000 LABORATORY	0.114286	3,720,791	1,445,664	4,392,495	2,856,881	4,595,015	2,418,252	550,744	418,093	\$ 13,259,045	\$ 7,138,890	
33	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.297669	208,956	88,603	369,876	82,135	208,623	80,754	15,383	28,839	\$ 802,838	\$ 280,331	
34	6500 RESPIRATORY THERAPY	0.127627	2,362,077	77,392	2,622,897	307,463	2,658,610	126,753	480,369	59,229	\$ 8,123,953	\$ 570,837	
35	6600 PHYSICAL THERAPY	0.378745	113,941	169,240	409,546	57,561	123,601	59,899	18,850	32,733	\$ 665,938	\$ 319,433	
36	6700 OCCUPATIONAL THERAPY	0.529116	106,795	45,198	118,578	10,028	75,772	11,612	19,729	439	\$ 320,874	\$ 67,277	
37	6800 SPEECH PATHOLOGY	0.311773	97,598	81,382	125,465	21,591	44,307	12,257	2,980	5,068	\$ 270,350	\$ 120,298	
38	6900 ELECTROCARDIOLOGY	0.268472	250,526	263,326	352,921	540,216	407,878	634,337	44,517	109,032	\$ 1,055,842	\$ 1,546,911	
39	7000 ELECTROENCEPHALOGRAPHY	0.089691	213,927	152,373	99,847	421,983	88,166	133,274	78,559	132,364	\$ 480,499	\$ 839,994	
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.148992	1,036,687	281,687	1,300,822	808,837	1,185,993	770,361	168,613	138,990	\$ 3,692,115	\$ 1,999,875	
41	7200 IMPL. DEV. CHARGED TO PATIENTS	0.236178	1,438,649	411,606	1,222,807	1,414,914	1,707,089	996,970	160,257	238,673	\$ 4,528,802	\$ 3,062,163	
42	7300 DRUGS CHARGED TO PATIENTS	0.161825	4,579,469	1,935,241	4,649,595	5,394,715	5,199,012	11,092,860	846,544	1,956,043	\$ 15,274,620	\$ 20,378,859	
43	7400 RENAL DIALYSIS	0.718773	17,499	-	42,366	1,239	152,841	25,260	-	2,718	\$ 212,706	\$ 29,217	
44	9000 CLINIC	0.403479	7,864	1,040,963	14,911	2,895,331	20,164	1,815,981	2,898	306,087	\$ 45,837	\$ 6,058,362	
45	9100 EMERGENCY	0.260530	715,577	1,103,320	700,604	2,808,448	798,870	1,035,975	90,782	334,086	\$ 2,305,833	\$ 5,281,829	
46	10500 KIDNEY ACQUISITION	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
47	10900 PANCREAS ACQUISITION	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
				19,229,601	11,273,142	21,522,352	27,330,766	22,223,354	25,710,528	3,298,065	5,220,188		
Totals / Payments													
128	Total Charges (includes organ acquisition from Section K)			\$ 24,189,966	\$ 11,273,142	\$ 28,534,785	\$ 27,330,766	\$ 26,707,097	\$ 25,710,528	\$ 4,297,478	\$ 5,220,188	\$ 83,729,326	\$ 69,534,624
129	Total Charges per PS&R or Exhibit Detail			\$ 24,189,967	\$ 11,273,142	\$ 28,534,785	\$ 27,330,766	\$ 26,707,097	\$ 25,710,528	\$ 4,297,478	\$ 5,220,188		
130	Unreconciled Charges (Explain Variance)			(1)	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											\$ -	\$ -
131.02	Total Calculated Cost (includes organ acquisition from Section K)			\$ 7,966,455	\$ 2,601,109	\$ 10,242,782	\$ 6,289,561	\$ 8,273,451	\$ 5,109,634	\$ 1,399,437	\$ 1,109,269	\$ 27,882,125	\$ 15,109,573

**I. Out-of-State Medicaid Data:**

Cost Report Year (07/01/2019-06/30/2020) AU MEDICAL CENTER

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 3,111,069	\$ 178,277	\$ -	\$ -	\$ 174,535	\$ 34,893	\$ 13,699	\$ 42,751	\$ 3,299,303	\$ 255,921
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 2,254,171	\$ 2,161,233	\$ -	\$ -	\$ -	\$ -	\$ 2,254,171	\$ 2,161,233
134	Private Insurance (including primary and third party liability)	\$ 259,330	\$ 13,497	\$ 1,376,527	\$ 1,861,004	\$ -	\$ -	\$ 1,307,975	\$ 1,049,190	\$ 2,943,832	\$ 2,923,691
135	Self-Pay (including Co-Pay and Spend-Down)	\$ 4,475	\$ 14,814	\$ 426	\$ 5,385	\$ 1,675	\$ 9,140	\$ 3,675	\$ 60,463	\$ 10,251	\$ 89,802
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 3,374,874	\$ 206,588	\$ 3,631,124	\$ 4,027,622						
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)					\$ 3,236,527	\$ 1,295,229	\$ -	\$ -	\$ 3,236,527	\$ 1,295,229
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 1,935,583	\$ 1,386,228	\$ -	\$ -	\$ 1,935,583	\$ 1,386,228
141	Medicare Cross-Over Bad Debt Payments					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)					\$ 1,167,974	\$ 303,914	\$ -	\$ -	\$ 1,167,974	\$ 303,914
143	<b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 4,591,581	\$ 2,394,521	\$ 6,611,658	\$ 2,261,939	\$ 1,757,157	\$ 2,080,230	\$ 74,088	\$ (43,135)	\$ 13,034,484	\$ 6,693,555
144	<b>Calculated Payments as a Percentage of Cost</b>	42%	8%	35%	64%	79%	59%	95%	104%	53%	56%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).

Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).

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

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

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



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

Cost Report Year (07/01/2019-06/30/2020)

AU MEDICAL CENTER

	Total Organ Acquisition Cost			Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		
	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Charges			Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost			From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis	
Similar to Instructions from Cost Report WS D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.																
Organ Acquisition Cost Centers (list below):																
1	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
2	Kidney Acquisition	\$ 7,897,063	\$ 517,220	\$ 8,414,283	\$ -	100	\$ 161,465	1	\$ -	0	\$ 2,569,086	18	\$ 428,181	3	\$ -	0
3	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
4	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
5	Pancreas Acquisition	\$ 79,957	\$ 5,237	\$ 85,194	\$ -	1	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
6	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
7	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
8		\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
9	Totals	\$ 7,977,020	\$ 522,457	\$ 8,499,477	\$ -	101	\$ 161,465	1	\$ -	-	\$ 2,569,086	18	\$ 428,181	3	\$ -	-
10	Total Cost						84,143		-		1,514,571		252,429			-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B: Enter Organ Acquisition Payments in Section D as part of your In-State Medicaid total payments.

Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (07/01/2019-06/30/2020)

AU MEDICAL CENTER

		Total Organ Acquisition Cost			Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost			Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	
Organ Acquisition Cost Centers (list below):															
11	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
12	Kidney Acquisition	\$ 7,897,063	\$ 517,220	\$ 8,414,283	\$ -	100	\$ -	0	\$ 142,727	1	\$ 999,089	7	\$ -	0	
13	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
14	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
15	Pancreas Acquisition	\$ 79,957	\$ 5,237	\$ 85,194	\$ -	1	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
16	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
17	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
18		\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
19	Totals	\$ 7,977,020	\$ 522,457	\$ 8,499,477	\$ -	101	\$ -	-	\$ 142,727	1	\$ 999,089	7	\$ -	-	
20	Total Cost							-		84,143		589,000			

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey)

Note B: Enter Organ Acquisition Payments in Section E as part of your Out-of-State Medicaid total payments.

## L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (07/01/2019-06/30/2020) AU MEDICAL CENTER

### Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line
1	Hospital Gross Provider Tax Assessment (from general ledger)*	\$ -	
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	\$ -	0 (WTB Account #)
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ -	- (Where is the cost included on w/s A?)
3	Difference (Explain Here ----->)	\$ -	
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>			
4	Reclassification Code	\$ -	- (Reclassified to / (from))
5	Reclassification Code	\$ -	- (Reclassified to / (from))
6	Reclassification Code	\$ -	- (Reclassified to / (from))
7	Reclassification Code	\$ -	- (Reclassified to / (from))
<b>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>			
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))
<b>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>			
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	\$ -	

### DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	\$ -
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid &amp; Uninsured:</b>		
18	Medicaid Hospital Charges Sec. G	733,886,849
19	Uninsured Hospital Charges Sec. G	189,977,034
20	Total Hospital Charges Sec. G	3,181,620,970
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	23.07%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	5.97%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25	Provider Tax Assessment Adjustment to DSH UCC	\$ -

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

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

## DSH Examination Eligibility Summary

Hospital Name	AU MEDICAL CENTER		
Hospital Medicaid Number	000000723A		
Cost Report Period	From	7/1/2019	To 6/30/2020

		As-Reported	Adjustments	As-Adjusted
<b>LIUR</b>				
1 Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	\$ 85,103,437	\$ -	\$ 85,103,437
2 Hospital Cash Subsidies	Survey F-2	\$ 2,334,343	\$ -	\$ 2,334,343
3 Total		\$ 87,437,780	\$ -	\$ 87,437,780
4 Net Hospital Patient Revenue	Survey F-3	\$ 683,593,440	\$ -	\$ 683,593,440
5 Medicaid Fraction		12.75%	0.00%	12.75%
6 Inpatient Charity Care Charges	Survey F-2	\$ 116,039,040	\$ -	\$ 116,039,040
7 Inpatient Hospital Cash Subsidies	Survey F-2	\$ 2,334,343	\$ -	\$ 2,334,343
8 Unspecified Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
9 Adjusted Inpatient Charity Care		\$ 113,704,697	\$ -	\$ 113,704,697
10 Inpatient Hospital Charges	Survey F-3	\$ 1,370,391,175	\$ -	\$ 1,370,391,175
11 Inpatient Charity Fraction		8.30%	0.00%	8.30%
12 LIUR		21.05%	0.00%	21.05%
<b>MIUR</b>				
13 In-State Medicaid Eligible Days	Survey H	34,081	-	34,081
14 Out-of-State Medicaid Eligible Days	Survey I	8,612	-	8,612
15 Total Medicaid Eligible Days		42,693	-	42,693
16 Total Hospital Days (excludes swing-bed)	Survey F-1	121,536	-	121,536
17 MIUR		35.13%	0.00%	35.13%

NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.

DSH Examination UCC Cost & Payment Summary

Georgia

Hospital Name **AU MEDICAL CENTER**  
Hospital Medicaid Number **00000723A**  
Cost Report Period From **7/1/2019** To **6/30/2020**

As-Reported:		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1 Medicaid Fee for Service	Inpatient	45,016,478	30,418,800	-	193,939	1,888	-	-	-	-	-	-	-	-	30,614,627	14,401,851	68.01%
2 Medicaid Fee for Service	Outpatient	20,359,536	16,433,535	-	53,982	44,356	-	-	-	-	-	-	-	-	16,531,873	3,827,663	81.20%
3 Medicaid Managed Care	Inpatient	30,123,104	-	12,771,381	140,417	2,659	-	-	-	-	-	-	-	-	12,914,457	17,208,647	42.87%
4 Medicaid Managed Care	Outpatient	18,838,661	-	11,793,799	3,765	22,285	-	-	-	-	-	-	-	-	11,819,849	7,018,812	62.74%
5 Medicare Cross-over (FFS)	Inpatient	27,862,937	557,764	-	-	2,057	-	-	8,963,655	8,759,112	495,782	2,403,987	-	-	21,182,357	6,680,580	76.02%
6 Medicare Cross-over (FFS)	Outpatient	16,340,191	734,398	-	-	15,659	-	-	3,924,023	4,330,052	500,989	850,331	-	-	10,355,452	5,984,739	63.37%
7 Other Medicaid Eligibles	Inpatient	5,321,398	200,434	-	2,845,283	104,509	-	-	-	-	-	-	-	-	3,150,226	2,171,172	59.20%
8 Other Medicaid Eligibles	Outpatient	2,231,832	223,950	-	1,962,043	218,163	-	-	-	-	-	-	-	-	2,404,156	(172,324)	107.72%
9 Uninsured	Inpatient	27,463,013	-	-	-	-	-	-	-	-	-	-	173,370	-	173,370	27,289,643	0.63%
10 Uninsured	Outpatient	20,919,947	-	-	-	-	-	-	-	-	-	-	995,214	-	995,214	19,924,733	4.76%
11 In-State Sub-total	Inpatient	135,786,930	31,176,998	12,771,381	3,179,639	111,113	-	-	8,963,655	8,759,112	495,782	2,403,987	173,370	-	68,035,037	67,751,893	50.10%
12 In-State Sub-total	Outpatient	78,690,167	17,391,883	11,793,799	2,019,790	300,463	-	-	3,924,023	4,330,052	500,989	850,331	995,214	-	42,106,544	36,583,623	53.51%
13 Out-of-State Medicaid	Inpatient	27,882,125	3,299,303	2,254,171	2,943,832	10,251	-	-	3,236,527	1,935,583	-	1,167,974	-	-	14,847,641	13,034,484	53.25%
14 Out-of-State Medicaid	Outpatient	15,109,573	255,921	2,161,233	2,923,691	89,802	-	-	1,295,229	1,386,228	-	303,914	-	-	8,416,018	6,693,555	55.70%
15 Sub-Total	I/P and O/P	257,468,795	52,124,105	28,980,584	11,066,952	511,628	-	-	17,419,434	16,410,975	996,771	4,726,206	1,168,584	-	133,405,239	124,063,556	51.81%

Adjustments:		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
1 Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
2 Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
3 Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
4 Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
9 Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10 Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11 In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12 In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15 Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%

DSH Examination UCC Cost & Payment Summary Georgia

Hospital Name		AU MEDICAL CENTER															
Hospital Medicaid Number		000000723A															
Cost Report Period		From	7/1/2019		To	6/30/2020											
As-Adjusted:																	
Service Type		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
						Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments												
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1 Medicaid Fee for Service	Inpatient	45,016,478	30,418,800	-	193,939	1,888	-	-	-	-	-	-	-	-	30,614,627	14,401,851	68.01%
2 Medicaid Fee for Service	Outpatient	20,359,536	16,433,535	-	53,982	44,356	-	-	-	-	-	-	-	-	16,531,873	3,827,663	81.20%
3 Medicaid Managed Care	Inpatient	30,123,104	-	12,771,381	140,417	2,659	-	-	-	-	-	-	-	-	12,914,457	17,208,647	42.87%
4 Medicaid Managed Care	Outpatient	18,838,661	-	11,793,799	3,765	22,285	-	-	-	-	-	-	-	-	11,819,849	7,018,812	62.74%
5 Medicare Cross-over (FFS)	Inpatient	27,862,937	557,764	-	-	2,057	-	-	8,963,655	8,759,112	495,782	2,403,987	-	-	21,182,357	6,680,580	76.02%
6 Medicare Cross-over (FFS)	Outpatient	16,340,191	734,398	-	-	15,659	-	-	3,924,023	4,330,052	500,989	850,331	-	-	10,355,452	5,984,739	63.37%
7 Other Medicaid Eligibles	Inpatient	5,321,398	200,434	-	2,845,283	104,509	-	-	-	-	-	-	-	-	3,150,226	2,171,172	59.20%
8 Other Medicaid Eligibles	Outpatient	2,231,832	223,950	-	1,962,043	218,163	-	-	-	-	-	-	-	-	2,404,156	(172,324)	107.72%
9 Uninsured	Inpatient	27,463,013	-	-	-	-	-	-	-	-	-	-	173,370	-	173,370	27,289,643	0.63%
10 Uninsured	Outpatient	20,919,947	-	-	-	-	-	-	-	-	-	-	995,214	-	995,214	19,924,733	4.76%
11 In-State Sub-total	Inpatient	135,786,930	31,176,998	12,771,381	3,179,639	111,113	-	-	8,963,655	8,759,112	495,782	2,403,987	173,370	-	68,035,037	67,751,893	50.10%
12 In-State Sub-total	Outpatient	78,690,167	17,391,883	11,793,799	2,019,790	300,463	-	-	3,924,023	4,330,052	500,989	850,331	995,214	-	42,106,544	36,583,623	53.51%
13 Out-of-State Medicaid	Inpatient	27,882,125	3,299,303	2,254,171	2,943,832	10,251	-	-	3,236,527	1,935,583	-	1,167,974	-	-	14,847,641	13,034,484	53.25%
14 Out-of-State Medicaid	Outpatient	15,109,573	255,921	2,161,233	2,923,691	89,802	-	-	1,295,229	1,386,228	-	303,914	-	-	8,416,018	6,693,555	55.70%
15 Cost Report Year Sub-Total	I/P and O/P	257,468,795	52,124,105	28,980,584	11,066,952	511,628	-	-	17,419,434	16,410,975	996,771	4,726,206	1,168,584	-	133,405,239	124,063,556	51.81%
16																	-
17																	
Less: Out of State DSH Payments from Adjusted Survey																	
Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments																	
124,063,556																	

Medicaid DSH Survey Adjustments

PROVIDER: AU MEDICAL CENTER  
FROM: 7/1/2019

TO: 6/30/2020

Mcaid Number: 000000723A  
Mcare Number: 110034

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
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**Medicaid DSH Report Notes**

PROVIDER: AU MEDICAL CENTER

Mcaid Number: 000000723A

FROM: 7/1/2019

TO: 6/30/2020

Mcare Number: 110034

**Myers and Stauffer DSH Report Notes**

Note #	Note for Report	Amounts
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