

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2018	06/30/2019

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

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)
10/01/2018	09/30/2019

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	
000001163A	
0	
0	
111326	

B. DSH OB 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 (07/01/18 -
 06/30/19)

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019 \$ 83,511
 (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2018 - 06/30/2019
 (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
 NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2018 - 06/30/2019 \$ 83,511

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.



 Hospital CEO or CFO Signature

Grant Byers

 Hospital CEO or CFO Printed Name

 CFO Title

912-259-4162

 Hospital CEO or CFO Telephone Number



 Date

grant.byers@sgmc.org

 Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Grant Byers
Title	CFO
Telephone Number	229-259-4162
E-Mail Address	grant.byers@sgmc.org
Mailing Street Address	2501 N Patterson Street
Mailing City, State, Zip	Valdosta, GA 31602

Outside Preparer:

Name	Wes Sternberg
Title	Partner
Firm Name	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	wssternberg@draffin-tucker.com

D. General Cost Report Year Information **10/1/2018 - 9/30/2019**

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

- 1. Select Your Facility from the Drop-Down Menu Provided:
- 2. Select Cost Report Year Covered by this Survey (enter "X"):

10/1/2018 through 9/30/2019	X	
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- 3. Status of Cost Report Used for this Survey (Should be audited if available):
- 3a. Date CMS processed the HCRIS file into the HCRIS database:

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	SOUTH GEORGIA MED CTR - LANIER		
5. Medicaid Provider Number:	000001163A		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	111326		
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.		
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural		

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

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2018 - 09/30/2019)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$ 3,371	\$ 49,167	\$52,538
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 9,704	\$ 185,174	\$194,878
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)	\$13,075	\$234,341	\$247,416
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	25.78%	20.98%	21.23%

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 (10/01/2018 - 09/30/2019)

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

1. Total Hospital Days Per Cost Report Excluding Swing-Bed(C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)

495

(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

	90,066
	436,213
\$	526,279

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)			
11. Hospital	\$1,306,498.00			\$ 543,667	\$ -	\$ -	\$ 762,831
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			\$5,322,585.00			\$ 2,214,863	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$3,223,818.00	\$6,962,957.00		\$ 1,341,513	\$ 2,897,464	\$ -	\$ 5,947,799
20. Outpatient Services		\$3,221,704.00			\$ 1,340,633	\$ -	\$ 1,881,071
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00			\$ -	
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$0.00			\$ -	
26. Other	\$0.00	\$0.00	\$903,960.00	\$ -	\$ -	\$ 376,161	\$ -
27. Total	\$ 4,530,316	\$ 10,184,661	\$ 6,226,545	\$ 1,885,180	\$ 4,238,097	\$ 2,591,024	\$ 8,591,701

- 29. Total Per Cost Report
- 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)
- 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)"
- 35. Adjusted Contractual Adjustments
- 36. Unreconciled Difference

Total Patient Revenues (G-3 Line 1)	20,941,522	Total Contractual Adj. (G-3 Line 2)	7,897,981
			816,319
			8,714,300
Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MED CTR - LANIER

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

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

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 2,481,642	\$ -	\$ -	\$ 1,740,241.00	\$ 741,401	716	\$ 1,306,498.00	\$ 1,035.48
2	03100	INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
10	04300	NURSERY	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
18		Total Routine	\$ 2,481,642	\$ -	\$ -	\$ 1,740,241	\$ 741,401	716	\$ 1,306,498	\$ 1,035.48
19		Weighted Average								\$ 1,035.48

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio	
20	09200	Observation (Non-Distinct)	221	-	\$ 228,841	\$ 25,683.00	\$ 214,282.00	\$ 239,965	0.953643

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	5400	RADIOLOGY-DIAGNOSTIC	\$ 334,441.00	\$ -	\$ 0.00	\$ 334,441	\$ 76,776.00	\$ 759,224.00	\$ 836,000	0.400049
22	5700	CT SCAN	\$ 428,060.00	\$ -	\$ 0.00	\$ 428,060	\$ 140,338.00	\$ 2,693,742.00	\$ 2,834,080	0.151040
23	6000	LABORATORY	\$ 1,452,651.00	\$ -	\$ 0.00	\$ 1,452,651	\$ 476,414.00	\$ 1,330,076.00	\$ 1,806,490	0.804129
24	6600	PHYSICAL THERAPY	\$ 987,612.00	\$ -	\$ 0.00	\$ 987,612	\$ 858,504.00	\$ 558,387.00	\$ 1,416,891	0.697028
25	6900	ELECTROCARDIOLOGY	\$ 34,542.00	\$ -	\$ 0.00	\$ 34,542	\$ 17,066.00	\$ 228,951.00	\$ 246,017	0.140405
26	7000	ELECTROENCEPHALOGRAPHY	\$ 24,987.00	\$ -	\$ 0.00	\$ 24,987	\$ 0.00	\$ 95,919.00	\$ 95,919	0.260501
27	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 441,282.00	\$ -	\$ 0.00	\$ 441,282	\$ 224,000.00	\$ 46,364.00	\$ 270,364	1.632177
28	7300	DRUGS CHARGED TO PATIENTS	\$ 498,776.00	\$ -	\$ 0.00	\$ 498,776	\$ 1,430,720.00	\$ 1,250,294.00	\$ 2,681,014	0.186040
29	9100	EMERGENCY	\$ 2,141,006.00	\$ -	\$ 0.00	\$ 2,141,006	\$ 66,711.00	\$ 2,915,028.00	\$ 2,981,739	0.718039

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MED CTR - LANIER

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		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
31		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
32		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
33		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
36		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MED CTR - LANIER

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	\$0.00	\$ -	-
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 6,343,357	\$ -	\$ -	\$ 6,343,357	\$ 3,316,212	\$ 10,092,267	\$ 13,408,479	
127	Weighted Average								0.490152
128	Sub Totals	\$ 8,824,999	\$ -	\$ -	\$ 7,084,758	\$ 4,622,710	\$ 10,092,267	\$ 14,714,977	
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)				\$893,831.00				
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				\$ 6,190,927				
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 (10/01/2018-09/30/2019) SOUTH GEORGIA MED CTR - LANIER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	\$ 1,035.48		14		3		50		10		95		77		34.75%
2	03100 INTENSIVE CARE UNIT	\$ -														
3	03200 CORONARY CARE UNIT	\$ -														
4	03300 BURN INTENSIVE CARE UNIT	\$ -														
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -														
6	03500 OTHER SPECIAL CARE UNIT	\$ -														
7	04000 SUBPROVIDER I	\$ -														
8	04100 SUBPROVIDER II	\$ -														
9	04200 OTHER SUBPROVIDER	\$ -														
10	04300 NURSERY	\$ -														
11		\$ -														
12		\$ -														
13		\$ -														
14		\$ -														
15		\$ -														
16		\$ -														
17		\$ -														
18			Total Days	14		3		50		10		95		77		24.02%
19	Total Days per PS&R or Exhibit Detail			14		3		50		10		95				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
21	Routine Charges			\$ 6,622		\$ 2,895		\$ 45,399		\$ 9,650		\$ 67,585		\$ 84,557		10.11%
21.01	Calculated Routine Charge Per Diem			\$ 473.00		\$ 965.00		\$ 907.80		\$ 965.00		\$ 711.42		\$ 838.40		
Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)	0.953643		574	5,240	-	11,644	4,770	28,089	876	12,474	137	16,646	6,220	57,447	33.53%
23	5400 RADIOLOGY-DIAGNOSTIC	0.409049		1,719	46,989	465	103,350	6,400	65,369	358	42,212	3,793	110,861	8,942	257,920	48.24%
24	5700 CT SCAN	0.151040		90,954	90,954	3,085	250,128	17,125	219,752	-	121,113	13,086	583,335	20,194	677,947	46.14%
25	6000 LABORATORY	0.804129		5,424	108,024	3,571	124,638	38,064	187,450	6,549	92,565	21,044	53,608	512,675	46.87%	
26	6600 PHYSICAL THERAPY	0.697028		466	19,763	-	18,036	1,495	33,540	-	37,062	8,741	3,744	1,961	108,401	8.67%
27	6900 ELECTROCARDIOLOGY	0.140405		-	15,224	-	16,586	3,719	18,512	200	11,200	1,000	46,712	3,919	61,522	46.08%
28	7000 ELECTROENCEPHALOGRAPHY	0.260501		-	15,835	-	-	-	6,334	-	3,167	-	3,167	-	25,336	29.72%
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.632177		872	2,917	-	3,801	3,153	5,624	96	2,987	5,837	8,571	4,121	15,329	12.52%
30	7300 DRUGS CHARGED TO PATIENTS	0.186040		25,175	42,842	8,626	140,526	64,063	90,309	13,390	52,419	87,965	313,360	111,254	326,096	31.40%
31	9100 EMERGENCY	0.719039		5,236	181,896	458	499,726	15,270	153,483	1,305	100,977	8,018	798,188	22,269	936,082	59.67%
32																
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MED CTR - LANIER

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	%
61													\$ -	-
62													\$ -	-
63													\$ -	-
64													\$ -	-
65													\$ -	-
66													\$ -	-
67													\$ -	-
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125													\$ -	-
126													\$ -	-
127													\$ -	-
			\$ 39,466	\$ 529,685	\$ 16,185	\$ 1,168,433	\$ 154,063	\$ 804,462	\$ 22,774	\$ 476,176	\$ 149,621	\$ 2,136,261	\$ -	-

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

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MED CTR - LANIER

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
Totals / Payments													
128 Total Charges (includes organ acquisition from Section J)	\$ 46,088	\$ 529,685	\$ 19,080	\$ 1,168,433	\$ 199,453	\$ 804,462	\$ 32,424	\$ 476,176	\$ 217,206 <i>(Agrees to Exhibit A)</i>	\$ 2,136,261 <i>(Agrees to Exhibit A)</i>	\$ 297,045	\$ 2,978,755	38.53%
129 Total Charges per PS&R or Exhibit Detail	\$ 46,088	\$ 529,685	\$ 19,080	\$ 1,168,433	\$ 199,453	\$ 804,462	\$ 32,424	\$ 476,176	\$ 217,206	\$ 2,136,261			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 30,285	\$ 287,776	\$ 8,561	\$ 596,522	\$ 121,672	\$ 400,073	\$ 20,212	\$ 236,873	\$ 156,800	\$ 1,006,122	\$ 180,730	\$ 1,521,244	46.57%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 29,192	\$ 219,690			\$ 6,390	\$ 52,879		\$ 11,525			\$ 35,582	\$ 284,094	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 11,890	\$ 300,726				\$ 2,572			\$ 11,890	\$ 303,298	
134 Private Insurance (including primary and third party liability)	\$ 2,218	\$ 1,940		\$ 885		\$ 580		\$ 38,406			\$ 2,218	\$ 41,811	
135 Self-Pay (including Co-Pay and Spend-Down)		\$ 594	\$ 13	\$ 753		\$ 957		\$ 1,063			\$ 13	\$ 3,367	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 31,410	\$ 222,224	\$ 11,903	\$ 302,364									
137 Medicaid Cost Settlement Payments (See Note B)		\$ (9,286)											
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)													
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 83,488	\$ 287,340					\$ 83,488	\$ 287,340	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 12,508	\$ 159,100			\$ 12,508	\$ 159,100	
141 Medicare Cross-Over Bad Debt Payments					\$ 10,220	\$ 29,820					\$ 10,220	\$ 29,820	
142 Other Medicare Cross-Over Payments (See Note D)					\$ 14,545	\$ 10,688					\$ 14,545	\$ 10,688	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 3,371 <i>(Agrees to Exhibit B and B-1)</i>	\$ 49,167 <i>(Agrees to Exhibit B and B-1)</i>			
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									\$ -	\$ -			
145 Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ (1,125)	\$ 74,838	\$ (3,342)	\$ 294,158	\$ 7,029	\$ 17,809	\$ 7,704	\$ 24,207	\$ 153,429	\$ 956,955	\$ 10,266	\$ 411,012	
146 Calculated Payments as a Percentage of Cost	104%	74%	139%	51%	94%	96%	62%	90%	2%	5%	94%	73%	
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)						303							
148 Percent of cross-over days to total Medicare days from the cost report						17%							

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

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MED CTR - LANIER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
		From Section G	From Section G										
	Routine Cost Centers (list below):			Days	Days	Days	Days	Days	Days	Days	Days		
1	03000 ADULTS & PEDIATRICS	\$ 1,035.48											
2	03100 INTENSIVE CARE UNIT	\$ -											
3	03200 CORONARY CARE UNIT	\$ -											
4	03300 BURN INTENSIVE CARE UNIT	\$ -											
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -											
6	03500 OTHER SPECIAL CARE UNIT	\$ -											
7	04000 SUBPROVIDER I	\$ -											
8	04100 SUBPROVIDER II	\$ -											
9	04200 OTHER SUBPROVIDER	\$ -											
10	04300 NURSERY	\$ -											
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
			Total Days										
19	Total Days per PS&R or Exhibit Detail												
20	Unreconciled Days (Explain Variance)												
				Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges		
21	Routine Charges												
21.01	Calculated Routine Charge Per Diem			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.953643										
23	5400 RADIOLOGY-DIAGNOSTIC		0.400049		4,298				788				5,086
24	5700 CT SCAN		0.151040		12,996								12,996
25	6000 LABORATORY		0.804129		3,833				202				4,035
26	6600 PHYSICAL THERAPY		0.697028										
27	6900 ELECTROCARDIOLOGY		0.140405		200								200
28	7000 ELECTROENCEPHALOGRAPHY		0.260501										
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		1.632177										
30	7300 DRUGS CHARGED TO PATIENTS		0.186040		3,067				69				3,136
31	9100 EMERGENCY		0.718039		12,682				2,084				14,766
32													
33													
34													
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I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MED CTR - LANIER

	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
									\$	\$
110										
111										
112										
113										
114										
115										
116										
117										
118										
119										
120										
121										
122										
123										
124										
125										
126										
127										
	\$	-	\$	37,076	\$	-	\$	-	\$	3,143

Totals / Payments

128	Total Charges (Includes organ acquisition from Section K)	\$	-	\$	37,076	\$	-	\$	-	\$	-	\$	3,143	\$	-	\$	40,219
129	Total Charges per PS&R or Exhibit Detail	\$	-	\$	37,076	\$	-	\$	-	\$	-	\$	3,143	\$	-	\$	
130	Unreconciled Charges (Explain Variance)																
131	Total Calculated Cost (includes organ acquisition from Section K)	\$	-	\$	16,469	\$	-	\$	-	\$	-	\$	1,987	\$	-	\$	18,456
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$	1,823						\$	15	\$	-	\$	-	\$	1,838
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		\$	2,547						\$	282	\$	-	\$	-	\$	2,829
134	Private Insurance (including primary and third party liability)		\$	69						\$	524	\$	-	\$	-	\$	593
135	Self-Pay (including Co-Pay and Spend-Down)											\$	-	\$	-	\$	-
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$	-	\$	4,439	\$	-	\$	-								
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)											\$	12	\$	-	\$	12
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											\$	346	\$	-	\$	346
141	Medicare Cross-Over Bad Debt Payments													\$	-	\$	-
142	Other Medicare Cross-Over Payments (See Note D)													\$	-	\$	-
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$	-	\$	12,030	\$	-	\$	-	\$	-	\$	808	\$	-	\$	12,838
144	Calculated Payments as a Percentage of Cost		0%	27%	0%	0%	0%	0%	0%	59%	0%	0%					

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