State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2019

DSH Version 6.00 2/21/2020

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2018	06/30/2019

2. Select Your Facility from the Drop-Down Menu Provided: SOUTH GEORGIA MEDICAL CENTER

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	10/01/2018	09/30/2019
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000001724A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001724G
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110122

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:

	DSH Examination Year (07/01/18 - 06/30/19)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	7/1/1955

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** — $ 3,441,102
   (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 Services07/01/2018 - 06/30/2019** — $ 3,441,102

Certification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	CFO Title	11/2/2020 Date
Grant Byers Hospital CEO or CFO Printed Name	229-259-4162 Hospital CEO or CFO Telephone Number	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 Sternenberg
Title	Partner
Firm Name	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	wsternenberg@draffin-tucker.com

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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 c 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:	SOUTH GEORGIA MEDICAL CENTER		
	10/1/2018 through 9/30/2019		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/10/2020		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	SOUTH GEORGIA MEDICAL CENTER		
5. Medicaid Provider Number:	000001724A		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001724G		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110122		
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.		
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban		

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

	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)	$ 180,416	$ 924,372	$1,104,788
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,124,111	$ 8,931,853	$11,055,964
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$2,304,527	$9,856,225	$12,160,752
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	7.83%	9.38%	9.08%

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 thes 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)	72,066 (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	25,427,896
8.	Outpatient Hospital Charity Care Charges	19,240,667
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 44,668,563

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	$80,088,625.00			$ 56,655,210	$ -	$ -	$ 23,433,415
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$403,115,499.00	$481,052,789.00		$ 285,166,506	$ 340,299,848	$ -	$ 258,701,934
20.	Outpatient Services		$62,729,734.00			$ 44,375,419	$ -	$ 18,354,315
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 14,508,449	-		$ 10,263,370	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$5,208,437.00			$ 3,684,482	
26.	Other	$5,025,878.00	$0.00	$68,430,194.00	$ 3,555,339	$ -	$ 48,407,961	$ 1,470,539
27.	Total	$ 488,230,002	$ 543,782,523	$ 88,147,080	$ 345,377,055	$ 384,675,267	$ 62,355,813	$ 301,960,203

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,120,159,605	Total Contractual Adj. (G-3 Line 2)	786,478,815
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)			+	5,929,320
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				792,408,135
36.	Unreconciled Difference	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 MEDICAL CENTER

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 35,151,494	$ -	$ 65,151	$0.00	$ 35,216,645	45,493	$44,964,197.00		$ 774.11
2	03100 INTENSIVE CARE UNIT	$ 26,838,312	$ -	$ -		$ 26,838,312	21,224	$35,124,428.00		$ 1,264.53
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	$ 4,161,006	$ -	$ -		$ 4,161,006	5,349	$5,025,878.00		$ 777.90
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 66,150,812	$ -	$ 65,151	$ -	$ 66,215,963	72,066	$ 85,114,503		
19	Weighted Average									$ 918.82

		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	-	-	-	$ -	$0.00	$0.00	$ -	-

		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below)									
21	5000 OPERATING ROOM	$30,289,599.00	$ -	$0.00		$ 30,289,599	$40,032,166.00	$56,575,259.00	$ 96,607,425	0.313533
22	5200 DELIVERY ROOM & LABOR ROOM	$5,046,079.00	$ -	$0.00		$ 5,046,079	$2,013,382.00	$2,136,612.00	$ 4,149,994	1.215924
23	5300 ANESTHESIOLOGY	$1,539,029.00	$ -	$0.00		$ 1,539,029	$6,305,890.00	$12,491,416.00	$ 18,797,306	0.081875
24	5400 RADIOLOGY-DIAGNOSTIC	$34,984,743.00	$ -	$0.00		$ 34,984,743	$34,056,945.00	$80,397,966.00	$ 114,454,911	0.305664
25	5700 CT SCAN	$4,702,013.00	$ -	$0.00		$ 4,702,013	$25,546,631.00	$75,964,766.00	$ 101,511,397	0.046320
26	5800 MRI	$1,627,724.00	$ -	$0.00		$ 1,627,724	$4,666,157.00	$13,596,147.00	$ 18,262,304	0.089130
27	6000 LABORATORY	$20,486,765.00	$ -	$0.00		$ 20,486,765	$54,938,843.00	$48,134,308.00	$ 103,073,151	0.198759
28	6300 BLOOD STORING PROCESSING & TRANS.	$2,769,966.00	$ -	$0.00		$ 2,769,966	$8,299,586.00	$3,008,996.00	$ 11,308,582	0.244944
29	6500 RESPIRATORY THERAPY	$5,381,964.00	$ -	$0.00		$ 5,381,964	$21,865,845.00	$4,728,077.00	$ 26,593,922	0.202376

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MEDICAL CENTER

	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	6600	PHYSICAL THERAPY	$3,622,337.00	$ -	$0.00	$ 3,622,337	$4,051,326.00	$1,288,810.00	$ 5,340,136	0.678323
31	6700	OCCUPATIONAL THERAPY	$1,619,512.00	$ -	$0.00	$ 1,619,512	$2,835,950.00	$53,559.00	$ 2,889,509	0.560480
32	6800	SPEECH PATHOLOGY	$1,207,045.00	$ -	$0.00	$ 1,207,045	$2,190,851.00	$42,484.00	$ 2,233,335	0.540468
33	6900	ELECTROCARDIOLOGY	$3,290,705.00	$ -	$0.00	$ 3,290,705	$10,140,554.00	$11,236,533.00	$ 21,377,087	0.153936
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$9,593,815.00	$ -	$0.00	$ 9,593,815	$21,545,314.00	$15,893,734.00	$ 37,439,048	0.256252
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$23,174,036.00	$ -	$0.00	$ 23,174,036	$33,392,871.00	$39,374,620.00	$ 72,767,491	0.318467
36	7300	DRUGS CHARGED TO PATIENTS	$40,302,208.00	$ -	$0.00	$ 40,302,208	$123,383,750.00	$115,464,781.00	$ 238,848,531	0.168735
37	7400	RENAL DIALYSIS	$1,611,817.00	$ -	$0.00	$ 1,611,817	$3,335,059.00	$306,956.00	$ 3,642,015	0.442562
38	7501	IV THERAPY	$648,033.00	$ -	$0.00	$ 648,033	$4,514,379.00	$357,765.00	$ 4,872,144	0.133008
39	9000	CLINIC	$2,003,178.00	$ -	$0.00	$ 2,003,178	$536,236.00	$2,407,708.00	$ 2,943,944	0.680440
40	9001	WOUND CARE	$1,613,780.00	$ -	$0.00	$ 1,613,780	$723,846.00	$1,564,665.00	$ 2,288,511	0.705166
41	9100	EMERGENCY	$25,403,324.00	$ -	$2,005,254.00	$ 27,408,578	$7,165,785.00	$36,124,742.00	$ 43,290,527	0.633131
42	9200	OBSERVATION	$8,611,771.00	$ -	$0.00	$ 8,611,771	$5,021,161.00	$9,185,591.00	$ 14,206,752	0.606175
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 MEDICAL CENTER

	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**	$ 229,529,443	$ -	$ 2,005,254		$ 231,534,697	$ 416,562,527	$ 530,335,495	$ 946,898,022	
127		**Weighted Average**									0.244519
128		**Sub Totals**	$ 295,680,255	$ -	$ 2,070,405		$ 297,750,660	$ 501,677,030	$ 530,335,495	$ 1,032,012,525	
129		NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*					$0.00				
130		NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*					$0.00				
131		NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 297,750,660				
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 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-Overs (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 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)	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	$ 774.11		3,801		3,934		4,912		4,073		3,709		16,720		46.30%
2	03100 INTENSIVE CARE UNIT	$ 1,264.53		1,948		285		2,980		1,805		1,807		7,018		42.83%
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	$ 777.90		220		2,691		-		257		556		3,168		70.18%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	5,969		6,910		7,892		6,135		6,072		26,906		47.05%
19	Total Days per PS&R or Exhibit Detail			5,969		6,910		7,892		6,135		6,072				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 6,866,643		$ 6,898,511		$ 9,689,203		$ 7,139,633		$ 7,130,143		$ 30,593,990		45.60%
21.01	Calculated Routine Charge Per Diem			$ 1,150.38		$ 998.34		$ 1,227.72		$ 1,163.75		$ 1,174.27		$ 1,137.07		
	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)		-											$ -	$ -	
23	5000 OPERATING ROOM		0.313533	1,674,209	2,227,487	2,124,106	4,208,036	2,552,477	2,990,081	2,390,037	2,750,895	2,621,924	2,935,996	$ 8,740,829	$ 12,176,499	27.88%
24	5200 DELIVERY ROOM & LABOR ROOM		1.215924	107,713	-	2,249,991	2,353	12,861	-	503,838	1,697	134,866	-	$ 2,874,403	$ 4,050	73.31%
25	5300 ANESTHESIOLOGY		0.081875	408,107	560,858	591,234	1,398,098	525,621	720,638	516,206	650,717	611,641	690,208	$ 2,041,168	$ 3,330,311	36.05%
26	5400 RADIOLOGY-DIAGNOSTIC		0.305664	1,021,410	2,200,646	755,225	2,697,342	3,116,735	4,775,011	2,557,132	4,350,951	3,603,082	4,841,220	$ 7,450,502	$ 14,023,950	26.76%
27	5700 CT SCAN		0.046320	2,057,790	2,387,668	539,051	3,187,458	2,606,760	4,030,859	1,988,880	3,794,967	2,930,405	9,423,757	$ 7,192,481	$ 13,400,952	33.37%
28	5800 MRI		0.089130	361,869	280,136	102,671	284,137	526,547	631,362	369,994	809,397	565,812	597,219	$ 1,361,081	$ 2,005,032	25.27%
29	6000 LABORATORY		0.198759	4,926,016	2,173,020	3,525,440	3,655,564	6,867,975	3,099,642	5,084,888	2,791,965	5,262,324	4,580,511	$ 20,404,319	$ 11,720,191	41.87%
30	6300 BLOOD STORING PROCESSING & TRANS.		0.244944	250,087	34,910	81,942	107,726	595,894	278,386	439,172	94,017	256,143	66,669	$ 1,367,095	$ 515,039	20.19%
31	6500 RESPIRATORY THERAPY		0.202376	2,068,199	142,417	672,943	266,739	3,098,359	390,210	2,051,483	266,209	1,455,650	356,811	$ 7,890,984	$ 1,065,575	41.98%
32	6600 PHYSICAL THERAPY		0.678323	184,998	-	17,868	5,115	371,604	56,313	294,729	54,009	194,267	31,020	$ 869,199	$ 115,437	23.60%
33	6700 OCCUPATIONAL THERAPY		0.560480	54,092	249	7,925	22,592	105,054	19,746	106,263	22,407	76,021	38,307	$ 273,334	$ 64,994	16.37%
34	6800 SPEECH PATHOLOGY		0.540468	82,763	2,058	365,231	12,510	120,693	28,959	101,768	30,830	166,257	31,410	$ 670,455	$ 74,357	42.86%
35	6900 ELECTROCARDIOLOGY		0.153936	1,720,741	883,692	220,321	546,965	1,008,227	752,480	728,506	698,856	837,258	1,314,360	$ 3,677,795	$ 2,881,993	41.73%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.256252	1,569,688	514,990	1,555,451	1,588,830	2,648,107	1,008,263	1,765,780	809,250	1,517,810	884,359	$ 7,539,026	$ 3,921,333	37.95%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.318467	1,572,365	930,029	2,550	76,260	2,721,967	2,405,807	2,745,198	2,268,824	1,372,425	1,369,391	$ 7,042,080	$ 5,680,919	21.69%
38	7300 DRUGS CHARGED TO PATIENTS		0.168735	11,459,851	3,290,693	6,431,069	4,295,153	15,108,703	9,120,290	10,305,795	8,860,829	11,215,136	8,668,007	$ 43,305,418	$ 25,566,964	38.31%
39	7400 RENAL DIALYSIS		0.442562	280,188	-	6,516	-	1,067,538	125,976	361,638	27,150	31,494	6,516	$ 1,715,880	$ 153,126	54.54%
40	7501 IV THERAPY		0.133008	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
41	9000 CLINIC		0.680440	80,119	-	25,158	1,967,905	122,978	34,738	74,890	41,681	70,906	23,746	$ 303,145	$ 2,044,324	83.53%
42	9001 WOUND CARE		0.705166	-	-	-	15,397	-	47,481	1,651	54,372	-	77,335	$ 1,651	$ 117,250	8.87%
43	9100 EMERGENCY		0.633131	772,278	1,815,369	174,043	3,847,456	1,543,464	1,573,328	919,738	1,374,422	1,243,223	7,710,409	$ 3,409,523	$ 8,610,575	49.83%
44	9200 OBSERVATION		0.606175	766,882	1,015,823	1,050,273	1,086,090	1,379,878	2,723,301	834,937	2,040,843	609,316	1,960,206	$ 4,031,970	$ 6,866,058	97.96%
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
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58			-											$ -	$ -	
59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MEDICAL CENTER

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	%
61			-											$ -	$ -
62			-											$ -	$ -
63			-											$ -	$ -
64			-											$ -	$ -
65			-											$ -	$ -
66			-											$ -	$ -
67			-											$ -	$ -
68			-											$ -	$ -
69			-											$ -	$ -
70			-											$ -	$ -
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123			-											$ -	$ -
124			-											$ -	$ -
125			-											$ -	$ -
126			-											$ -	$ -
127			-											$ -	$ -
				$ 31,419,365	$ 18,460,045	$ 20,499,008	$ 29,271,725	$ 46,101,442	$ 34,812,872	$ 34,142,523	$ 31,794,288	$ 34,775,960	$ 45,607,457		

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

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MEDICAL CENTER

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges *(includes organ acquisition from Section J)***	$ 38,286,008	$ 18,460,045	$ 27,397,519	$ 29,271,725	$ 55,790,645	$ 34,812,872	$ 41,282,156	$ 31,794,288	$ 41,906,103 (Agrees to Exhibit A)	$ 45,607,457 (Agrees to Exhibit A)	$ 162,756,328	$ 114,338,929	36.29%
129	Total Charges per PS&R or Exhibit Detail	$ 38,286,008	$ 18,460,045	$ 27,397,519	$ 29,271,725	$ 55,790,645	$ 34,812,872	$ 41,282,156	$ 31,794,288	$ 41,906,103	$ 45,607,457			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 12,599,234	$ 4,907,637	$ 12,570,470	$ 8,948,545	$ 18,684,084	$ 8,966,256	$ 14,272,648	$ 7,912,023	$ 13,645,765	$ 12,476,164	$ 58,126,436	$ 30,734,461	39.65%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 10,130,502	$ 4,947,351			$ 1,106,236	$ 597,463	$ 453,106	$ 498,899			$ 11,689,844	$ 6,043,713	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 7,867,939	$ 4,883,309	$ -	$ 19	$ 252,482	$ 107,125			$ 8,120,421	$ 4,990,453	
134	Private Insurance (including primary and third party liability)	$ 188,061	$ 5,811	$ 188,472	$ 49,118	$ 4,774	$ 3,361	$ 3,320,778	$ 2,198,777			$ 3,702,085	$ 2,257,067	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 12,357	$ 3,350	$ 12,941	$ 388	$ 14,102	$ 2,186	$ 34,071			$ 5,924	$ 73,471	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 10,318,563	$ 4,965,519	$ 8,059,761	$ 4,945,368									
137	Medicaid Cost Settlement Payments (See Note B)		$ (292,610)									$ -	$ (292,610)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 12,699,950	$ 5,764,538	$ 775,944	$ 429,751			$ 13,475,894	$ 6,194,289	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 7,188,456	$ 4,613,879			$ 7,188,456	$ 4,613,879	
141	Medicare Cross-Over Bad Debt Payments					$ 310,791	$ 289,994			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 310,791	$ 289,994	
142	Other Medicare Cross-Over Payments (See Note D)					$ 105,857	$ (676)					$ 105,857	$ (676)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 180,416	$ 924,372			
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)**	$ 2,280,671	$ 234,728	$ 4,510,709	$ 4,003,177	$ 4,456,088	$ 2,297,455	$ 2,279,696	$ 29,521	$ 13,465,349	$ 11,551,792	$ 13,527,164	$ 6,564,881	
146	**Calculated Payments as a Percentage of Cost**	82%	95%	64%	55%	76%	74%	84%	100%	1%	7%	77%	79%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					28,690								
148	**Percent of cross-over days to total Medicare days from the cost report**					28%								

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.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MEDICAL CENTER

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 Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 774.11		205						430		635	
2	03100 INTENSIVE CARE UNIT	$ 1,264.53		71						195		266	
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	$ 777.90		25						5		30	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	301		-		-		630		931	
19	Total Days per PS&R or Exhibit Detail			301		-		-		630			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 347,233						$ 744,493		$ 1,091,726	
21.01	Calculated Routine Charge Per Diem			$ 1,153.60		$ -		$ -		$ 1,181.73		$ 1,172.64	
	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)		-									$ -	$ -
23	5000 OPERATING ROOM		0.313533	77,264	44,346					186,994	153,660	$ 264,258	$ 198,006
24	5200 DELIVERY ROOM & LABOR ROOM		1.215924	23,178	-					5,683	-	$ 28,861	$ -
25	5300 ANESTHESIOLOGY		0.081875	19,038	16,066					43,426	24,954	$ 62,464	$ 41,020
26	5400 RADIOLOGY-DIAGNOSTIC		0.305664	179,234	168,597					197,683	167,846	$ 376,917	$ 336,443
27	5700 CT SCAN		0.046320	104,269	313,500					216,162	296,154	$ 320,431	$ 609,654
28	5800 MRI		0.089130	-	34,007					30,143	22,496	$ 30,143	$ 56,503
29	6000 LABORATORY		0.198759	231,420	208,841					595,725	150,764	$ 827,145	$ 359,605
30	6300 BLOOD STORING PROCESSING & TRANS.		0.244944	16,390	1,482					51,449	8,515	$ 67,839	$ 9,997
31	6500 RESPIRATORY THERAPY		0.202376	117,645	31,176					216,286	30,652	$ 333,931	$ 61,828
32	6600 PHYSICAL THERAPY		0.678323	11,778	3,038					29,930	5,535	$ 41,708	$ 8,573
33	6700 OCCUPATIONAL THERAPY		0.560480	3,118	5,430					10,685	1,005	$ 13,803	$ 6,435
34	6800 SPEECH PATHOLOGY		0.540468	2,510	2,261					7,493	2,355	$ 10,003	$ 4,616
35	6900 ELECTROCARDIOLOGY		0.153936	36,637	38,432					82,665	52,516	$ 119,302	$ 90,948
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.256252	49,216	35,007					215,900	46,185	$ 265,115	$ 81,191
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.318467	37,969	27,772					191,608	59,440	$ 229,577	$ 87,212
38	7300 DRUGS CHARGED TO PATIENTS		0.168735	706,436	269,596					1,115,853	662,921	$ 1,822,288	$ 932,518
39	7400 RENAL DIALYSIS		0.442562	2,172	-					64,074	13,032	$ 66,246	$ 13,032
40	7501 IV THERAPY		0.133008	-	-					-	-	$ -	$ -
41	9000 CLINIC		0.680440	3,997	760					10,157	1,921	$ 14,154	$ 2,681
42	9001 WOUND CARE		0.705166	-	6,415					-	357	$ -	$ 6,772
43	9100 EMERGENCY		0.633131	37,585	280,599					129,216	149,735	$ 166,801	$ 430,334
44	9200 OBSERVATION		0.606175	33,079	92,167					105,315	218,886	$ 138,394	$ 311,053
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MEDICAL CENTER

				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	
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
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65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
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75			-									$ -	$ -
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107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA MEDICAL CENTER

				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			-									$ -	$ -
				$ 1,692,934	$ 1,579,492	$ -	$ -	$ -	$ -	$ 3,506,446	$ 2,068,929		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 2,040,167	$ 1,579,492	$ -	$ -	$ -	$ -	$ 4,250,939	$ 2,068,929	$ 6,291,106	$ 3,648,421
129	Total Charges per PS&R or Exhibit Detail	$ 2,040,167	$ 1,579,492	$ -	$ -	$ -	$ -	$ 4,250,939	$ 2,068,929		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 663,489	$ 446,601	$ -	$ -	$ -	$ -	$ 1,428,950	$ 546,611	$ 2,092,439	$ 993,212
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 39,190	$ 42,908					$ 8,136	$ 2,088	$ 47,326	$ 44,996
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ 139,052	$ 62,569					$ 19,321	$ 9,757	$ 158,373	$ 72,326
134	Private Insurance (including primary and third party liability)	$ 48,838	$ 35,502					$ 313,691	$ 87,683	$ 362,529	$ 123,185
135	Self-Pay (including Co-Pay and Spend-Down)	$ 188	$ 39						$ 1,886	$ 188	$ 1,925
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 227,268	$ 141,018	$ -	$ -						
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)							$ 889,230	$ 310,899	$ 889,230	$ 310,899
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 101,116	$ 52,025	$ 101,116	$ 52,025
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)**	$ 436,221	$ 305,583	$ -	$ -	$ -	$ -	$ 97,456	$ 82,273	$ 533,677	$ 387,856
144	**Calculated Payments as a Percentage of Cost**	34%	32%	0%	0%	0%	0%	93%	85%	74%	61%

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (10/01/2018-09/30/2019) SOUTH GEORGIA 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)*		$ 4,314,808		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	8301-8000-8710 & 7505-8000-8710	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 4,314,808	5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 4,314,808		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	287,034,785
19	Uninsured Hospital	**Charges Sec. G**	87,513,560
20	Total Hospital	**Charges Sec. G**	1,032,012,525
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		27.81%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.48%
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.*