State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2018

DSH Version 5.25 4/17/2019

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2017	06/30/2018

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	10/01/2017	09/30/2018
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 (07/01/17 - 06/30/18)
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

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:	DSH Payment Year (07/01/19 - 06/30/20)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have 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

List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

Alexander Culbreth
Nicole Yarbrough

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
6. Is 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

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2017 - 06/30/2018** — $ 2,747,033
(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

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	______ Date
Grant Byers Hospital CEO or CFO Printed Name	229-333-1020 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	229-333-1020
E-Mail Address	grant.byers@sgmc.org
Mailing Street Address	2501 N Patterson Street, 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

Example of Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payer Plan (B)	Secondary Payer Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Code (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N) *	Routine Days of Care (O)	Total Patient Payments for Services Provided (P) **	Total Private Insurance Payments for Services Provided (Q) **	Claim Status (Exhausted or Non-Covered Service ***, if applicable) (R)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25			$ -	
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010	Outpatient	450	$ 1,100.00			$ -	Non-Covered Service

Notes for Completing Exhibit A:

* All charges for non-hospital services should be excluded.

** Payments reported in Columns P & Q are not reported in the survey. These amounts are used for examination purposes only. Amount should include all payments received to date on the account.

*** Report services not covered under the patient's insurance package as a "Non-Covered Service". Note - the service must be covered under the state Medicaid plan.

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

Example of Exhibit B - Self Pay Collections

Claim Type (A)	Primary Payer Plan (B)	Secondary Payer Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Code (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O) ***	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q) *	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S) **	Insurance Status When Services Were Provided (Insured or Uninsured) (T) *	Claim Status (Exhausted or Non-Covered Service****, if applicable) (U)	Calculated Hospital Uninsured Collections If (T)="Uninsured" or (U)="Exhausted" or (U)="Non-Covered Service", (Q)/((Q)+(R)+(S))*(N), 0) *****
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	1/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	2/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	3/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	4/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	9/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	10/31/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	11/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Self-Pay		500	12345	7777777	7/8/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/15/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84
Self Pay Payments	Self-Pay		500	12345	7777777	7/8/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/31/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1980	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2010	$ 130	No	Inpatient	$ 14,000	$ 400	$ 50	Insured	Non-Covered Service	$ 126

Notes for Completing Exhibit B:

* Charges and insurance status will be the same when listing multiple payments for the same patient and dates of service.

** Other Non-Hospital Charges should include RHC, FQHC, Pharmacy, etc.

*** If Section 1011 (Undocumented Alien) payments are applied at a patient level include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.

**** Report services not covered under the patient's insurance package as a "Non-Covered Service". Note - the service must be covered under the state Medicaid plan.

***** The total Calculated Hospital Uninsured Collections (column V) should tie to the total Inpatient and Outpatient payments reported in Section H, Line 143 of the DSH Survey.

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

Example of Exhibit C (Other Medicaid Eligible example)

Claim Type (A) **	Primary Payer Plan (B)	Secondary Payer Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Medicaid Recipient # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O) *	Routine Days of Care (P)	Total Medicare Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1980	999-99-9999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	120	$ 1,200	3	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1980	999-99-9999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	206	$ 1,000	1	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1980	999-99-9999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	250	$ 100	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1980	999-99-9999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	300	$ 375	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1980	999-99-9999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	450	$ 1,500	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	987654321	7/12/1985	888-88-8888	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	250	$ 100	-	$ -	$ -	$ -	$ -	$ 900	$ 75	$ 975
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	987654321	7/12/1985	888-88-8888	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	300	$ 375	-	$ -	$ -	$ -	$ -	$ 900	$ 75	$ 975
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	987654321	7/12/1985	888-88-8888	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	450	$ 1,500	-	$ -	$ -	$ -	$ -	$ 900	$ 75	$ 975
Other Medicaid Eligibles	Cigna	Medicaid	12345	555555	654321978	3/5/2000	888-88-8888	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	300	$ 375	-	$ -	$ -	$ 100	$ -	$ 1,000	$ -	$ 1,100
Other Medicaid Eligibles	Cigna	Medicaid	12345	555555	654321978	3/5/2000	888-88-8888	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	450	$ 1,500	-	$ -	$ -	$ 100	$ -	$ 1,000	$ -	$ 1,100

Notes for Completing Exhibit C:

* All charges for non-hospital services should beexcluded.

** A separate Exhibit C file should be submitted for each claim type reported (e.g. Medicaid Managed Care, Other Medicaid Eligibles, Out-of-State Medicaid, etc.). The format above should be used for each Exhibit C.

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

DSH Version 7.30 3/26/2019

D. General Cost Report Year Information 10/1/2017 - 9/30/2018

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: SOUTH GEORGIA MEDICAL CENTER

	10/1/2017 through 9/30/2018		
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: 3/18/2019

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

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

	State Name	Provider No.
9. State Name & Number	Florida	010207500
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2017 - 09/30/2018)

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)	$ 158,653	$ 837,604	$996,257
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,572,920	$ 6,745,669	$8,318,589
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)	$1,731,573	$7,583,273	$9,314,846
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	9.16%	11.05%	10.70%

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 thehospital (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 (10/01/2017 - 09/30/2018)

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)	72,842	(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	25,632,249
8. Outpatient Hospital Charity Care Charges	15,699,909
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	$ 41,332,158

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

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

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11. Hospital	$78,059,831.00			$ 54,826,289	$ -	$ -	$ 23,231,542
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	$417,432,453.00	$441,078,868.00		$ 293,199,548	$ 309,808,506	$ -	$ 255,503,266
20. Outpatient Services		$59,106,625.00			$ 41,515,784	$ -	$ 17,590,841
21. Home Health Agency			$0.00			$ -	
22. Ambulance			$ 13,373,697	-		$ 9,393,524	
23. Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24. ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25. Hospice			$4,091,059.00			$ 2,873,511	
26. Other	$5,264,338.00	$0.00	$54,006,711.00	$ 3,697,608	$ -	$ 37,933,666	$ 1,566,730
27. Total	$ 500,756,622	$ 500,185,493	$ 71,471,467	$ 351,725,445	$ 351,324,291	$ 50,200,701	$ 297,892,379
28. Total Hospital and Non Hospital		Total from Above	$ 1,072,413,582		Total from Above	$ 753,250,437	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,072,413,582	Total Contractual Adj. (G-3 Line 2)	746,618,119
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)			+	6,632,318
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
35. Adjusted Contractual Adjustments				753,250,437

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) 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	$ 42,598,482	$ -	$ 62,084	$0.00	$ 42,660,566	50,545	$49,107,505.00		$ 844.01
2	03100	INTENSIVE CARE UNIT	$ 25,240,329	$ -	$ -		$ 25,240,329	16,574	$28,952,326.00		$ 1,522.89
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	$ 4,315,638	$ -	$ -		$ 4,315,638	5,723	$5,264,338.00		$ 754.09
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 72,154,449	$ -	$ 62,084	$ -	$ 72,216,533	72,842	$ 83,324,169		
19		Weighted Average									$ 991.41

Observation Data (Non-Distinct)

Line #		Description	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)	-	-	-	$ -			$ -	-

Line #		Cost Center Description	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	$31,996,902.00	$ -	$0.00		$ 31,996,902	$47,504,037.00	$49,910,332.00	$ 97,414,369	0.328462
22	5200	DELIVERY ROOM & LABOR ROOM	$5,144,753.00	$ -	$0.00		$ 5,144,753	$1,702,247.00	$2,082,524.00	$ 3,784,771	1.359330
23	5300	ANESTHESIOLOGY	$1,340,579.00	$ -	$0.00		$ 1,340,579	$6,558,019.00	$11,099,905.00	$ 17,657,924	0.075919
24	5400	RADIOLOGY-DIAGNOSTIC	$34,086,623.00	$ -	$0.00		$ 34,086,623	$38,076,604.00	$77,850,148.00	$ 115,926,752	0.294036
25	5700	CT SCAN	$4,646,756.00	$ -	$0.00		$ 4,646,756	$21,146,444.00	$63,411,530.00	$ 84,557,974	0.054953
26	5800	MRI	$1,633,577.00	$ -	$0.00		$ 1,633,577	$4,414,000.00	$11,888,468.00	$ 16,302,468	0.100204
27	6000	LABORATORY	$18,276,742.00	$ -	$0.00		$ 18,276,742	$53,117,686.00	$49,133,149.00	$ 102,250,835	0.178744
28	6300	BLOOD STORING PROCESSING & TRANS.	$2,991,452.00	$ -	$0.00		$ 2,991,452	$8,121,825.00	$2,783,553.00	$ 10,905,378	0.274310
29	6500	RESPIRATORY THERAPY	$5,594,615.00	$ -	$0.00		$ 5,594,615	$22,036,586.00	$3,982,196.00	$ 26,018,782	0.215022

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) 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	$3,676,805.00	$ -	$0.00	$ 3,676,805	$4,339,054.00	$939,373.00	$ 5,278,427	0.696572
31	6700	OCCUPATIONAL THERAPY	$1,741,473.00	$ -	$0.00	$ 1,741,473	$2,915,433.00	$51,287.00	$ 2,966,720	0.587003
32	6800	SPEECH PATHOLOGY	$1,379,063.00	$ -	$0.00	$ 1,379,063	$2,415,445.00	$46,305.00	$ 2,461,750	0.560196
33	6900	ELECTROCARDIOLOGY	$3,806,686.00	$ -	$0.00	$ 3,806,686	$9,950,653.00	$9,536,935.00	$ 19,487,588	0.195339
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$7,827,498.00	$ -	$0.00	$ 7,827,498	$16,512,288.00	$11,147,708.00	$ 27,659,996	0.282990
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$22,824,970.00	$ -	$0.00	$ 22,824,970	$42,300,878.00	$33,079,301.00	$ 75,380,179	0.302798
36	7300	DRUGS CHARGED TO PATIENTS	$41,551,514.00	$ -	$0.00	$ 41,551,514	$128,811,460.00	$113,508,700.00	$ 242,320,160	0.171474
37	7400	RENAL DIALYSIS	$1,605,083.00	$ -	$0.00	$ 1,605,083	$3,462,909.00	$367,524.00	$ 3,830,433	0.419034
38	7501	IV THERAPY	$628,032.00	$ -	$0.00	$ 628,032	$4,046,885.00	$259,930.00	$ 4,306,815	0.145823
39	9000	CLINIC	$1,965,137.00	$ -	$0.00	$ 1,965,137	$465,060.00	$2,447,828.00	$ 2,912,888	0.674635
40	9001	WOUND CARE	$1,381,972.00	$ -	$0.00	$ 1,381,972	$1,125,814.00	$1,290,266.00	$ 2,416,080	0.571989
41	9100	EMERGENCY	$27,559,211.00	$ -	$584,562.00	$ 28,143,773	$7,737,089.00	$33,539,182.00	$ 41,276,271	0.681839
42	9200	OBSERVATION	$8,717,498.00	$ -	$0.00	$ 8,717,498	$9,209,741.00	$3,291,645.00	$ 12,501,386	0.697323
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 (10/01/2017-09/30/2018) 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**	$ 230,376,941	$ -	$ 584,562		$ 230,961,503	$ 435,970,157	$ 481,647,789	$ 917,617,946	
127		**Weighted Average**									0.251697
128		**Sub Totals**	$ 302,531,390	$ -	$ 646,646		$ 303,178,036	$ 519,294,326	$ 481,647,789	$ 1,000,942,115	
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**					$ 303,178,036				
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 (10/01/2017-09/30/2018) SOUTH GEORGIA MEDICAL CENTER

Line #	Code	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: Inpatient	In-State Medicaid FFS Primary: Outpatient	In-State Medicaid Managed Care Primary: Inpatient	In-State Medicaid Managed Care Primary: Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary): Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary): Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere): Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere): Outpatient	Uninsured: Inpatient (See Exhibit A)	Uninsured: Outpatient (See Exhibit A)	Total In-State Medicaid: Inpatient	Total In-State Medicaid: Outpatient	% Survey to Cost Report Totals
			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	$ 844.01		3,552		3,758		4,355		3,534		3,834		15,199		37.87%
2	03100	INTENSIVE CARE UNIT	$ 1,522.89		1,822		481		2,387		1,207		1,771		5,837		46.90%
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	$ 754.09		320		2,555				236		507		3,111		63.50%
11			$ -												-		
12			$ -												-		
13			$ -												-		
14			$ -												-		
15			$ -												-		
16			$ -												-		
17			$ -												-		
18				Total Days	5,694		6,794		6,742		4,977		6,112		24,207		42.07%
19		Total Days per PS&R or Exhibit Detail			5,694		6,794		6,742		4,977		6,112				
20		Unreconciled Days (Explain Variance)			-		-		-		-		-				
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21		Routine Charges			$ 6,089,946		$ 6,596,502		$ 9,241,320		$ 5,444,551		$ 6,925,598		$ 27,372,319		41.58%
21.01		Calculated Routine Charge Per Diem			$ 1,069.54		$ 970.93		$ 1,370.71		$ 1,093.94		$ 1,133.11		$ 1,130.76		
		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		0.328462	1,547,984	1,567,500	2,156,286	3,364,460	3,186,088	4,121,480	1,618,335	1,605,323	2,849,335	2,468,523	$ 8,508,693	$ 10,658,763	25.02%
24	5200	DELIVERY ROOM & LABOR ROOM		1.359330	129,501		1,870,876	3,332	17,390		398,149	-	91,047	4,558	$ 2,415,916	$ 3,332	66.86%
25	5300	ANESTHESIOLOGY		0.075919	333,665	418,505	547,525	1,332,941	638,450	971,349	355,576	356,808	557,933	577,229	$ 1,875,216	$ 3,079,603	34.62%
26	5400	RADIOLOGY-DIAGNOSTIC		0.294038	749,719	2,100,343	697,415	2,129,820	3,713,851	8,011,663	1,461,838	1,173,069	3,838,384	4,915,456	$ 6,622,721	$ 13,504,892	25.03%
27	5700	CT SCAN		0.054563	1,392,062	1,626,589	481,526	2,389,563	2,484,286	5,256,915	1,261,306	999,901	2,638,071	8,435,445	$ 5,619,182	$ 10,244,966	32.00%
28	5800	MRI		0.100204	273,119	267,618	81,671	206,860	531,580	1,001,928	257,153	148,237	536,850	476,864	$ 1,143,523	$ 1,622,633	23.30%
29	6000	LABORATORY		0.178744	4,086,963	2,299,121	3,158,098	2,998,146	6,743,732	4,046,227	3,844,412	1,781,561	5,369,363	6,774,807	$ 17,835,185	$ 11,125,055	40.48%
30	6300	BLOOD STORING, PROCESSING & TRANS.		0.274310	248,515	39,153	154,818	82,280	700,688	287,169	421,681	22,780	477,680	83,982	$ 1,525,702	$ 431,382	23.28%
31	6500	RESPIRATORY THERAPY		0.215022	1,870,390	132,196	821,230	195,062	2,932,448	205,556	1,520,983	186,616	1,841,626	231,560	$ 6,944,151	$ 719,430	37.15%
32	6600	PHYSICAL THERAPY		0.095572	156,421	222	17,712	15,260	434,093	75,448	177,679	199,527	201,257	27,114	$ 785,905	$ 290,457	25.03%
33	6700	OCCUPATIONAL THERAPY		0.587003	69,989	-	8,258	13,443	161,383	32,115	75,369	190,359	38,594	19,006	$ 314,079	$ 235,917	22.72%
34	6800	SPEECH PATHOLOGY		0.560196	126,328	1,356	329,608	10,114	133,609	27,986	94,714	77,383	169,151	25,378	$ 684,259	$ 116,939	40.77%
35	6900	ELECTROCARDIOLOGY		0.195339	1,321,427	1,061,277	265,807	502,509	1,414,179	1,254,969	466,012	197,226	884,014	1,142,145	$ 3,477,425	$ 3,015,081	43.95%
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.282990	1,505,811	436,708	1,727,998	1,542,237	2,039,551	1,421,279	1,015,639	244,756	1,498,975	838,740	$ 6,289,209	$ 3,644,980	44.61%
37	7200	IMPL. DEV. CHARGED TO PATIENTS		0.302798	2,066,933	703,037	55,833	7,423	4,876,058	3,705,246	1,632,396	274,948	1,814,415	1,244,658	$ 8,631,320	$ 4,690,654	21.80%
38	7300	DRUGS CHARGED TO PATIENTS		0.171474	10,750,125	7,351,316	6,811,538	3,327,692	15,598,244	15,308,899	8,905,116	1,881,749	12,318,848	8,093,760	$ 42,065,023	$ 27,869,856	37.56%
39	7400	RENAL DIALYSIS		0.419034	438,971	-			717,136	120,100	444,934	52,838	80,240	105,058	$ 1,601,041	$ 172,938	51.58%
40	7501	IV THERAPY		0.145823		-					-		-	-	$ -	$ -	0.00%
41	9000	CLINIC		0.874635	70,030	9,357	27,635	966,739	121,452	37,329	65,442	36,656	78,097	15,166	$ 284,559	$ 1,050,081	49.16%
42	9001	WOUND CARE		0.571989		-		1,883		165,931	-	26,150	-	92,495	$ -	$ 183,964	11.44%
43	9100	EMERGENCY		0.681839	783,542	1,873,847	272,977	5,382,402	1,373,674	2,224,319	713,020	533,068	1,090,184	7,492,753	$ 3,153,213	$ 10,013,656	52.92%
44	9200	OBSERVATION		0.697323	574,042	1,016,538	868,519	913,654	1,215,702	3,291,743	844,789	704,808	809,264	1,786,396	$ 3,503,002	$ 5,926,743	96.78%
45				-											$ -	$ -	
46				-											$ -	$ -	
47				-											$ -	$ -	
48				-											$ -	$ -	
49				-											$ -	$ -	
50				-											$ -	$ -	
51				-											$ -	$ -	
52				-											$ -	$ -	
53				-											$ -	$ -	
54				-											$ -	$ -	
55				-											$ -	$ -	
56				-											$ -	$ -	
57				-											$ -	$ -	
58				-											$ -	$ -	
59				-											$ -	$ -	
60				-											$ -	$ -	
61				-											$ -	$ -	
62				-											$ -	$ -	
63				-											$ -	$ -	
64				-											$ -	$ -	
65				-											$ -	$ -	
66				-											$ -	$ -	
67				-											$ -	$ -	
68				-											$ -	$ -	
69				-											$ -	$ -	
70				-											$ -	$ -	
71				-											$ -	$ -	
72				-											$ -	$ -	
73				-											$ -	$ -	
74				-											$ -	$ -	
75				-											$ -	$ -	
76				-											$ -	$ -	
77				-											$ -	$ -	
78				-											$ -	$ -	
79				-											$ -	$ -	
80				-											$ -	$ -	
81				-											$ -	$ -	

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

Cost Report Year (10/01/2017-09/30/2018) SOUTH GEORGIA MEDICAL CENTER

Line	Description	In-State Medicaid FFS Primary (Inpatient)	In-State Medicaid FFS Primary (Outpatient)	In-State Medicaid Managed Care Primary (Inpatient)	In-State Medicaid Managed Care Primary (Outpatient)	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) (Inpatient)	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) (Outpatient)	In-State Other Medicaid Eligibles (Not Included Elsewhere) (Inpatient)	In-State Other Medicaid Eligibles (Not Included Elsewhere) (Outpatient)	Uninsured (Inpatient)	Uninsured (Outpatient)	Total In-State Medicaid (Inpatient)	Total In-State Medicaid (Outpatient)	%
82	-											$ -	$ -	
83	-											$ -	$ -	
84	-											$ -	$ -	
85	-											$ -	$ -	
86	-											$ -	$ -	
87	-											$ -	$ -	
88	-											$ -	$ -	
89	-											$ -	$ -	
90	-											$ -	$ -	
91	-											$ -	$ -	
92	-											$ -	$ -	
93	-											$ -	$ -	
94	-											$ -	$ -	
95	-											$ -	$ -	
96	-											$ -	$ -	
97	-											$ -	$ -	
98	-											$ -	$ -	
99	-											$ -	$ -	
100	-											$ -	$ -	
101	-											$ -	$ -	
102	-											$ -	$ -	
103	-											$ -	$ -	
104	-											$ -	$ -	
105	-											$ -	$ -	
106	-											$ -	$ -	
107	-											$ -	$ -	
108	-											$ -	$ -	
109	-											$ -	$ -	
110	-											$ -	$ -	
111	-											$ -	$ -	
112	-											$ -	$ -	
113	-											$ -	$ -	
114	-											$ -	$ -	
115	-											$ -	$ -	
116	-											$ -	$ -	
117	-											$ -	$ -	
118	-											$ -	$ -	
119	-											$ -	$ -	
120	-											$ -	$ -	
121	-											$ -	$ -	
122	-											$ -	$ -	
123	-											$ -	$ -	
124	-											$ -	$ -	
125	-											$ -	$ -	
126	-											$ -	$ -	
127	-											$ -	$ -	
	Totals / Payments	$ 28,516,717	$ 20,996,683	$ 20,155,332	$ 25,386,020	$ 48,033,894	$ 51,557,651	$ 25,573,620	$ 10,661,770	$ 36,841,338	$ 44,849,142			
128	Total Charges *(includes organ acquisition from Section J)*	$ 34,606,663	$ 20,996,683	$ 26,751,834	$ 25,386,020	$ 58,275,014	$ 51,557,651	$ 31,018,171	$ 10,661,770	$ 43,766,936 (Agrees to Exhibit A)	$ 44,849,142 (Agrees to Exhibit A)	$ 150,651,682	$ 108,602,124	34.98%
129	Total Charges per PS&R or Exhibit Detail	$ 34,606,663	$ 20,996,683	$ 26,751,834	$ 25,386,020	$ 58,275,014	$ 51,557,651	$ 31,018,171	$ 10,661,770	$ 43,766,936	$ 44,849,142			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	Total Calculated Cost (Includes organ acquisition from Section J)	$ 12,797,578	$ 5,555,182	$ 12,842,269	$ 8,581,516	$ 19,382,718	$ 13,476,894	$ 11,679,824	$ 3,056,647	$ 15,068,089	$ 12,831,804	$ 56,702,409	$ 30,770,239	38.31%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 9,679,643	$ 4,586,672			$ 1,337,215	$ 933,636	$ 19,054	$ 3,768			$ 11,035,912	$ 5,524,078	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		$ -	$ 7,530,975	$ 4,171,930			$ 28,408	$ 26,773			$ 7,559,383	$ 4,198,703	
134	Private Insurance (including primary and third party liability)	$ 94,127	$ 17,896	$ 125,130	$ 43,872	$ 5,991	$ 18,453	$ 2,192,583	$ 1,702,803			$ 2,417,831	$ 1,783,004	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 11,447	$ 2,685	$ 5,383	$ 1,188	$ 12,509	$ 337	$ 12,460			$ 4,210	$ 41,799	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 9,773,770	$ 4,616,056	$ 7,658,790	$ 4,221,185									
137	Medicaid Cost Settlement Payments (See Note B)		$ 404,614									$ -	$ 404,614	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 12,470,980	$ 8,805,059	$ 4,580,341	$ 888,123			$ 17,051,330	$ 9,693,182	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 1,272,481	$ 453,274			$ 1,272,481	$ 453,274	
141	Medicare Cross-Over Bad Debt Payments					$ 153,933	$ 450,252					$ 153,933	$ 450,252	
142	Other Medicare Cross-Over Payments (See Note D)					$ 19,922	$ (735)	$ 6,981	$ (193)	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 26,903	$ (928)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 158,653	$ 837,604			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -			
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	$ 3,023,808	$ 534,513	$ 5,183,499	$ 4,460,331	$ 5,393,480	$ 3,257,720	$ 3,579,039	$ (30,361)	$ 14,909,436	$ 11,994,200	$ 17,180,426	$ 8,222,203	
146	Calculated Payments as a Percentage of Cost	76%	90%	60%	49%	72%	76%	69%	101%	1%	7%	70%	73%	
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)					35,774								
148	Percent of cross-over days to total Medicare days from the cost report					19%								

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

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.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) 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 – Inpatient	Out-of-State Medicaid FFS Primary – Outpatient	Out-of-State Medicaid Managed Care Primary – Inpatient	Out-of-State Medicaid Managed Care Primary – Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) – Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) – Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) – Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) – Outpatient	Total Out-Of-State Medicaid – Inpatient	Total Out-Of-State Medicaid – Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 844.01		12						145		157	
2	03100 INTENSIVE CARE UNIT	$ 1,522.89		2						104		106	
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	$ 754.09		16								16	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	30		-		-		249		279	
19	Total Days per PS&R or Exhibit Detail			30		-		-		249			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 34,248						$ 310,746		$ 344,994	
21.01	Calculated Routine Charge Per Diem			$ 1,141.60		$ -		$ -		$ 1,247.98		$ 1,236.54	
	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		0.328462	4,202	4,396					39,287	43,291	$ 43,489	$ 47,687
24	5200 DELIVERY ROOM & LABOR ROOM		1.359330	6,177	-					1,928	-	$ 8,105	$ -
25	5300 ANESTHESIOLOGY		0.075919	1,271	1,387					11,409	9,745	$ 12,680	$ 11,132
26	5400 RADIOLOGY-DIAGNOSTIC		0.294036	6,183	6,622					82,388	38,948	$ 88,571	$ 45,570
27	5700 CT SCAN		0.054953	-	16,401					45,541	59,120	$ 45,541	$ 75,521
28	5800 MRI		0.100204	-	-					10,962	7,370	$ 10,962	$ 7,370
29	6000 LABORATORY		0.178744	16,921	14,165					197,770	52,197	$ 216,691	$ 66,362
30	6300 BLOOD STORING PROCESSING & TRANS.		0.274310	1,411	-					18,656	-	$ 20,067	$ -
31	6500 RESPIRATORY THERAPY		0.215022	4,572	4,787					105,807	14,203	$ 110,379	$ 18,990
32	6600 PHYSICAL THERAPY		0.696572	338	225					13,411	2,371	$ 13,749	$ 2,596
33	6700 OCCUPATIONAL THERAPY		0.587003	-	-					6,007	480	$ 6,007	$ 480
34	6800 SPEECH PATHOLOGY		0.560196	321	-					6,793	852	$ 7,114	$ 852
35	6900 ELECTROCARDIOLOGY		0.195339	190	2,271					26,061	15,767	$ 26,251	$ 18,038
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.262990	2,041	1,523					52,815	11,306	$ 54,856	$ 12,829
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.302798	139	3,575					39,436	10,799	$ 39,575	$ 14,374
38	7300 DRUGS CHARGED TO PATIENTS		0.171474	37,088	8,665					549,212	62,197	$ 586,300	$ 70,862
39	7400 RENAL DIALYSIS		0.419034	-	-					13,442	3,102	$ 13,442	$ 3,102
40	7501 IV THERAPY		0.145823	-	-						-	$ -	$ -
41	9000 CLINIC		0.674635	75	-					3,718	377	$ 3,793	$ 377
42	9001 WOUND CARE		0.571989	-	-						-	$ -	$ -
43	9100 EMERGENCY		0.681839	-	21,761					34,616	38,680	$ 34,616	$ 60,441
44	9200 OBSERVATION		0.697323	1,996	4,758					33,943	32,323	$ 35,939	$ 37,081
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) SOUTH GEORGIA MEDICAL CENTER

Line					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				-									$ -	$ -
64				-									$ -	$ -
65				-									$ -	$ -
66				-									$ -	$ -
67				-									$ -	$ -
68				-									$ -	$ -
69				-									$ -	$ -
70				-									$ -	$ -
71				-									$ -	$ -
72				-									$ -	$ -
73				-									$ -	$ -
74				-									$ -	$ -
75				-									$ -	$ -
76				-									$ -	$ -
77				-									$ -	$ -
78				-									$ -	$ -
79				-									$ -	$ -
80				-									$ -	$ -
81				-									$ -	$ -
82				-									$ -	$ -
83				-									$ -	$ -
84				-									$ -	$ -
85				-									$ -	$ -
86				-									$ -	$ -
87				-									$ -	$ -
88				-									$ -	$ -
89				-									$ -	$ -
90				-									$ -	$ -
91				-									$ -	$ -
92				-									$ -	$ -
93				-									$ -	$ -
94				-									$ -	$ -
95				-									$ -	$ -
96				-									$ -	$ -
97				-									$ -	$ -
98				-									$ -	$ -
99				-									$ -	$ -
100				-									$ -	$ -
101				-									$ -	$ -
102				-									$ -	$ -
103				-									$ -	$ -
104				-									$ -	$ -
105				-									$ -	$ -
106				-									$ -	$ -
107				-									$ -	$ -
108				-									$ -	$ -
109				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) SOUTH GEORGIA MEDICAL CENTER

Line	Description		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		-									$ -	$ -
	Totals / Payments		$ 84,925	$ 90,536	$ -	$ -	$ -	$ -	$ 1,293,202	$ 403,128		
128	**Total Charges (includes organ acquisition from Section K)**		$ 119,173	$ 90,536	$ -	$ -	$ -	$ -	$ 1,603,948	$ 403,128	$ 1,723,121	$ 493,664
129	Total Charges per PS&R or Exhibit Detail		$ 119,173	$ 90,536	$ -	$ -	$ -	$ -	$ 1,603,948	$ 403,128		
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**		$ 50,557	$ 29,714	$ -	$ -	$ -	$ -	$ 586,437	$ 115,875	$ 636,994	$ 145,589
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 10,512	$ 4,731					$ 1,316	$ 2	$ 11,828	$ 4,733
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)								$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)			$ 673					$ 5,665	$ 945	$ 5,665	$ 1,618
135	Self-Pay (including Co-Pay and Spend-Down)			$ 29					$ 32	$ 307	$ 32	$ 336
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ 10,512	$ 5,433	$ -	$ -						
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)								$ 174,926	$ 42,860	$ 174,926	$ 42,860
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								$ 127,123	$ 10,313	$ 127,123	$ 10,313
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)**		$ 40,045	$ 24,281	$ -	$ -	$ -	$ -	$ 277,375	$ 61,448	$ 317,420	$ 85,729
144	**Calculated Payments as a Percentage of Cost**		21%	18%	0%	0%	0%	0%	53%	47%	50%	41%

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 (10/01/2017-09/30/2018) SOUTH GEORGIA MEDICAL CENTER

#	Organ Acquisition Cost Centers (list below):	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted 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-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							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	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)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
1	Lung Acquisition	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		0										
9	Totals	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	Total Cost							-		-		-		-		-

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 H 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 (10/01/2017-09/30/2018) SOUTH GEORGIA MEDICAL CENTER

#	Organ Acquisition Cost Centers (list below):	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted 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-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							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)
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	Totals	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	Total Cost							-		-		-		-

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 I 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 (10/01/2017-09/30/2018) SOUTH GEORGIA MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

Line	Description		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 4,451,026		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	7505-8300-8710 & 8301-8000-8710	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 4,451,026	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		$ 4,451,026		

DSH UCC Provider Tax Assessment Adjustment:

Line	Description		Amount
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**	261,470,591
19	Uninsured Hospital	**Charges Sec. G**	88,616,078
20	Total Hospital	**Charges Sec. G**	1,000,942,115
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		26.12%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.85%
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.*