D letho hoomist account from the	During the Interim DSH Payment Year.  1. 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.)  List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:  Mandy Lucas  Jonathan Wade	<ul><li>3a. Was the hospital open as of December 22, 1987?</li><li>3b. What date did the hospital open?</li></ul>	B. DSH OB Qualifying Information  Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.  During the DSH Examination Year:  1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)  2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?  3. Was the hospital exempt from the requirement listed under #1 above because it did not offer nonemergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	6. Medicaid Provider Number: 7. Medicaid Subprovider Number 1 (Psychiatric or Rehab): 8. Medicaid Subprovider Number 2 (Psychiatric or Rehab): 9. Medicare Provider Number:	Identification of cost reports needed to cover the DSH Year:  Cost Report  Begin Date(s)  Cost Report Year 1  Cost Report Year 2 (if applicable)  Cost Report Year 3 (if applicable)	1. DSH Year.  1. DSH Year.  2. Select Your Facility from the Drop-Down Menu Provided:  SOUTH GEORGIA MED CTR - LANIER	A. General DSH Year Information
Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?  Is the hospital exempt from the requirement listed under #1 above because it did not offer non-generatives to the nanezal population whom federal Moderals and the second secon	Social Security Act.  The have agreed to e of a hospital the the ed to perform OB services:		a Social Security Act.  agreed to the of a hospital the sr non- tions	Data 000001163A 0 0 111326	Cost Report End Date(s) 09/30/2018	2017 End 06/30/2018 MED CTR - LANIER	
No	(07/0479 - 06/30/20), Yes	Yes 7/1/1950	PSH Examination Year (07/0/117 - (07/0/117 - (07/0/117 - (07/0/177		Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES		DSH Version 5.25
					I SURVEY PART II FILES		4/17/2019

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Explanation for "No" answers:	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.	Certification:	Medicaid Supplemental Payments for DSH Year 07/01/2017 - 06/30/2018     (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)
	Answer Yes		\$ 109,472

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 ratained 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	Title	Date
Grant Byers	912-259-4162	grant byers@same org
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Contact information for individuals authorized to respond to inquiries related to this survey:	slated to this survey:	
Hospital Contact:		Outside Preparer:
Name (Grant Byers	yers	Name Wes Sternenberg
THE CHO		Title: Partner
101 + 602-627 actum august 100	4102	Firm Name: Draffin & Tucker, LLP
E-Wall Address grant byers@sgmc.or	ers@sgmc.org	Telephone Number 229-883-7878
Malling Screet Address 2501 N	Mailing Street Address[2501 N Patterson Street, Valdosta, GA 31602	E-Mail Address wsterrenberg@draffin-tucker.com

#### Example of Exhibit A - Uninsured Charges

Uniterral Charges Charity Uniterral Charges Madicians Uniterral Charges Madicians Uniterral Charges Madicians Uniterral Charges Blue Cross	Primary Payer Plan Claim Type (A) (B)
Self-Pay Self-Pay Self-Pay Self-Pay Self-Pay Self-Pay	Secondary Payer Plan (C)
12345 12345 12345 12345 12345 12345 12345 12345	Hospital's Medicald Provider # (D)
2012222 2022222 2022222 2022222 20222 20222	Patient Identifier Code (PCN) (E)
1/1/1960 1/1/1960 1/1/1960 1/1/1960 1/1/1960 1/1/1960 1/1/2/1965 7/12/1965 7/12/1965	Padlent's Birth Date (F)
999-99-999 999-99-999 999-99-999 999-99-	Patient's Social Security Number
Férmale Fernale Fernale Fernale Fernale Fernale Male Male	Patient's Gender (H)
Doe, Jane Lones, Janes Smith, Mike	Name (i)
3/1/2010 3/1/2010 3/1/2010 3/1/2010 3/1/2010 3/1/2010 6/15/2010 8/10/2010	Admit Date (J)
3/1/2010 3/1/2010 3/1/2010 3/1/2010 3/1/2010 3/1/2010 3/1/2010 6/15/2010 8/19/2010	Discharge Date (K)
Inputient Impatient Impatient Impatient Impatient Impatient Impatient Impatient Outpatient Outpatient Outpatient	Service Indicator (Inpatient / Outpatient)
200 200 250 360 360 450 450	Revenue
4,000.00 4,500.00 5,200.25 2,700.00 15,000.75 1,000.25 5,1000.07 15,000.75 1,000.00	Total Charges for Services
Co -	Routine Days
\$ 500.00	Total Patient Payments for Service
M M M M M M 10 M M	Total Private Insurance Payments for Services
approace) (N)  Educated  Educated  Educated  Ann-Covered Service	vato Claim Status s for (Exhausted or Non- is Covered Service, if

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 (x/s or x/sx). 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 Staufer will generate raports.

#### Example of Exhibit B - Self Pay Collections

Self Pay Payments	Claim Type (A)
Nedicare Medicare Medicare Blue Cross Blue Cross	Primary Payer Phin (D) Pr
Medical Medical	Secondary Payer Plan (C)
500 500 150 150 500 500	Code (D)
12345 12345 12346 12346 12346 12346 12346	Hospital's Medicald
1111111 313333 3000000 9000000 9000000 1777777 7777777 7777777	34"
2/17/2025 2/17/2025 2/17/2025 2/17/2025 9/25/19/79 9/25/19/79 9/25/19/79 9/25/19/79 9/25/19/79 9/25/19/79 9/25/19/79	Patient's Birth Date (S)
300-00-00 300-00 300	Patient's Social Security Number (M)
	Patient's Gender (I)
Jones, Arthus Jones, Arthus Jones, Arthus Smith, John Smith, John Call, Houth Johnson, Jo	Nome (J)
7/12/1985 V 7/12/	Admit Day (0)
7/14/1985 7/14/1985 7/14/1985 9/2/1/2000 9/2/1/2000 9/2/1/2010 9/2/2005	Discharge Date
2/12/10 3/12/10 6 3/12/10 6/12/20 6/12	Date of Chall
*****	Amount of h Cash
	Indicate of Collection 1011 Payme
	IF Sen
hypotheni hypotheni hypotheni hypotheni Outpatieni Outpatieni Outpatieni hypotheni hypotheni hypotheni	vice indicator ent / Outpatient)
****	Total Hospita for Services
10,000 S 10,000 S 10,000 S 10,000 S 2,000 S 2,000 S 12,000 S 12,000 S	Provided P
1,000	Total Physician   Physician   Charges for Cl Services 8 Previded F
9,,889,,	Total Other Non- Hospital Hospital Charges for Sarvices ( Provided U
Haused Haused Haused Haused Haused Haused Haused Unbaused Unbaused	Insurance Status When Swylens Were Provided (Insured or Universed)
Extraountad Extraordinad Extraordinad Extraordinad	Saim Status (Extrac or Non-Coverne Farvice If applic
B	Sho (star
1	Calculated Hospital Uninsured Collections If (1)="Uninsured" or (1)="Editables" or (1)="Editables" or (1)="Editables" or (1)="Non-Covered Surviva" Surviva" (1)="10+1547194, (1)

Notes for Completing Exhibit B:

Charges and insurance status will be the same what felding multiple payments for the same patient and dates of service.

\* Other Non-Hospital Changes should include RHO. FDHO, Pharmany, etc...

\*\* If Suction 1011 (Unidocumented After) payments are applied at a patient text

obunist. If they are not applied at potient level, include theirs in Section E of the survey document

mince package as a "Noo-Covered Service" Heat

Tripot services not covered order the patients distance policings as a Tripo-Dayweld Service. How, the service may be served endor the star Medical plan.

The trial Calculated Hospital Uninsured Collections (column V) structs the to the total registers and Collections are reported in Section H. Unit 145 of the IDSH Servicy.

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

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Total Charge for Services for Invaded (1)
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Tabli Bedicare Payments for Bandon Parolded (2)
Total Musicapy pago Promests for Savdous Premises (%
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Please strong that above state is the designated this recturated with this survey document. The electronic tills must be submitted in Excel (alls or along). If this is not present, the date must be submitted as a CEV (and) file value deliner by TAB or liques symbol above the EXPER toy). The date may not be accepted if not in one of these formats. Please do not after column headings. If have column headings will be used to input perfect designate detail into a detailuse from which flagers and flagers and

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?  Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality 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  16. Total Medicaid managed care non-claims payments (see question 13 above) received	8. Out-of-State DSH Payments (See Note 2) 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B) 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B) 11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B. Isse physician and non-hospital portion of payments) 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	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 1-1-1014 Section 1011 Payment Related to Hospital Services (See Note 1) 5. Section 1011 Payment Related to Non-Hospital Services (Revice) 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)	E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2017 - 09/30/2018)	(List additional states on a separate attachment)	12. State Name & Number  13. State Name & Number	11. State Name & Number	9. State Name & Number	O Ctoto Namo 9 Nambo	Out-of-State Medicald Provider Number. List all states where you had a Medicald provider agreement during the cost most your	DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	8. Medicare Provider Number:	<ol><li>Medicaid Subprovider Number 2 (Psychiatric or Rehab):</li></ol>	<ol><li>Medicaid Subprovider Number 1 (Psychiatric or Rehab):</li></ol>	5. Medicaid Provider Number:	4. Hospital Name:		3a. Date CMS processed the HCRIS file into the HCRIS database:	<ol><li>Status of Cost Report Used for this Survey (Should be audited if available):</li></ol>			<ol> <li>Select Your Facility from the Drop-Down Menu Provided:</li> </ol>	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.	The following information is provided based on the information we received from	N Comord Cook Dancet Van Information
Did your hospital receive any Medicaid <u>managed care</u> payments not paid at the claim level?  Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, suppliements, quality payments, bonus payments, capitation payments received by the MCO), or other incentive payments. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services.  Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services.	) י (א) on Exhibit B. less physician and non-hospital portion of psyments) Basis Patient Payments:	B & B-1 (See Note 1)  sed in Exhibits B & B-1 (See Note 1)  uded in Exhibits B & B-1 (See Note 1)  e 1)  ibits B & B-1 (See Note 1)  n Exhibits B & B-1 (See Note 1)  a Note 1)	0/01/2017 - 09/30/2018)					State Name Provider No.	ad a Mariinaid provider agreement during the cost providers.	Small Rural Yes	Non-State Govt.	111326 Yes	0 Yes		000001163A Yes	SOUTH GEORGIA MED CTR - LANIER Yes	Data Correct?	3/18/2019	1 - As Submitted	X	through	SOUTH GEORGIA MED CTR - LANIER	correct information along with supporting documentation when you submit your	TWITZUTY - 9/3WZU18 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 that the 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 that the 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 that the 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 that the 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 that the 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 that the provided based on the information we received from the state of the provided based on the information we received from the state of the provided based on the information we received from the state of the provided based on the information we received from the state of the provided based on the provi	
No north received by the house that by the MCO), or other incentive payments.	Inpatient   Outpatient   Total	\$P\$P															If Incorrect, Proper Information						r survey.	lo" to either agree or disagree with the accuracy	DSH Version 7.30 3/26/2019

Note 1: Subitile 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 you rhospital 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.

# 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)

574 (See Note in Section F-3, below)

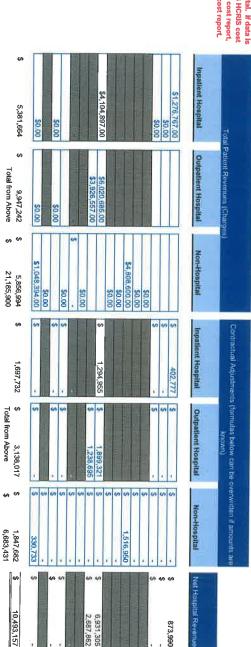
F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation)

- Outpatient Hospital Subsidies Inpatient Hospital Subsidies
- Unspecified I/P and O/P Hospital Subsidies
   Non-Hospital Subsidies
- Total Hospital Subsidies
- Inpatient Hospital Charity Care Charges
   Outpatient Hospital Charity Care Charges
   Non-Hospital Charity Care Charges
- Total Charity Care Charges

631,819

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

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. already present in this section, it was completed using CMS HCRIS cost NOTE: All data in this section must be verified by the hospital. If data is comulas can be overwritten as needed with actual data



11. Hospital
12. Subprovider I (Psych or Rehab)
13. Subprovider II (Psych or Rehab)
14. Swing Bed - SNF
15. Swing Bed - NF
15. Swing Bed - NF
16. Skilled Nursing Facility
17. Nursing Facility
17. Nursing Facility
18. Other Long-Term Care
19. Ancillary Services
20. Outpatient Services
21. Home Health Agency
22. Ambulance
23. Outpatient Rehab Providers
24. ASC
25. Hospice
26. Other

27. Total

28. Total Hospital and Non Hospital

29. Total Per Cost Report

30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue) Total Patient Revenues (G-3 Line 1)

21,185,900

Total Contractual Adj. (G-3 Line 2)

6,648,099

35,332

- 31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3 Line 2 (Impact is a decrease in net patient revenue)
- 2 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

6,683,431

### State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part II

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

Cost Report Year (10/01/2017-09/30/2018) SOUTH GEORGIA MED CTR - LANIER

Coal Report		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	Medicald Per Diem /
VILIT   S   2.654.483   S   S   S   S   S   S   S   S   S	7 2 7 € 7 ≥	Il data in this section must be verified by the If data is already present in this section, it was d using CMS HCRIS cost report data. If the las a more recent version of the cost report, the lab and the updated to the hospital's version of the cost ormulas can be overwritten as needed with actual	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
S	71	Routine Cost Centers /list balow)									
NIT	O	3000 ADULTS & PEDIATRICS	2,654,483	1	69	\$1,803,943,00		794	\$1 278 787 00		
NIIT   S	O	3100 INTENSIVE CARE UNIT	le)s		64	41,000,010,000		+71	91,270,707,00	THE RELEASE	3 1,1/4/8
NUIT	al	3200 CORONARY CARE UNIT	6.9		69 6		SA 6		\$0.00		o en
State   Stat	lol	3300 BURN INTENSIVE CARE UNIT	69			見しいがけば	€0 €		\$0.00		n en
Statistical Statistics   Stat	10	3400 SURGICAL INTENSIVE CARE UNIT		-		Sell VIII	S	19.	\$0.00	The second second	69 6
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S	ol	4100 SUBPROVIDER II	69 6	vi. i		STATE OF THE PARTY	. ·		\$0.00		÷9
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Iline   \$ 2,654,483 \$			69 64		1		n <del>(</del> 01		\$0,00		en
Hospital   Subprovider     Subprovider     Observation Days   Observ								724	1,27		\$ 1,174.78
Cost Report Worksheet B. Worksheet B. Part I, Col. 25 Part I, Col. 26 Part I, Col. 25 Part I, Col. 25 Part I, Col. 2 and Cost Report Cost Report Col. 4  Col. 4  Col. 4  Cost Report Worksheet C. Part I, Col. 2 and Cost Report Col. 4  Col. 4  Col. 4  Col. 4  Col. 4  Col. 4  Col. 5348,586.00 \$  \$ 343,586 \$ \$100,453.00 \$  \$ 1,365,254 \$ \$580,574.00 \$  \$ 1,032,202.00 \$  \$ 1,032,202.00 \$  \$ 1,035,253 \$ \$ \$100,453.00 \$  \$ 1,033,202 \$ \$1,009,630.00 \$  \$ 1,035,253 \$ \$ \$1,009,630.00 \$  \$ 1,035,254 \$ \$580,574.00 \$  \$ 1,032,002 \$ \$ \$ \$1,009,630.00 \$  \$ 1,035,254 \$ \$580,574.00 \$  \$ 1,032,002 \$ \$ \$ \$ \$1,009,630.00 \$  \$ 1,035,254 \$ \$580,574.00 \$  \$ 1,032,002 \$ \$ \$ \$ \$1,009,630.00 \$  \$ 1,035,254 \$ \$580,574.00 \$  \$ 1,032,002 \$ \$ \$ \$ \$1,009,630.00 \$  \$ 1,055,254 \$ \$ \$580,574.00 \$  \$ 1,055,254 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	0	bservation Data (Non-Distinct)				Subprovider II Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)		les	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Col. 4  Source Sour	0	9200 Observation (Non-Distinct)		150	- F	Ŷ.		\$29,085.00	\$168,791.00	\$ 197.876	0.890543
Cost Report Worksheet B, Worksheet C, (Interm & Resident Col. 2 and Offset ONL Y)*  S 20.00  S 348,585  S 20.00  S 348,585  S 30.00  S 348,585  S 30.00  S 348,585  S 30.00  S 348,585  S 30.00  S 348,585  S 348											
\$ - \$0.00 \$ .48.586 \$100,453.00 \$. \$ - \$0.00 \$ .46.2715 \$210,616.00 \$. \$ - \$0.00 \$ .1,365,254 \$580,574.00 \$. \$ . \$0.00 \$ .1,365,254 \$580,574.00 \$. \$ . \$0.00 \$ .1,03,202 \$1,09,630.00 \$. \$ . \$0.00 \$ .1,03,202 \$1,09,630.00 \$. \$ . \$0.00 \$ .411,708 \$130,938.00 \$. \$ . \$0.00 \$ .411,708 \$130,938.00 \$. \$ . \$0.00 \$ .760,448 \$2,025,834.00 \$. \$ . \$0.00 \$ .760,448 \$2,025,834.00 \$. \$ . \$0.00 \$ .760,448 \$2,025,834.00 \$. \$ . \$0.00 \$ .760,448 \$2,025,834.00 \$.	D	usellary Cost Centers (from W/S C excluding Observed	Cost Report Worksheel 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			Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ralio
State	D (0 )	Harillary Cost Centers (from W/S C excluding Obserts (10 RADIOLOGY-DIAGNOSTIC 5700 CT SCAN CT		en en	\$0.00			\$100,453.00 \$210,616.00		\$ 751,948 \$ 2,160,093	0.463576 0.214211
ELECTROCARDIOLOGY         \$47,830,00         \$ 50,00         \$ 47,830         \$31,303,00           ELECTROCENCEPHAL/OGRAPHY         \$35,553,00         \$ 50,00         \$ 35,553         \$554,00           MEDICAL SUPPLIES CHARGED TO PATIENT         \$411,708,00         \$ - \$0,00         \$ 411,708         \$ 411,708           DRUGS CHARGED TO PATIENTS         \$760,448,00         \$ - \$0,00         \$ 760,448         \$ 2,025,834,00           EMERGENCY         \$ 2,28,400,00         \$ 760,448         \$ 2,025,834,00         \$ 760,448					\$0.00	が一般の					0.628115
MEDICAL SUPPLIES CHARGED TO PATIENT   \$411,708.00   \$   \$50.00   \$   \$130,938.00   \$   \$130,938.00   \$   \$10,000   \$   \$   \$10,000   \$   \$   \$10,000   \$   \$   \$   \$10,000   \$   \$   \$   \$10,000   \$   \$   \$   \$   \$   \$   \$   \$   \$	II on		$\rightarrow$	n (n	\$0.00			\$3		\$ 236,804	0.728321
SEDITOPATIENT    STRUCTURES	1.1	MEDICAL SUPPLIES CHARGED			\$0.00			\$130,938.00	_	\$ 79,424 \$ 163,168	0.447635
2,238,400 \$ 165,727,00	101-		_	50 60	\$0.00		2	\$2,025,834.00 \$165,727.00		ωw	0.238898

Cost Report Year (10/01/2017-09/30/2018)

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

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																																																												Cost Center Description
\$0.00 \$	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	60.00	\$0.00	\$0.00	\$0.00	30.00	\$0.00	00.00	\$0.00	20.00	50.00	20.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	30.00	90.00	50.00	\$0.00	\$0.00	\$0.00	50.00	\$0.00	30.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	00.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	50.00	\$0.00	\$0.00	\$0.00	Total Allowable Cost
x1 65	691		9 4	\$ 6	641	6/31	6	A &	A) 6	AI G	9 6	A 4			AI &	9 4		ni e		0	69	641	\$	69	64	4	9 6		59		A) 6	A	n 6	9 64		64	69	€9	\$		A	A S	69	69	69	69	8	69	€41	69	69	69	69	64	69 6	99 (	69 (	co e	69	Costs Removed on Cost Report *
															0.00	2 64	9 64	9 4	9 4	A	50	S	\$0	\$0	\$0	\$0	30	90	50	90	40	900	80	50	\$0	\$0	\$0.	\$0.	50	So	-0.0 -0.0	#D	SO	\$0	08	50	SO	\$0	SO	SO	SO	SO	90	\$0	So	20.00	So	SO	\$0	Add-Back (If Applicable)
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\$0.00	\$ \$0.00	\$ 50.00	\$0.00	50.00	\$ 00.00	\$ \$0.00	\$ \$0.00	\$0.00	90.00	\$0.00	0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	50.00	\$0.00	90.00	6000	\$0.00	5080	\$ \$0.00	\$0.00	\$ 50.00	\$0.00	\$0.00	90.00	\$0.00	\$ 60.00	90.00	80.00	\$0.00	\$0.00	\$0.00	\$0.00	\$ 50.00	\$ 50.00	\$0.00	\$0.00	90000	0.00	\$0.00	\$ 50.00	\$0.00	\$ \$0.00	\$0.00	\$ 50,00	\$0.00	\$0.00	\$0.00	\$0.00	\$ 50,000	\$0.00	50.00	A 6000	\$2000	\$6,00	\$0.00	Total Cost Ancillary Charges And
	\$ \$0.00 \$	\$0.00 \$	\$0.00 \$	50.00 SOURCE STATE OF SOURCE S	\$ 0.00 \$ 0.00 \$	\$0.00 \$0.00 \$	\$ \$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00 \$0.00	\$0.00	\$0.00	\$0.00 \$0.00 \$	\$0.00	\$0.00	\$0.00	\$0.00	50.00	50.00	\$0.00	\$ \$0.00 \$	\$ 50.00 \$	\$ 50.00 \$0.00 \$	\$0.00 \$0.00	\$0.00	6	\$0.00 m	\$0.00 \$0.00 \$	90.00	50.00	\$0.00 \$	\$0.00	\$0.00 \$	\$ \$0.00 \$	\$ \$0.00 \$	\$ 50.00	\$0.00	60 6	90.00	\$0.00	\$0.00	\$ - \$0.00 \$	\$ 50.00	\$ \$0.00 \$	\$ 0.00 \$	\$ 50.00 \$	\$0.00	\$0.00	\$0.00	\$0.00 \$0.00 \$	\$0.00 \$0.00 \$	\$0.00	50.00	60.00 G	\$0.00	\$6.00	\$ 00.00	Total Cost Ancillary Charges

Page 2

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

SOUTH GEORGIA MED CTR - LANIER

Conditionable   Control Description   Conditionable   Control Description   Conditionable   Control Description   Conditional   Control Control Description   Control Co								
Coal Coates Description   Visit Joseph   Visit Coat Servinovo   Application   Visit Coat   Application   Visit Coat   Application   Visit Coat   Application   Visit Coate   Application   Applicati				\$ 6,789,441			Grand Total	132
Coal Coate						d)	Other Cost Adjustments (support must be submitte	131.01
Coad Cardier Obscription   Value   Coad Remittance   Value   Coad Cardier Obscription   Coad Remittance   Value   Value   Coad Remittance   Value   Value   Coad Remittance   Value   Value   Value   Coad Remittance   Value   Valu					calculation of cost.)	lospital must calculate. Submit support for	NF, SNF, and Swing Bed Cost for Other Payers (F	131
Coast Contine Description   Total Annoques   Total Contine Description   Total Conti				\$734,794.00	Title 18, Column 3, Line 200 and	of applicable Cost Report Worksheet D-3, 10)	NF, SNF, and Swing Bed Cost for Medicare (Sum Worksheet D, Part V, Title 18, Column 5-7, Line 20	130
Cost Center Description   Cost Section of Cost Center Description   Cost Section of Cost Center Description   Cost Cente		9,766,925		7,52	\$ Title 19, Column 3, Line 200 and	9,328,178 \$ - of applicable Cost Report Worksheet D-3,	Sub Totals  NF, SNF, and Swing Bed Cost for Medicaid (Sum Worksheet D, Part V, Title 19, Column 5-7, Line 20	128 129
							Weignted Average	127
		9,766,925	4,285,214		49	6,673,695 \$		126
			\$0.00	69	\$0.00	\$0.00 \$		125
Cost Center Description   Costs Amontony   Costs Center Costs Center Cost   Costs Center Cost   Costs Center Cost   Costs Center Cost   Costs   Costs Center Cost   Costs			\$0.00	60	\$0.00	\$0.00 \$		124
Cost Center Description   Costs Amontony   Costs Amontony Changes			\$0.00	49	\$0.00			123
Cost Center Description   Cost Seremoved   Applicable)   Cost Center Description   Cost   C			\$0.00	69	\$0.00	\$0.00 \$		122
Cost Center Description   Cost Repairs   Cost   C			\$0.00	69	\$0.00	\$0.00 \$		121
Cost Centur Description   Cost Repaired   Cost Century Century Cost Century			\$0.00	49	\$0.00			120
Cost Caritir Description   Cost Report   Applicable   Cost   Co			\$0.00	69	\$0.00			119
Cost Cantin Description   Cost Report   Applicable)   Total Cost   Ancillary Charges and Life   Charges an	69		\$0.00	60	\$0.00	_		118
Cost Centier Description   Cost Removed   Applicable)   Total Cost   Total Cost   Applicable)   Total Cost   Total Cost   Total Cost   Applicable)   Total Cost   Total Cos			\$0.00	65	\$0.00	45		117
Cost Centar Description   Cost Reprort   Applicable)   Total Cost   Applicable   Total Cost   Tota			\$0.00	49	\$0.00	49		116
Cost Centur Description   Cost Reprover   Applicable   Total Cost   Applicable   Total Cost   Applicable   Total Cost   Applicable   Total Charges and Off   Storie	\$	\$0.00	\$0.00	59	\$0.00	64		1
Cost Centur Description   Cost Reprort   Applicable   Cost	5	\$0.00	\$0.00	59	\$0.00			1
Cost Centur Description   Cost Report   Cost Report   Cost Centur Description   Cost Report   Cost	*	\$0.00	\$0.00	69	\$0.00	46		
Cost Center Description			\$0.00	\$	\$0.00			
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Cost Ceritar Description   Cost windown   Cost wi		\$0.00	\$0.00	5	\$0.00	69		
Cost Centur Description   Cost Annovative   Cost Centur Description   Cost   Cost Centur Description   Cost   Cost Report   Applicable)   Total Cost   Cost Centurges And Cillary Charges   Cost Centurges   Cos	S	\$0.00	\$0.00	•	\$0.00	69		109
Cost Centur Description   Cost Repport   Applicable)   Total Cost		\$0.00	\$0.00	69	\$0.00			
Cost Centier Description   Cost National Cost   C	8	\$0.00	\$0.00	69	\$0.00	69		
Cost Centiur Description   Cost Removed   Applicable   Cost   Cost Removed   Applicable   Cost   Applicable   Cost   Cost   Applicable   Cost   Cos	\$	\$0.00	\$0.00	69	\$0.00			
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Cost Centur Description   Cost Removed   Applicable)   Total Cost   Applicable   Total Cost   Tot		\$0.00	\$0,00		\$0.00	9		f 1
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Cost Center Description	49	\$0.00	\$0.00	64	\$0.00	4		
Cost Center Description	69	\$0.00	\$0.00	61	\$0.00	9		3 S
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Cost Center Description Cost on Cost Report* Applicable) Total Cost Ancillary Charges Ancillary Charges				•	\$0.00			98
IP Days and IP	Total Charges	Ancillary Charges			Applicable)	on Cost Report	Cost Center Description	**
The Administration of the Control of		Charges and O/P	UP Days and UP		Add-Back (III			Line

<sup>\*</sup> 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.

Total Days per PSAR or Exhibit Deptil    Comparison   Comparison	Access   Continue Principles   Continue   Continue Principles   Continue Principles	From Section G	Antical Dam Co Dinn Co Dinn Co Dinn Co Dinn Co Dinn Co Dinn Co
(Variance)	USAZI	rum Section G	210
			A CAR
Total Days  0.000440 0.000440 0.000440 0.000440 0.000440 0.0004440 0.000440		From Section G	Madigate Contin Charge Ratio for Acuttley Cost Contars
80dfini Charjes. 8 ddfini Charjes. 3 4A(107) 470,24 Ancillary Charjes. 170,253 170,253 170,553	Days 92	From PS&R Summary (Nota A)	Digastical.
Accidity Congress  Accidity Cong		From PS&R Summery (Note A)	Outputers
15 13 16 Oxidine Chairgea 3 376 3	i vin	From I Summary	Total Consult
Anothery Daviger  4,316  4,316  4,316  117 (20)  117 (20		From PS&R Summary (Note A)	Outputed Output
68 66 66 67 67 67 67 67 67 67 67 67 67 67	Days 68	From PS&R Summary (Note A)	Married Woman
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31 31 31 31 31 31 31 31 31 31	Days 35	From PS&R Summary (Note A)	H-first Olive to
Antillay, Chayan 477 1405/01 1407/11 1407/11 1517/19 20,038		From PS&R Summary (Note A)	The Author Expense (Inc.)
8.8000n Charpet  8.0000n Charpet  5 9 964,071  Ancillay Chap  1.07(0)  2.07	Days 102	From Hospital's Own Internal Analysis	Description At 1
Andling Chay  An		70	Outpetion (
Routine City 170 170 170 170 170 170 170 170 170 170	Days 206		Takens
Canada   C		On the second	

Property of Myers and Smuffer LC

## H. In-State Medicald and All Uninsured inpatient and Outpatient Hospital Data:

	147 148	145 146	140 141 142 143	13 13 13 13 13 13 13 13 13 13 13 13 13 1	131	129 130	128		126	124	121	120	1 1 7	1 1 1	1 1 2	111	100	107	106	₹ 5	102	8 8	98 98 88 88	97 98	18 Y	2 2 2	3 9	8 8	86 Q	3 % 3	<b>2</b> 2	82	
Note A. Tress amounts must agree Note 9 - Moricaid cest onthemor) pa Note 5 - Moricaid cest onthemori pa Note C - Offini Medicaid Phymenia iii Note C - Offini Indude offise Medica Note 5 - Manual include offise Medicaid	Total Medicare Days from W/S S-3. Percent of cross-over days to total	Calculated Payment Shortfall / (Lo Calculated	Medicare Institutal (nex-HMO) Paid Amount (solidate connum modebalcables) Medicare Konsey Ore (PMO) Paid Amount (solidate connum modebalcables) Medicare Cosa-Pove Bad Otak Poymenta (Solidate Cosa-Pove Bad Otak Poymenta (Solidate) Other Medicare Cosa-Pove Paymenta (Solidate) Payment (term Hospital Universited During Otak Poport Veatr (Cash Baski) Socian 1011 Payment Related to Inpatient Hospital Sarvices NOT Included in Exhibits 8 & 6-1 (from Section E)	Total Medical Park Amount (excitates TPL, Co-Pby and Spent-Down). Total Medical Managed Can Pitol Amount (excitates TPL, Co-Pby and Prinde Insurance (excitating primary and third party liability). Self-2by (recluting Lo-pby and Spand-Down) Total Advaned Amount from Medicad PSEs or RA Datial (Ad Paymants). Medicald Cost Settlement Payments (See Nobe II). Other Medical Payments Reported in Cost Report You'r (See Nobe II).	Total Calculated Cos	Total Charges per PS&R or Exhibit Detail Unreconcile	Total Charges	Totals / Payments																									
With A. These amount must grays to you require and expedient feeded pind claims summary. For Managed Care. Cress-Over data, and other eligibles, use the hospita's bags if POAR summaries are not available (submit Soft will harvey). Note the hospital care is a propriet made by Moderat during a cost report sufficiently those or community of POAR summary or POAR.  1000 C. Order Moderated PoAR primer such as Collect and the poar Society agreement. Society agreement about MOT be presented, but the post of a care freed primer such as Collect and Moderate Society agreement. Society agreement about MOT be presented, the propriet made on a state freed pure trains strainly to execute the society of a manage.  1000 D. Order Moderated PoAR primer such as Collect and the propriet of the propriet above. This is because a popular feel freed that the propriet is desired. The propriet of the society of the propriet of the Moderate Collection and Moderate Collection Society (and the propriet above.)  1010 Feel freed that the such as the society of the propriet of the society of the Moderate Collection and the propriet above. This is because a popular to paid claims under propriet above. This is because a popular to the Moderate Collection (in the paid claims) and the propriet above. This is because a popular to the Moderate Collection (in the paid claims) and the propriet above.	Total Medicam Days from WIS S.3 of the Cost Report Excluding Swing-Bed (CFR, WIS S.3, Pt. I, Col. 6, Sum of Linc. 2.3, 4, 14, 16, 17, 18 less lines § 8, 6) Percent of cross-over days to total Medicam days from the cost report	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH) Calculated Payments as a Percentage of Cost	Medicer i fedinoal (hon-Halio) paid Announ (excludes comun modedeclacibles) Medicere Managed Cere (HAIO) Paid Announ (excludes coinsurancedeclacibles) Medicare Cross-Over Ball Debt Paymonis Orbert Medicare Cross-Over Paymonis (See Noba D) Paymoni firm Hospibli Universared During Cest Noba D) Sordion 1011 Paymoni Related to Inpatient Hospibli Sancies NOT Included in Esh	Total Medical Pat Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E) Total Medical Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E) Total Medicand Roman (excluding primary and third party liability) Sef-Park Inhuman (excluding primary and third party liability) Total Advanced Amount from Medical PSER or RA, Dalail (All Payments) Medical Cocal Settlement Payments (See Nobe E) Other Medical Cocal Settlement Payments (See Nobe E)	3	xhibit Detail Unreconciled Churges (Explain Veriance)	Total Charges (includes orgen acquisition from Section J)		800	100 PM			00000				OUT THE		NAME OF TAXABLE PARTY.					100 500					2000				
ed paid claims summary. For dicaid during a cost report so; payments. IDSH payments a the paid cluims data reports	-Bed (C/R, W/S S-3, Pt. I, Co		dibles) dibles) in Exhibits B & B-1 (from Se	end-Down) (See Note E)	Saction J)		] (1.100		- 14 4										Ī	- -									J.				
Managed Core. Cross- tiement that are not red bould NOT be included d above. This symules	L 6, Sum of Lns. 2, 3,	S 118,770 45%	ction E)	\$ 9.993 \$ 96.793	\$ 215,563	\$ 290,006	\$ 286,036	621.00													110												Fried Mary
Oxer data, and other eli- ected on the statem paid. LUPL payments made psyments paid based o	4, 14, 16, 17, 18 less li	\$ 71,223 75%		\$ 222.497 \$ 916 \$ 900 \$ 224,011 \$ (6.490)	\$ 289,738	\$ 550,592	\$ 550,592	250,002						100																			the state of
gibles, use the hospital of summary (RA summar on a stee fiscal year han the Medicine sent rep	nes 5 & 6)	\$ 17,003 56%		\$ 22.023 \$ 22.023	\$ 19.026	\$ ##.482	\$ 69,682	\$ 50.MC																									
asps if PS&R summan yet PS&R as should be reported to the selllement (e.g., Me		\$ 270,194 54%		3 114.381 5 1.885 5 316.498	\$ 587,030	1 1/152,388	\$ 1,152,388	\$ 1,152,365																								A STATE OF THE PERSON NAMED IN	
is are not existable (nut- ) Section C of me survey from Creduate Modical	14%	\$ (1.762) 101%	\$ 107.788 \$ 10.041 \$ 51,498	\$ 1.552	\$ 176.158	\$ 258,497	\$ 258,497	\$ 106,506			100	7.2																					Name of Street
tel logs with survey).  Reduction payments).		\$ (4.067) 101%	\$ 302,158 \$ 25,001	\$ 04.403	\$ 406,680	1 165,440	\$ 883,449	1 103,441									4.7 2															Miles	A Contraction of the Contraction
		\$ 2,029 96%	\$ 10,077 \$ 10,195		\$ 52,901	\$ 49.894	\$ 49,894	1 24,787																								il division in	Profession Order M
		S 56,813	3 14,659 1 14,659	** 00 Jan 00	S	\$ 296.574	\$ 296,574	1 290,574																							000	Thental	of the second
NOTE: Inpatient uni is correct. NOTE: Outpatient un		\$ 249	Ogrees to Halana III and III.		\$ 248,827 \$			1 277,202																								ç	
NOTE: Inpatent unhaured payment rate is outside normal ranges, please verify this is correct.  NOTE: Outsident uninsured payment rate is outside normal ranges, please verify the correct correct.		\$ 1,147,986	Open to School Buryol Dr. Spigmen to Extend Buryol Br.  10 19 19 19 19 19 19 19 19 19 19 19 19 19		\$ 1,187,751	\$ 259(54)	\$ 332,842 \$ 2,504,941  (Agrees to Exhibit A) (Agrees to Exhibit A)	\$ 2504,141																								- West	
outside normal ranges is outside normal range		\$ 136,040 72%	\$ 148,465 \$ 10,495 \$ 10,041 \$ 51,488	150 M	\$ 483,648		\$ 664,109			000 000					*					*1.												Zonski-D	
, please verify this is, please verify	į	\$ 394,163 73%	\$ 3.00 st7 \$ 18.659 \$ 25.001 \$ (11.881)	287.000 318.561 32.584 1,437 (5.498)	\$ 1,450,007		\$ 2,883,003		***					+ +		- 1	un un	64 bis	un u	in a		e da	ed ed	en e	i i	e est	er es					Astropy	
					49.87%		41.76%																									M.	

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

CONTRIDER YOUR TO THE THE SOUTH GEORGIA MED CTR - LANIER

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Property of Myers and Stauffer LC

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

SOUTH GEORGIA MED CTR - LANIER

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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 PSAR 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 dain's paid summary (RA summary or PSAR).

Note C - Other Medicaid Payments such as Outlies 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 Medicaic cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicaic cost report settlement (e.g., Medicaic Graduate Medicail Education payments).

Note E - Medicaid Managed Care payments should Include all Medicaid Managed Care payments should include all Medicaid Managed Care payments and Medicaid Managed Care payments.

## 4. Transplant Facilities Only: Organ Acquisition Cost in-State Medicald and Uninsured SOUTH GEORGA MED CTR - LANER

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	2 Q	Apport Organ Acquisition Cost	Coat and the Add- On Cost	Medicare with Medicard/ Grass-Over & uninsured). See Note C balow.	S IN IN LINE	Cogo (Note A)	Data or Provider Logil (Note A)	Date or Provider Loge (Note A)	Date or Provider Loga (Note A)	Data or Provider Logs (Note A)	Data or Provider Logis (Mans A)	Logs (Note A)	Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	Fram Hospitata Own Internal Analysis
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## K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

### SOUTH GEORGIA MED CTR - LANIER

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		Acquisition Cost	Differni Resident	0	Over / Unitesured Organic Sold	Organia (Count)	Charges	Caudile Organs (Count)	Charges	0	Des (Count)		Usuable Organs (Cauch)	Usuable Organs Charges U
		Coal Report Worksheat D-4, PL III, Col. 1, Ln 61	Aut On Coat Factor an Section B, Line 133 x Total Coat Raport Organ Acquisition Coat	Sum of Oest Report Organ Acquisitus Cost and the Add- Cost	Similar to transcusions there Could Report 1975 Dod Pt, III Co. 3 , Lin 45 (postulation and). Additional Coops Oper & Linibrature(), See Relate C backers	Cost Report Workshoet D 4, Pt. III, Line 62	From Paid Chains Daib or Provider Logs (Note A)	From Paid Claims Data or Provider Login (Note A)	5 2 2	Fram Paid Claims Data or Provider Logs (Note A)			From Paid Claims Date or Provider Logs (Note A)  From Paid Claims From From Paid Claims From From Paid Claims From From Paid Claims From From From From From From From From	From Paul Claims Delto or Provider Logo (Picto A) L
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# L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect 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 approximed to the various payers through the step down aflocation 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.

SOUTH GEORGIA MED CTR - LANIER

Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:  18 Medicaid Hospital Charges Sec. G 19 Uninsured Hospital Charges Sec. G 20 Total Hospital Charges Sec. G 21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC 22 Percentage of Provider Tax Assessment Adjustment to DSH UCC 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	17 Gross Allowable Assessment Not Included in the Cost Report	DSH UCC Provider Tax Assessment Adjustment:	16 Tolal Net Provider Tax Assessment Expense Included in the Cost Report	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from wis A-8 of the Medicare cost report) 12 Reason for adjustment 13 Reason for adjustment 14 Reason for adjustment 15 Reason for adjustment 16 Reason for adjustment	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from wis A-8 of the Medicare cost report)  Reason for adjustment  Reason for adjustment  Reason for adjustment  Reason for adjustment  Reason for adjustment	Provider Tax Assessment Reclassifications (from w/s A.6 of the Medicare cost report) 4 Reclassification Code 5 Reclassification Code 6 Reclassification Code 7 Reclassification Code	2 Hospital Gross Provider Tax Assessment Included in Expanse on the Cost Report (W/S A. Col. 2)  3 Difference (Explain Here ———>)	Worksheet A Provider Tax Assessment Reconciliation:  1 Hospital Gross Provider Tax Assessment (from general ledger)*  1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment
2.8 2.8 15.3 sured UCC \$ \$ \$	60		ost Report	justments (from w/s A-8 of the Medicare cost report)	ments (from wis A-8 of the Medicare cost report)	of the Medicare cost report)	on the Cost Report (W/S A; Col. 2)  CAH	Pollar Amount os Gross Provider Tax Assessment
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<sup>\*</sup>Assessment must exclude any non-hospital assessment such as Nursing Facility.

<sup>&</sup>quot;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.