State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

DSH Version 5.20 11/1/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

2. Select Your Facility from the Drop-Down Menu Provided: SOUTH GEORGIA MED CTR - BERRIEN

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	10/01/2016	09/30/2017
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:	000000173A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110234

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 (07/01/16 - 06/30/17)
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.)	No
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?	Yes
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	7/1/1965

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 (07/01/18 - 06/30/19)
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.)	No

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

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?	Yes

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

$ 58,909

Certification:

Answer
Yes

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.**

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	229-259-4162 Hospital CEO or CFO Telephone Number	grant.byers@sgmc.org Hospital CEO or CFO E-Mail

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

Hospital Contact:

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

Outside Preparer:

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

Example of Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor 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			$ -	
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 Payor Plan (B)	Secondary Payor 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) (V) *****
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	7/9/2000	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	7/9/2000	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 B-1

Summary of Self Pay Cash Collections During the Cost Report Year (Unknown Insurance Status)

NOTE: This is NOT intended for DOS prior to the cost report period. It is intended to be used for claims that are too old to determine the patient's true insurance status. Claims with DOS prior to the cost report period should be included in Exhibit B unless the patient's insurance status cannot be determined.

Patient Identifier Code (PCN) (A)	Name (B)	Admit Date (C)	Discharge Date (D)	Date of Cash Collection (E)	Amount of Cash Collections (F)	Indicate if Collection is a 1011 Payment (G) ***	Total Hospital Charges for Services Provided (H) *	Total Physician Charges for Services Provided (I)	Total Other Non-Hospital Charges for Services Provided (J) **	Calculated Uninsured Percentage (K) ****	Calculated Hospital Uninsured Collections (= (H)/((H)+(I)+(J))*(F)*(K))
8888888	Johnson, Joe	5/12/1999	5/25/1999	5/1/2010	$ 500	No	$ 55,000	$ 1,100	$ -	7%	$ 33
8888888	Johnson, Joe	5/12/1999	5/25/1999	3/1/2010	$ 250	Yes	$ 55,000	$ 1,100	$ -	7%	$ 16
8888888	Johnson, Joe	5/12/1999	5/25/1999	5/15/2010	$ 100	No	$ 55,000	$ 1,100	$ -	7%	$ 7
8888888	Johnson, Joe	5/12/1999	5/25/1999	6/15/2010	$ 300	No	$ 55,000	$ 1,100	$ -	7%	$ 20
5555555	Smith, Scott	7/1/2004	7/15/2004	2/18/2010	$ 800	No	$ 35,000	$ 550	$ 330	7%	$ 52
5555555	Smith, Scott	7/1/2004	7/15/2004	3/25/2010	$ 500	No	$ 35,000	$ 550	$ 330	7%	$ 33
5555555	Smith, Scott	7/1/2004	7/15/2004	4/28/2010	$ 200	No	$ 35,000	$ 550	$ 330	7%	$ 13
5555555	Smith, Scott	7/1/2004	7/15/2004	6/15/2010	$ 100	No	$ 35,000	$ 550	$ 330	7%	$ 7

Notes for Completing Exhibit B-1:

* Charges 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.

**** The uninsured percentage should be calculated based on the total uninsured payments as a percentage of the self pay payments shown on Exhibit B. This percentage will be the same for all of the older service date collections since documentation is not available to support the insurance status.

Please submit the above data in an electronic file with this survey document. The electronic file must be submitted in Excel (.xls, .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).

Example of Exhibit C [Other Medicaid Eligible example]

Claim Type (A) *	Primary Payor Plan (B)	Secondary Payor 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 (O)+(R)+(S)+(T)+(U)+(V)
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	666888	123456789	1/1/1960	999-99-999	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	666888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	208	$ 1,500	1	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	666888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	250	$ 100	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	666888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	300	$ 375	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	666888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	450	$ 1,500	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Aetna	Medicaid	12345	666886	978854321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	250	$ 100	-	$ -	$ -	$ -	$ -	$ 900	$ 75	$ 975
Other Medicaid Eligibles	Aetna	Medicaid	12345	666886	978854321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	300	$ 375	-	$ -	$ -	$ -	$ -	$ 900	$ 75	$ 975
Other Medicaid Eligibles	Aetna	Medicaid	12345	666886	978854321	7/12/1985	999-99-999	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	999-99-999	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	999-99-999	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 be excluded.

** 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.

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D. General Cost Report Year Information 10/1/2016 - 9/30/2017

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 MED CTR - BERRIEN		
2. Select Cost Report Year Covered by this Survey (enter "X"):	10/1/2016 through 9/30/2017: 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:	3/19/2018		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	SOUTH GEORGIA MED CTR - BERRIEN	Yes	
5. Medicaid Provider Number:	000000173A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110234	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	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		
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: (10/01/2016 - 09/30/2017)

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)	$ 7,754	$ 37,724	$45,478
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,526	$ 155,985	$158,511
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)	$10,280	$193,709	$203,989
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	75.43%	19.47%	22.29%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

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

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2016 - 09/30/2017)

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)	3,288 (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	262,909
8.	Outpatient Hospital Charity Care Charges	398,214
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 661,123

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	$4,600,474.00			$ 3,467,832	$ -	$ -	$ 1,132,642
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	$2,633,447.00	$9,104,939.00		$ 1,985,089	$ 6,863,293	$ -	$ 2,890,004
20.	Outpatient Services		$3,564,522.00			$ 2,686,933	$ -	$ 877,589
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$382.00	$186,338.00	$0.00	$ 288	$ 140,461	$ -	$ 45,971
27.	Total	$ 7,234,303	$ 12,855,799	$ -	$ 5,453,209	$ 9,690,687	$ -	$ 4,946,206
28.	Total Hospital and Non Hospital		Total from Above	$ 20,090,102		Total from Above	$ 15,143,896	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	20,090,102	Total Contractual Adj. (G-3 Line 2) 13,241,674
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)			+ 1,902,222
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			15,143,896

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MED CTR - BERRIEN

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	$ 3,734,495	$ -	$ -	$0.00	$ 3,734,495	3,596	$4,600,474.00		$ 1,038.51
2	03100 INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ -	$ -	$ -		$ -	-	$0.00		$ -
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 3,734,495	$ -	$ -	$ -	$ 3,734,495	3,596	$ 4,600,474		
19	Weighted Average									$ 1,038.51

		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	308	-	-	$ 319,861	$8,420.00	$328,021.00	$ 336,441	0.950719

Line #	Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*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*
21	5400 RADIOLOGY-DIAGNOSTIC	$790,938.00	$ -	$0.00		$ 790,938	$61,628.00	$1,263,573.00	$ 1,325,201	0.596844
22	5700 CT SCAN	$184,269.00	$ -	$0.00		$ 184,269	$172,666.00	$3,171,690.00	$ 3,344,356	0.055099
23	6000 LABORATORY	$1,153,250.00	$ -	$0.00		$ 1,153,250	$520,714.00	$2,741,809.00	$ 3,262,523	0.353484
24	6500 RESPIRATORY THERAPY	$112,210.00	$ -	$0.00		$ 112,210	$24,891.00	$471,731.00	$ 496,622	0.225946
25	6600 PHYSICAL THERAPY	$57,091.00	$ -	$0.00		$ 57,091	$48,881.00	$1,789.00	$ 50,670	1.126722
26	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$99,317.00	$ -	$0.00		$ 99,317	$58,313.00	$116,978.00	$ 175,291	0.566584
27	7300 DRUGS CHARGED TO PATIENTS	$610,224.00	$ -	$0.00		$ 610,224	$1,746,354.00	$1,337,369.00	$ 3,083,723	0.197885
28	9100 EMERGENCY	$1,907,931.00	$ -	$0.00		$ 1,907,931	$101,115.00	$3,126,966.00	$ 3,228,081	0.591042
29		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
30		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MED CTR - BERRIEN

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
31		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
32		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
33		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
34		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
35		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
36		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
37		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
38		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
39		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
40		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
41		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MED CTR - BERRIEN

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
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**	$ 4,915,230	$ -	$ -		$ 4,915,230	$ 2,742,982	$ 12,559,926	$ 15,302,908	
127	**Weighted Average**									0.342098
128	**Sub Totals**	$ 8,649,725	$ -	$ -		$ 8,649,725	$ 7,343,456	$ 12,559,926	$ 19,903,382	
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 Payors *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01	Other Cost Adjustments (support must be submitted)									
132	**Grand Total**					$ 8,649,725				
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 (10/01/2016-09/30/2017): SOUTH GEORGIA MED CTR - BERRIEN

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicaid FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):															
1	03000 ADULTS & PEDIATRICS	$ 1,038.51		Days 47		Days 17		Days 121		Days 764		Days 201		Days 949		34.98%
2	03100 INTENSIVE CARE UNIT	$ -												-		
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ -												-		
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	47		17		121		764		201		949		31.98%
19	Total Days per PS&R or Exhibit Detail			47		17		121		764		201				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
21	Routine Charges			Routine Charges $ 34,247		Routine Charges $ 14,175		Routine Charges $ 99,724		Routine Charges $ 1,184,875		Routine Charges $ 172,448		Routine Charges $ 1,333,021		
21.01	Calculated Routine Charge Per Diem			$ 728.66		$ 833.82		$ 824.17		$ 1,550.88		$ 857.95		$ 1,404.66		32.72%
	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	0200 Observation (Non-Distinct)		0.950719		19,207	-	13,104	1,570	44,083	146	5,172	1,480	53,599	$ 1,716	$ 81,566	
23	5400 RADIOLOGY-DIAGNOSTIC		0.596844	2,983	92,263	747	150,433	6,904	159,838	2,295	26,466	5,328	177,709	$ 12,939	$ 429,000	41.12%
24	5700 CT SCAN		0.055099	17,331	149,972	10,125	341,581	36,791	463,709	4,287	39,978	13,373	372,811	$ 68,534	$ 1,015,250	47.17%
25	6000 LABORATORY		0.363484	28,432	203,527	10,872	320,996	59,639	236,927	15,237	165,658	44,166	615,967	$ 114,180	$ 927,108	58.98%
26	6500 RESPIRATORY THERAPY		0.226946	724	50,225	181	36,264	2,490	108,821	3,100	9,605	1,267	57,720	$ 6,495	$ 204,915	52.20%
27	6600 PHYSICAL THERAPY		1.129722	605	-	-	-	1,566	436	1,479	3,503	4,355	-	$ 3,672	$ 3,939	54.48%
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.566584	3,912	10,267	771	14,994	4,456	16,912	2,295	8,835	13,742	24,044	$ 10,835	$ 51,028	23.62%
29	7300 DRUGS CHARGED TO PATIENTS		0.197885	65,819	136,064	23,187	209,391	155,236	159,922	45,240	297,515	161,204	375,142	$ 289,485	$ 804,895	56.85%
30	9100 EMERGENCY		0.591042	4,762	200,136	3,523	624,880	17,270	311,816	5,139	36,449	12,243	964,610	$ 30,694	$ 1,173,281	52.91%
31			-											$ -	$ -	67.62%
32			-											$ -	$ -	
33			-											$ -	$ -	
34			-											$ -	$ -	
35			-											$ -	$ -	
36			-											$ -	$ -	
37			-											$ -	$ -	
38			-											$ -	$ -	
39			-											$ -	$ -	
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
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46			-											$ -	$ -	
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72			-											$ -	$ -	
73			-											$ -	$ -	
74			-											$ -	$ -	
75			-											$ -	$ -	
76			-											$ -	$ -	
77			-											$ -	$ -	
78			-											$ -	$ -	
79			-											$ -	$ -	
80			-											$ -	$ -	
81			-											$ -	$ -	
82			-											$ -	$ -	

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

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

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
83												$ -	$ -	
84												$ -	$ -	
85												$ -	$ -	
86												$ -	$ -	
87												$ -	$ -	
88												$ -	$ -	
89												$ -	$ -	
90												$ -	$ -	
91												$ -	$ -	
92												$ -	$ -	
93												$ -	$ -	
94												$ -	$ -	
95												$ -	$ -	
96												$ -	$ -	
97												$ -	$ -	
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119												$ -	$ -	
120												$ -	$ -	
121												$ -	$ -	
122												$ -	$ -	
123												$ -	$ -	
124												$ -	$ -	
125												$ -	$ -	
126												$ -	$ -	
127												$ -	$ -	
	Totals / Payments	$ 123,968	$ 863,681	$ 49,406	$ 1,711,653	$ 385,944	$ 1,522,467	$ 79,222	$ 593,181	$ 257,138	$ 3,141,602			
128	**Total Charges** *(includes organ acquisition from Section J)*	$ 158,215	$ 863,681	$ 63,581	$ 1,711,653	$ 385,668	$ 1,522,467	$ 1,294,097	$ 593,181	$ 429,586 (Agrees to Exhibit A)	$ 3,141,602 (Agrees to Exhibit A)	$ 1,871,561	$ 4,690,982	50.95%
129	Total Charges per PS&R or Exhibit Detail	$ 158,215	$ 863,681	$ 63,581	$ 1,711,653	$ 385,668	$ 1,522,467	$ 1,294,097	$ 593,181	$ 429,586	$ 3,141,602			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 80,156	$ 318,320	$ 29,650	$ 861,986	$ 200,184	$ 498,315	$ 816,210	$ 173,013	$ 281,772	$ 1,093,979	$ 1,126,200	$ 1,649,634	48.02%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 60,896	$ 291,155	$ 24,687	$ 465,091	$ 33,724	$ 41,845		$ 2,170			$ 119,309	$ 800,261	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)								$ 433			$ -	$ 433	
134	Private Insurance (including primary and third party liability)		$ 115			$ 175	$ 721	$ 2,632	$ 13,313			$ 2,807	$ 14,150	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 738		$ 333			$ 43	$ 619			$ 43	$ 1,690	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 60,896	$ 292,009	$ 24,687	$ 465,424									
137	Medicaid Cost Settlement Payments (See Note B)		$ (45,136)									$ -	$ (45,136)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 118,374	$ 230,473	$ 554,122	$ 11,183			$ 672,496	$ 241,656	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 58,793	$ 17,574			$ 58,793	$ 17,574	
141	Medicare Cross-Over Bad Debt Payments					$ 1,551	$ 6,021					$ 1,551	$ 6,021	
142	Other Medicare Cross-Over Payments (See Note D)					$ (1,342)	$ 424	$ (3,872)	$ 115			$ (5,214)	$ 539	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									(Agrees to Exhibit B and B-1) $ 7,754	(Agrees to Exhibit B and B-1) $ 37,724			
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)**	$ 19,258	$ 69,447	$ 4,963	$ 196,562	$ 47,702	$ 218,831	$ 204,492	$ 127,606	$ 274,018	$ 1,056,255	$ 276,415	$ 612,446	
146	**Calculated Payments as a Percentage of Cost**	76%	78%	83%	70%	76%	56%	75%	26%	3%	3%	75%	63%	
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)**					2,647								
148	**Percent of cross-over days to total Medicare days from the cost report**					5%								

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

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MED CTR - BERRIEN

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 1,038.51										-	
2	03100 INTENSIVE CARE UNIT	$ -										-	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ -										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-		-	
20	Unreconciled Days (Explain Variance)			-		-		-		-		-	
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.950719									$ -	$ -
23	5400 RADIOLOGY-DIAGNOSTIC		0.596844								183	$ -	$ 183
24	5700 CT SCAN		0.055099		2,835							$ -	$ 2,835
25	6000 LABORATORY		0.353484		665						1,057	$ -	$ 1,722
26	6500 RESPIRATORY THERAPY		0.225946								181	$ -	$ 181
27	6600 PHYSICAL THERAPY		1.126722									$ -	$ -
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.566584									$ -	$ -
29	7300 DRUGS CHARGED TO PATIENTS		0.197885		458						369	$ -	$ 827
30	9100 EMERGENCY		0.591042		1,165						614	$ -	$ 1,779
31			-									$ -	$ -
32			-									$ -	$ -
33			-									$ -	$ -
34			-									$ -	$ -
35			-									$ -	$ -
36			-									$ -	$ -
37			-									$ -	$ -
38			-									$ -	$ -
39			-									$ -	$ -
40			-									$ -	$ -
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42			-									$ -	$ -
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60			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MED CTR - BERRIEN

				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	
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MED CTR - BERRIEN

			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	
67		-									$ -	$ -
68		-									$ -	$ -
69		-									$ -	$ -
70		-									$ -	$ -
71		-									$ -	$ -
72		-									$ -	$ -
73		-									$ -	$ -
74		-									$ -	$ -
75		-									$ -	$ -
76		-									$ -	$ -
77		-									$ -	$ -
78		-									$ -	$ -
79		-									$ -	$ -
80		-									$ -	$ -
81		-									$ -	$ -
82		-									$ -	$ -
83		-									$ -	$ -
84		-									$ -	$ -
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89		-									$ -	$ -
90		-									$ -	$ -
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123		-									$ -	$ -
124		-									$ -	$ -
125		-									$ -	$ -
126		-									$ -	$ -
127		-									$ -	$ -
			$ -	$ 5,123	$ -	$ -	$ -	$ -	$ -	$ 2,404		

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MED CTR - BERRIEN

	Totals / Payments	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	
128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ 5,123	$ -	$ -	$ -	$ -	$ -	$ 2,404	$ -	$ 7,527
129	Total Charges per PS&R or Exhibit Detail	$ -	$ 5,123	$ -	$ -	$ -	$ -	$ -	$ 2,404		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ 1,170	$ -	$ -	$ -	$ -	$ -	$ 960	$ -	$ 2,130
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)									$ -	$ -
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)		$ 265						$ 44	$ -	$ 309
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ 265	$ -	$ -						
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)									$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								$ 234	$ -	$ 234
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall)**	$ -	$ 905	$ -	$ -	$ -	$ -	$ -	$ 682	$ -	$ 1,587
144	**Calculated Payments as a Percentage of Cost**	0%	23%	0%	0%	0%	0%	0%	29%	0%	25%

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 (10/01/2016-09/30/2017) SOUTH GEORGIA MED CTR - BERRIEN

		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*
	Organ Acquisition Cost Centers (list below):															
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 (10/01/2016-09/30/2017) SOUTH GEORGIA MED CTR - BERRIEN

		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)*
	Organ Acquisition Cost Centers (list below):													
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 (10/01/2016-09/30/2017) SOUTH GEORGIA MED CTR - BERRIEN

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*	$ 72,913		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*	Expense	002-7342-8000-8710	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	$ 72,913	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	$ 72,913		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ -

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