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 MEDICAL CENTER

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	10/01/2016	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:	000001724A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001724G
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110122

B. DSH OB Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:

	DSH Examination Year (07/01/16 - 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.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	7/1/1955

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

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/18 - 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.)	Yes

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

Alexander Culbreth
Nicole Yarbrough

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
6. Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 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.)

$ 3,251,394

Certification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	Title	Date
	CFO	

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Grant Byers	229-333-1020	grant.byers@sgmc.org

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

Hospital Contact:

Name	Grant Byers
Title	CFO
Telephone Number	229-333-1020
E-Mail Address	grant.byers@sgmc.org
Mailing Street Address	2501 N Patterson Street
Mailing City, State, Zip	Valdosta, GA 31602

Outside Preparer:

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

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		$ 500.00	$ -	Exhausted
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010	Outpatient	450	$ 1,100.00			$ -	Non-Covered Service

Notes for Completing Exhibit A:

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

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

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

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

Example of Exhibit B - Self Pay Collections

Claim Type (A)	Primary 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) *****
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	2/15/1960	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 (Q)+(R)+(S)+(T)+(U)+(V)
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	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	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	206	$ 1,500	1	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	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	888888	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	888888	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	888888	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	888888	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	888888	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 MEDICAL CENTER		
	10/1/2016 through 9/30/2017		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/19/2018		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	SOUTH GEORGIA MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000001724A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001724G	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110122	Yes	
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):	Urban	Yes	

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

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2016 - 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)	$ 171,429	$ 1,249,818	$1,421,247
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,039,237	$ 9,168,346	$11,207,583
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$2,210,666	$10,418,164	$12,628,830
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	7.75%	12.00%	11.25%

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)	65,895 (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	16,361,054
8.	Outpatient Hospital Charity Care Charges	11,317,437
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 27,678,491

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	$64,931,389.00			$ 44,078,190	$ -	$ -	$ 20,853,199
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	$369,365,788.00	$429,063,033.00		$ 250,741,216	$ 291,266,246	$ -	$ 256,421,359
20.	Outpatient Services		$53,091,151.00			$ 36,040,533	$ -	$ 17,050,618
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ 12,237,690			$ 8,307,465	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$3,614,098.00			$ 2,453,404	
26.	Other	$5,018,220.00	$0.00	$23,428,721.00	$ 3,406,581	$ -	$ 15,904,413	$ 1,611,639
27.	Total	$ 439,315,397	$ 482,154,184	$ 39,280,509	$ 298,225,987	$ 327,306,779	$ 26,665,281	$ 295,936,815
28.	Total Hospital and Non Hospital		Total from Above	$ 960,750,090		Total from Above	$ 652,198,047	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	960,750,090	Total Contractual Adj. (G-3 Line 2) 646,010,466
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+ 6,187,581
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			652,198,047

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MEDICAL CENTER

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 35,666,349	$ -	$ 120,379	$0.00	$ 35,786,728	46,394	$41,940,365.00		$ 771.37
2	03100 INTENSIVE CARE UNIT	$ 20,118,112	$ -	$ -		$ 20,118,112	13,791	$22,991,024.00		$ 1,458.79
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 4,099,481	$ -	$ -		$ 4,099,481	5,710	$5,018,220.00		$ 717.95
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 59,883,942	$ -	$ 120,379	$ -	$ 60,004,321	65,895	$ 69,949,609		
19	Weighted Average									$ 910.61

Line #		*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)	-	-	-	$ -			$ -	-

Line #		*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$27,535,325.00	$ -	$0.00		$ 27,535,325	$33,866,988.00	$51,010,063.00	$ 84,877,051	0.324414
22	5200 DELIVERY ROOM & LABOR ROOM	$4,136,595.00	$ -	$0.00		$ 4,136,595	$1,113,865.00	$2,664,417.00	$ 3,778,282	1.094835
23	5300 ANESTHESIOLOGY	$1,196,471.00	$ -	$0.00		$ 1,196,471	$6,024,952.00	$11,855,178.00	$ 17,880,130	0.066916
24	5400 RADIOLOGY-DIAGNOSTIC	$31,173,309.00	$ -	$0.00		$ 31,173,309	$30,234,765.00	$66,022,734.00	$ 96,257,499	0.323853
25	5700 CT SCAN	$4,366,503.00	$ -	$0.00		$ 4,366,503	$16,814,924.00	$59,579,546.00	$ 76,394,470	0.057157
26	5800 MRI	$1,650,167.00	$ -	$0.00		$ 1,650,167	$3,664,446.00	$12,622,591.00	$ 16,287,037	0.101318
27	6000 LABORATORY	$18,107,762.00	$ -	$0.00		$ 18,107,762	$41,245,801.00	$53,398,502.00	$ 94,644,303	0.191324
28	6300 BLOOD STORING PROCESSING & TRANS.	$3,037,468.00	$ -	$0.00		$ 3,037,468	$6,416,522.00	$2,245,417.00	$ 8,661,939	0.350668
29	6500 RESPIRATORY THERAPY	$5,687,583.00	$ -	$0.00		$ 5,687,583	$22,369,410.00	$4,118,352.00	$ 26,487,762	0.214725
30	6600 PHYSICAL THERAPY	$3,418,491.00	$ -	$0.00		$ 3,418,491	$4,187,137.00	$935,578.00	$ 5,122,715	0.667320

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6700	OCCUPATIONAL THERAPY	$1,464,981.00	$ -	$0.00		$ 1,464,981	$2,522,553.00	$39,726.00	$ 2,562,279	0.571749
32	6800	SPEECH PATHOLOGY	$1,199,935.00	$ -	$0.00		$ 1,199,935	$2,108,588.00	$84,134.00	$ 2,192,722	0.547235
33	6900	ELECTROCARDIOLOGY	$3,795,782.00	$ -	$0.00		$ 3,795,782	$8,241,623.00	$8,613,090.00	$ 16,854,713	0.225206
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$13,672,448.00	$ -	$0.00		$ 13,672,448	$38,296,629.00	$17,878,556.00	$ 56,175,187	0.243389
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$23,968,098.00	$ -	$0.00		$ 23,968,098	$44,376,312.00	$26,435,360.00	$ 70,811,672	0.338477
36	7300	DRUGS CHARGED TO PATIENTS	$39,273,882.00	$ -	$0.00		$ 39,273,882	$102,227,560.00	$110,874,423.00	$ 213,101,983	0.184296
37	7400	RENAL DIALYSIS	$1,317,993.00	$ -	$0.00		$ 1,317,993	$2,796,970.00	$438,416.00	$ 3,235,386	0.407368
38	7501	IV THERAPY	$324,380.00	$ -	$0.00		$ 324,380	$2,856,743.00	$246,948.00	$ 3,103,691	0.104514
39	9000	CLINIC	$2,358,637.00	$ -	$0.00		$ 2,358,637	$176,183.00	$2,513,578.00	$ 2,689,761	0.876895
40	9001	WOUND CARE	$1,727,470.00	$ -	$0.00		$ 1,727,470	$916,651.00	$1,470,460.00	$ 2,387,111	0.723666
41	9100	EMERGENCY	$20,881,814.00	$ -	$2,790,143.00		$ 23,671,957	$8,081,404.00	$28,396,908.00	$ 36,478,312	0.648932
42	9200	OBSERVATION	$7,749,198.00	$ -	$0.00		$ 7,749,198	$5,711,629.00	$5,824,338.00	$ 11,535,967	0.671742
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 MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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**	$ 218,044,292	$ -	$ 2,790,143		$ 220,834,435	$ 384,251,655	$ 467,268,317	$ 851,519,972	
127	**Weighted Average**									0.259341
128	**Sub Totals**	$ 277,928,234	$ -	$ 2,910,522		$ 280,838,756	$ 454,201,264	$ 467,268,317	$ 921,469,581	
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**					$ 280,838,756				
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 MEDICAL CENTER

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers (From Section G)	Medicaid Cost to Charge Ratio for Ancillary Cost Centers (From Section G)	In-State Medicaid FFS Primary: Inpatient (From PS&R Summary (Note A))	In-State Medicaid FFS Primary: Outpatient (From PS&R Summary (Note A))	In-State Medicaid Managed Care Primary: Inpatient (From PS&R Summary (Note A))	In-State Medicaid Managed Care Primary: Outpatient (From PS&R Summary (Note A))	In-State Medicare FFS Cross-Overs (with Medicaid Secondary): Inpatient (From PS&R Summary (Note A))	In-State Medicare FFS Cross-Overs (with Medicaid Secondary): Outpatient (From PS&R Summary (Note A))	In-State Other Medicaid Eligibles (Not Included Elsewhere): Inpatient (From PS&R Summary (Note A))	In-State Other Medicaid Eligibles (Not Included Elsewhere): Outpatient (From PS&R Summary (Note A))	Uninsured: Inpatient (See Exhibit A) (From Hospital's Own Internal Analysis)	Uninsured: Outpatient (See Exhibit A) (From Hospital's Own Internal Analysis)	Total In-State Medicaid: Inpatient	Total In-State Medicaid: Outpatient	% Survey to Cost Report Totals
		Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000	ADULTS & PEDIATRICS	$ 771.37		3,151		4,020		3,877		2,114		3,317		14,162		38.69%
2	03100	INTENSIVE CARE UNIT	$ 1,458.79		783		163		950		748		596		2,644		25.00%
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	$ 717.95		312		2,884				246		285		3,442		65.69%
11			$ -												-		
12			$ -												-		
13			$ -												-		
14			$ -												-		
15			$ -												-		
16			$ -												-		
17			$ -												-		
18				Total Days	4,246		7,067		4,827		4,108		4,198		20,248		38.30%
19		Total Days per PS&R or Exhibit Detail			4,246		7,067		4,827		4,108		4,198				
20		Unreconciled Days (Explain Variance)			-		-		-		-		-				
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21		Routine Charges			$ 4,158,366		$ 6,356,688		$ 6,109,924		$ 4,322,668		$ 4,403,275		$ 20,947,640		37.52%
21.01		Calculated Routine Charge Per Diem			$ 979.36		$ 899.49		$ 1,265.78		$ 1,052.26		$ 1,048.90		$ 1,034.55		
		Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200	Observation (Non-Distinct)		-	-	-	-	-	-	-	-	-	-	-	$ -	$ -	
23	5000	OPERATING ROOM		0.324414	1,660,250	1,475,140	1,792,126	10,679,718	2,773,550	3,362,372	975,720	748,301	1,601,770	1,899,212	$ 7,201,646	$ 16,256,531	32.22%
24	5200	DELIVERY ROOM & LABOR ROOM		1.094835	149,922	-	1,851,220	-	18,802	-	433,894	-	75,667	2,426	$ 2,453,438	$ -	67.69%
25	5300	ANESTHESIOLOGY		0.066916	312,771	382,346	492,956	2,381,062	404,549	802,242	230,366	187,007	363,134	475,004	$ 1,530,242	$ 3,752,677	34.68%
26	5400	RADIOLOGY-DIAGNOSTIC		0.323853	650,866	2,056,480	746,986	2,719,692	2,282,741	7,147,861	1,018,465	641,607	2,320,247	3,345,922	$ 4,699,058	$ 12,567,840	24.31%
27	5700	CT SCAN		0.057157	1,018,609	1,773,588	504,423	2,566,970	1,805,717	4,881,396	683,641	538,776	1,883,208	7,293,057	$ 4,012,390	$ 9,760,730	30.84%
28	5800	MRI		0.101318	214,507	202,506	91,643	257,860	395,724	944,497	101,445	104,508	384,058	485,087	$ 803,319	$ 1,509,371	19.87%
29	6000	LABORATORY		0.191324	2,856,095	2,444,297	2,424,016	4,487,134	4,280,297	4,205,106	2,394,304	1,030,218	3,202,346	6,531,738	$ 11,954,712	$ 12,166,755	36.67%
30	6300	BLOOD STORING, PROCESSING & TRANS.		0.360668	167,307	58,971	132,204	50,708	536,794	278,300	267,926	10,859	408,232	247,670	$ 1,104,231	$ 398,238	25.67%
31	6500	RESPIRATORY THERAPY		0.214725	1,578,010	157,629	1,078,517	462,914	2,296,433	285,411	1,429,080	137,180	1,024,259	255,407	$ 6,382,046	$ 1,043,134	34.38%
32	6600	PHYSICAL THERAPY		0.667320	158,358	-	34,246	17,281	352,323	65,504	223,222	7,596	142,638	28,610	$ 768,149	$ 90,381	21.02%
33	6700	OCCUPATIONAL THERAPY		0.571749	51,179	-	8,817	24,216	97,409	31,311	138,508	2,583	68,690	26,188	$ 295,913	$ 58,110	18.29%
34	6800	SPEECH PATHOLOGY		0.547225	72,542	1,064	361,562	6,426	86,801	43,710	108,317	6,576	89,612	15,286	$ 629,212	$ 57,776	37.13%
35	6900	ELECTROCARDIOLOGY		0.225206	1,457,322	833,276	221,893	689,096	970,179	1,045,176	350,880	112,154	584,250	912,943	$ 3,000,274	$ 2,479,702	42.35%
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.243389	1,540,451	489,357	950,337	1,132,981	2,696,985	1,434,812	1,400,123	199,519	1,266,968	832,903	$ 6,586,896	$ 3,256,669	22.00%
37	7200	IMPL. DEV. CHARGED TO PATIENTS		0.338477	2,146,106	440,550	782,754	796,152	4,937,070	2,730,223	761,680	111,509	1,028,445	826,763	$ 8,628,810	$ 4,077,434	21.03%
38	7300	DRUGS CHARGED TO PATIENTS		0.184296	7,194,904	8,914,851	5,518,066	6,099,917	10,216,767	11,292,263	6,259,121	944,956	6,920,140	8,966,600	$ 29,188,858	$ 27,251,787	33.97%
39	7400	RENAL DIALYSIS		0.407368	106,570	-	-	-	547,017	76,516	484,327	7,238	33,086	165,440	$ 1,140,214	$ 83,754	46.27%
40	7501	IV THERAPY		0.104514	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
41	9000	CLINIC		0.876895	32,026	91,596	14,245	788,805	20,066	339,788	12,127	57,676	15,410	7,475	$ 79,064	$ 1,277,865	51.77%
42	9001	WOUND CARE		0.723666	-	-	-	113,230	-	142,712	3,790	16,928	4,938	66,966	$ 3,790	$ 272,870	15.67%
43	9100	EMERGENCY		0.648932	548,568	1,777,493	208,450	3,307,080	988,150	2,170,805	480,557	409,287	980,012	7,250,003	$ 2,226,725	$ 7,664,671	51.00%
44	9200	OBSERVATION		0.671742	365,724	764,800	864,905	1,360,416	829,713	2,354,032	396,399	409,171	368,765	1,356,149	$ 2,256,741	$ 4,888,419	78.28%
45				-											$ -	$ -	
46				-											$ -	$ -	
47				-											$ -	$ -	
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MEDICAL CENTER

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
83												$ -	$ -	
84												$ -	$ -	
85												$ -	$ -	
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126												$ -	$ -	
127												$ -	$ -	
	Totals / Payments	$ 22,284,693	$ 21,665,144	$ 18,078,956	$ 37,931,884	$ 36,426,087	$ 43,634,037	$ 18,153,992	$ 5,683,649	$ 22,786,888	$ 39,011,797			
128	**Total Charges** *(includes organ acquisition from Section J)*	$ 26,443,059	$ 21,665,144	$ 24,435,644	$ 37,931,884	$ 42,536,011	$ 43,634,037	$ 22,476,660	$ 5,683,649	$ 27,170,163 (Agrees to Exhibit A)	$ 39,011,797 (Agrees to Exhibit A)	$ 115,893,374	$ 106,914,714	32.41%
129	Total Charges per PS&R or Exhibit Detail	$ 26,443,059	$ 21,665,144	$ 24,435,644	$ 37,931,884	$ 42,536,011	$ 43,634,037	$ 22,476,660	$ 5,683,649	$ 27,170,163	$ 39,011,797			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 9,359,838	$ 5,816,540	$ 11,589,813	$ 11,337,162	$ 13,765,246	$ 11,895,233	$ 8,622,187	$ 1,636,901	$ 9,294,713	$ 11,358,801	$ 43,357,064	$ 30,485,836	34.55%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 8,866,873	$ 4,995,782			$ 1,060,039	$ 799,961	$ (21,466)				$ 9,905,446	$ 5,795,743	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 8,062,472	$ 7,360,206			$ 185,974				$ 8,258,446	$ 7,360,206	
134	Private Insurance (including primary and third party liability)	$ 25,960	$ 6,632	$ 2,784	$ 31,491	$ 1,580	$ 12,969	$ 2,100,052	$ 1,113,919			$ 2,130,376	$ 1,165,011	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 11,771									$ -	$ 11,771	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 8,892,833	$ 5,004,185	$ 8,065,256	$ 7,391,697									
137	Medicaid Cost Settlement Payments (See Note B)		$ 269,948									$ -	$ 269,948	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 9,572,892	$ 7,224,192	$ 3,044,566	$ 178,096			$ 12,617,458	$ 7,402,288	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 1,110,709	$ 301,019			$ 1,110,709	$ 301,019	
141	Medicare Cross-Over Bad Debt Payments					$ 82,200	$ 313,964					$ 82,200	$ 313,964	
142	Other Medicare Cross-Over Payments (See Note D)					$ 82,072	$ (319,952)	$ 25,668	$ (9,142)	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 107,770	$ (329,094)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 171,429	$ 1,249,815			
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)**	$ 467,005	$ 342,407	$ 3,504,557	$ 3,945,465	$ 2,986,463	$ 3,864,099	$ 2,176,834	$ 53,009	$ 9,123,284	$ 10,108,983	$ 9,134,659	$ 8,204,980	
146	**Calculated Payments as a Percentage of Cost**	95%	94%	70%	65%	78%	68%	75%	97%	2%	11%	79%	73%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 15, 17, 18 less lines 5 & 6)**					30,863								
148	**Percent of cross-over days to total Medicare days from the cost report**					16%								

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

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 771.37		212						350		562	
2	03100 INTENSIVE CARE UNIT	$ 1,458.79		67						141		208	
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	$ 717.95		22						2		24	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	301		-		-		493		794	
19	Total Days per PS&R or Exhibit Detail			301		-		-		493			
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			$ 328,097		$		$		$ 566,024		$ 894,121	
				$ 1,090.02		$ -		$ -		$ 1,148.12		$ 1,126.10	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)	-										$ -	$ -
23	5000 OPERATING ROOM	0.324414		91,716	65,288							$ -	$ -
24	5200 DELIVERY ROOM & LABOR ROOM	1.094635		19,076	-					140,973	88,127	$ 232,689	$ 153,415
25	5300 ANESTHESIOLOGY	0.066916		14,604	18,311					7,058	-	$ 26,134	$ -
26	5400 RADIOLOGY-DIAGNOSTIC	0.323853		86,603	75,304					26,101	20,104	$ 40,705	$ 38,415
27	5700 CT SCAN	0.057157		97,418	228,458					145,282	156,030	$ 231,885	$ 231,334
28	5800 MRI	0.101318		9,525	2,675					154,104	127,746	$ 251,522	$ 356,204
29	6000 LABORATORY	0.191324		210,150	146,734					27,058	14,695	$ 36,583	$ 17,370
30	6300 BLOOD STORING, PROCESSING & TRANS	0.350668		14,178	-					405,997	90,613	$ 616,147	$ 237,347
31	6500 RESPIRATORY THERAPY	0.214725		169,171	23,385					45,912	4,042	$ 60,090	$ 4,042
32	6600 PHYSICAL THERAPY	0.667320		9,338	2,552					194,903	15,192	$ 364,074	$ 38,577
33	6700 OCCUPATIONAL THERAPY	0.571749		2,738	1,315					32,817	2,460	$ 42,155	$ 5,012
34	6800 SPEECH PATHOLOGY	0.547235		2,889	808					14,694	956	$ 17,432	$ 2,271
35	6900 ELECTROCARDIOLOGY	0.225206		38,129	20,330					15,520	2,956	$ 18,409	$ 3,764
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.243389		106,901	33,768					86,462	15,324	$ 124,591	$ 35,654
37	7200 IMPL. DEV. CHARGED TO PATIENTS	0.338477		37,442	29,489					222,458	51,586	$ 329,359	$ 85,354
38	7300 DRUGS CHARGED TO PATIENTS	0.184296		390,656	304,019					213,812	51,630	$ 251,254	$ 81,119
39	7400 RENAL DIALYSIS	0.407368		13,442	-					928,457	442,739	$ 1,319,113	$ 746,758
40	7501 IV THERAPY	0.104514			-					58,938	2,068	$ 72,380	$ 2,068
41	9000 CLINIC	0.876895								-	-	$ -	$ -
42	9001 WOUND CARE	0.723666		711	213					1,933	9,897	$ 2,644	$ 10,110
43	9100 EMERGENCY	0.648932		-	4,914					-	648	$ -	$ 5,562
44	9200 OBSERVATION	0.671742		59,555	231,893					97,623	93,690	$ 157,178	$ 325,583
45		-		25,445	53,602					29,442	51,216	$ 54,887	$ 104,818
46		-										$ -	$ -
47		-										$ -	$ -
48		-										$ -	$ -
49		-										$ -	$ -
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60		-										$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MEDICAL CENTER

			Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
67		-									$ -	$ -
68		-									$ -	$ -
69		-									$ -	$ -
70		-									$ -	$ -
71		-									$ -	$ -
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121		-									$ -	$ -
122		-									$ -	$ -
123		-									$ -	$ -
124		-									$ -	$ -
125		-									$ -	$ -
126		-									$ -	$ -
127		-									$ -	$ -
			$ 1,399,687	$ 1,243,058	$ -	$ -	$ -	$ -	$ 2,849,544	$ 1,241,719		

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) SOUTH GEORGIA MEDICAL CENTER

	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)**	$ 1,727,784	$ 1,243,058	$ -	$ -	$ -	$ -	$ 3,415,568	$ 1,241,719	$ 5,143,352	$ 2,484,777
129	Total Charges per PS&R or Exhibit Detail	$ 1,727,784	$ 1,243,058	$ -	$ -	$ -	$ -	$ 3,415,568	$ 1,241,719		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 635,256	$ 365,155	$ -	$ -	$ -	$ -	$ 1,191,263	$ 335,347	$ 1,826,519	$ 700,502
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 171,480	$ 122,368					$ 14,691	$ 5,641	$ 186,171	$ 128,009
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)		$ 1,722					$ 142,455	$ 6,574	$ 142,455	$ 8,296
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 171,480	$ 124,090	$ -	$ -						
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)							$ 572,840	$ 172,228	$ 572,840	$ 172,228
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 130,903	$ 40,334	$ 130,903	$ 40,334
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)							$ 4,975	$ (7,298)	$ 4,975	$ (7,298)
143	**Calculated Payment Shortfall / (Longfall)**	$ 463,776	$ 241,065	$ -	$ -	$ -	$ -	$ 325,399	$ 117,868	$ 789,175	$ 358,933
144	**Calculated Payments as a Percentage of Cost**	27%	34%	0%	0%	0%	0%	73%	65%	57%	49%

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 MEDICAL CENTER

		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 MEDICAL CENTER

		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 MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 4,118,545		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	001-7505-8000-8710 & 001-8301-8000-8710	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 4,118,545	5.08	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 4,118,545		

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.*