State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2022

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2021	06/30/2022

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	10/01/2021	09/30/2022
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 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 (07/01/21 - 06/30/22)
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

Property of Myers and Stauffer LC

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2021 - 06/30/2022** $ 4,712,826
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2021 - 06/30/2022** $ 762,335
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2021 - 06/30/2022** $ 5,475,161

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.

John Moore	CFO	
Hospital CEO or CFO Signature	Title	Date
John Moore	229-259-4162	john.moore@sgmc.org
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	John Moore
Title	CFO
Telephone Number	229-259-4162
E-Mail Address	john.moore@sgmc.org
Mailing Street Address	2501 N Patterson Street
Mailing City, State, Zip	Valdosta, GA 31602

Outside Preparer:

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

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D. General Cost Report Year Information 10/1/2021 - 9/30/2022

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

	10/1/2021 through 9/30/2022		
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: 3/2/2023

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

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: (10/01/2021 - 09/30/2022)

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)	$ 229,245	$ 1,196,517	$1,425,762
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,490,275	$ 8,795,435	$10,285,710
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$1,719,520	$9,991,952	$11,711,472
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	13.33%	11.97%	12.17%

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 (10/01/2021 - 09/30/2022)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	72,924 **(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	39,373,010
8.	Outpatient Hospital Charity Care Charges	43,371,890
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 82,744,900

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	$81,071,236.00			$ 59,119,223	$ -	$ -	$ 21,952,013
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$3,028,934.00			$ 2,208,776	$ -	$ -	$ 820,158
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	$451,931,857.00	$667,561,234.00		$ 329,560,291	$ 486,802,758	$ -	$ 303,130,042
20.	Outpatient Services		$68,051,429.00			$ 49,624,846	$ -	$ 18,426,583
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 17,688,637	-	-	$ 12,899,007	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$7,569,809.00			$ 5,520,099	
26.	Other	$21,575,612.00	$0.00	$2,700,040.00	$ 15,733,489	$ -	$ 1,968,938	$ 5,842,123
27.	Total	$ 557,607,639	$ 735,612,663	$ 27,958,486	$ 406,621,779	$ 536,427,604	$ 20,388,044	$ 350,170,918
28.	Total Hospital and Non Hospital		Total from Above	$ 1,321,178,788		Total from Above	$ 963,437,428	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,321,178,788	Total Contractual Adj. (G-3 Line 2)	961,250,100
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)			+	2,187,328
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Adjusted Contractual Adjustments				963,437,428
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) | SOUTH GEORGIA MEDICAL CENTER

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 42,008,785	$ 303,062	$ 65,150	$0.00	$ 42,376,997	45,199	$45,492,968.00		$ 937.56
2	03100 INTENSIVE CARE UNIT	$ 39,430,240	$ 66,526	$ -		$ 39,496,766	23,071	$38,607,202.00		$ 1,711.97
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	$ 3,555,356	$ -	$ -		$ 3,555,356	4,654	$5,620,170.00		$ 763.94
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 84,994,381	$ 369,588	$ 65,150	$ -	$ 85,429,119	72,924	$ 89,720,340		
19	Weighted Average									$ 1,171.48

Line #	Observation Data (Non-Distinct)	*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200 Observation (Non-Distinct)	12,023	-	-	$ 11,272,284	$8,271,930.00	$7,185,505.00	$ 15,457,435	0.729247

Line #	Cost Center Description	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$31,711,709.00	$ -	$ -		$ 31,711,709	$44,985,914.00	$86,101,153.00	$ 131,087,067	0.241913
22	5200 DELIVERY ROOM & LABOR ROOM	$4,918,182.00	$ -	$ -		$ 4,918,182	$5,435,020.00	$571,209.00	$ 6,006,229	0.818847
23	5300 ANESTHESIOLOGY	$1,666,031.00	$ -	$ -		$ 1,666,031	$7,793,914.00	$17,937,288.00	$ 25,731,202	0.064747
24	5400 RADIOLOGY-DIAGNOSTIC	$32,537,145.00	$ -	$ -		$ 32,537,145	$36,020,975.00	$95,560,113.00	$ 131,581,088	0.247278
25	5700 CT SCAN	$4,869,143.00	$ -	$ -		$ 4,869,143	$30,638,200.00	$77,376,702.00	$ 108,014,902	0.045078
26	5800 MRI	$1,888,720.00	$ -	$ -		$ 1,888,720	$5,234,699.00	$19,076,401.00	$ 24,311,100	0.077690
27	6000 LABORATORY	$30,390,276.00	$ -	$ -		$ 30,390,276	$78,627,179.00	$116,300,735.00	$ 194,927,914	0.155905
28	6300 BLOOD STORING PROCESSING & TRANS.	$3,624,027.00	$ -	$ -		$ 3,624,027	$8,590,854.00	$3,560,077.00	$ 12,150,931	0.298251
29	6500 RESPIRATORY THERAPY	$8,449,167.00	$ -	$ -		$ 8,449,167	$19,405,095.00	$5,543,280.00	$ 24,948,375	0.338666
30	6600 PHYSICAL THERAPY	$2,595,804.00	$ -	$ -		$ 2,595,804	$2,431,691.00	$1,032,951.00	$ 3,464,642	0.749227

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) 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	$1,912,616.00	$ -	$ -	$ 1,912,616	$3,495,557.00	$46,787.00	$ 3,542,344	0.539929
32	6800 SPEECH PATHOLOGY	$1,051,277.00	$ -	$ -	$ 1,051,277	$1,985,037.00	$34,558.00	$ 2,019,595	0.520539
33	6900 ELECTROCARDIOLOGY	$4,730,254.00	$ -	$ -	$ 4,730,254	$11,812,381.00	$16,664,006.00	$ 28,476,387	0.166111
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$7,574,174.00	$ -	$ -	$ 7,574,174	$25,778,568.00	$20,782,315.00	$ 46,560,883	0.162672
35	7200 IMPL. DEV. CHARGED TO PATIENTS	$21,751,857.00	$ -	$ -	$ 21,751,857	$22,170,371.00	$48,318,508.00	$ 70,488,879	0.308586
36	7300 DRUGS CHARGED TO PATIENTS	$51,122,816.00	$ -	$ -	$ 51,122,816	$140,171,379.00	$156,964,144.00	$ 297,135,523	0.172052
37	7400 RENAL DIALYSIS	$2,026,095.00	$ -	$ -	$ 2,026,095	$3,539,902.00	$634,046.00	$ 4,173,948	0.485415
38	7501 IV THERAPY	$803,878.00	$ -	$ -	$ 803,878	$3,815,121.00	$1,056,961.00	$ 4,872,082	0.164997
39	9000 CLINIC	$3,052,034.00	$ 221,753	$ -	$ 3,273,787	$313,304.00	$740,234.00	$ 1,053,538	3.107422
40	9001 WOUND CARE	$1,835,487.00	$ -	$ -	$ 1,835,487	$17,382.00	$1,523,526.00	$ 1,540,908	1.191172
41	9100 EMERGENCY	$25,115,520.00	$ 118,268	$ 182,366	$ 25,416,154	$14,943,164.00	$35,056,384.00	$ 49,999,548	0.508328
42		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
43		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
44		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
45		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
46		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
47		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
48		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
49		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
50		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
51		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
52		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
53		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
54		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
55		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
56		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
57		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
58		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
59		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
60		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
61		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
62		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
63		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
64		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
65		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
66		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
67		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
68		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
69		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
70		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
71		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
72		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
73		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
74		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
75		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
76		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
77		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
78		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
79		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
80		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
81		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
82		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
83		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
84		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
85		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
86		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
87		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
88		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
89		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
90		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) 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	$ -	-
92		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 243,626,212	$ 340,021	$ 182,366		$ 244,148,599	$ 475,477,637	$ 712,066,883	$ 1,187,544,520	
127	**Weighted Average**									0.215083
128	**Sub Totals**	$ 328,620,593	$ 709,609	$ 247,516		$ 329,577,718	$ 565,197,977	$ 712,066,883	$ 1,277,264,860	

129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*	$0.00
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*	$0.00
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*	
131.01	Other Cost Adjustments (support must be submitted)	
132	**Grand Total**	$ 329,577,718
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost	0.22%

* 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 (10/01/2021-09/30/2022) SOUTH GEORGIA MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 937.56		4,060		3,584		6,098		3,138		3,566		16,880		63.79%
2	03100 INTENSIVE CARE UNIT	$ 1,711.97		1,643		382		3,876		1,577		2,310		7,478		44.61%
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	$ 763.94		283		2,627		-		145		129		3,055		68.52%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	5,986		6,593		9,974		4,860		6,005		27,413		47.51%
19	Total Days per PS&R or Exhibit Detail			5,986		6,593		9,974		4,860		6,005				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 6,933,590		$ 8,303,635		$ 11,935,241		$ 5,929,806		$ 7,467,863		$ 33,102,272		46.94%
21.01	Calculated Routine Charge Per Diem			$ 1,158.30		$ 1,259.46		$ 1,196.64		$ 1,220.12		$ 1,243.61		$ 1,207.54		
	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)		0.729247	741,130	990,475	397,905	751,257	603,094	1,257,920	301,352	1,007,644	211,085	1,082,570	$ 2,043,482	$ 4,007,296	49.03%
23	5000 OPERATING ROOM		0.241913	1,596,315	2,486,993	2,770,562	12,136,422	4,024,798	6,193,914	1,672,966	2,594,543	3,696,478	4,379,652	$ 10,064,641	$ 23,411,872	32.08%
24	5200 DELIVERY ROOM & LABOR ROOM		0.818847	214,780	2,940	2,964,405	212	23,645	1,137	503,776	309	121,816	410	$ 3,706,606	$ 4,598	64.96%
25	5300 ANESTHESIOLOGY		0.064747	406,522	695,374	752,005	2,576,915	900,579	1,382,304	397,057	584,567	851,380	1,063,817	$ 2,456,163	$ 5,239,160	37.85%
26	5400 RADIOLOGY-DIAGNOSTIC		0.247278	857,905	2,306,489	1,633,657	5,010,379	4,374,653	9,117,541	1,389,730	2,933,568	4,403,210	7,015,995	$ 8,255,945	$ 19,367,978	30.39%
27	5700 CT SCAN		0.045078	1,743,727	2,677,545	1,078,565	4,951,031	4,292,318	7,060,867	1,715,289	2,507,416	3,587,488	10,143,384	$ 8,829,898	$ 17,196,859	38.02%
28	5800 MRI		0.077690	320,934	574,111	159,575	724,218	771,441	2,048,068	236,865	540,812	575,933	1,531,852	$ 1,488,815	$ 3,887,209	31.27%
29	6000 LABORATORY		0.155905	5,164,737	5,092,677	5,300,297	15,951,374	11,593,553	6,827,914	5,007,877	6,922,465	7,598,757	14,387,935	$ 27,066,464	$ 34,794,430	44.21%
30	6300 BLOOD STORING PROCESSING & TRANS.		0.298251	322,248	115,280	253,298	77,547	804,432	382,871	391,268	94,512	773,574	252,250	$ 1,771,246	$ 670,210	29.87%
31	6500 RESPIRATORY THERAPY		0.338666	1,559,854	110,738	840,627	320,314	3,588,663	468,028	1,311,300	217,905	1,399,272	233,712	$ 7,300,444	$ 1,116,985	41.99%
32	6600 PHYSICAL THERAPY		0.749227	161,505	-	43,127	14,994	472,430	127,807	182,029	54,286	209,391	38,953	$ 859,091	$ 197,087	39.19%
33	6700 OCCUPATIONAL THERAPY		0.539929	105,171	-	24,886	3,127	319,692	66,934	118,346	33,960	134,558	21,302	$ 568,095	$ 104,021	24.26%
34	6800 SPEECH PATHOLOGY		0.520539	89,651	618	451,404	7,742	126,164	27,489	63,838	16,020	89,772	17,372	$ 731,057	$ 51,869	45.09%
35	6900 ELECTROCARDIOLOGY		0.166111	1,283,903	1,325,830	280,377	1,220,021	1,447,065	1,654,015	511,035	638,335	962,714	1,984,723	$ 3,522,380	$ 4,838,201	40.71%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.162672	2,006,574	748,573	1,715,424	1,520,685	4,351,347	2,120,238	1,979,463	686,887	2,398,031	1,356,858	$ 10,052,808	$ 5,076,382	41.76%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.308586	717,911	2,121,778	429,901	1,413,738	3,538,918	4,750,635	717,894	1,140,535	2,065,332	1,349,805	$ 5,404,624	$ 9,426,686	26.13%
38	7300 DRUGS CHARGED TO PATIENTS		0.172052	10,197,117	9,335,933	6,661,589	7,505,060	19,465,597	22,666,867	9,498,840	6,182,743	12,462,004	10,400,126	$ 45,823,144	$ 45,690,604	39.74%
39	7400 RENAL DIALYSIS		0.485415	371,747	-	26,152	4,572	1,111,895	205,009	667,787	84,240	104,377	93,726	$ 2,177,581	$ 293,821	67.15%
40	7501 IV THERAPY		0.164997	-	-	371,131	24,894	422,051	133,276	200,349	36,153	195,619	48,020	$ 993,531	$ 194,323	30.53%
41	9000 CLINIC		3.107422	62,497	110,186	9,926	9,500	109,431	28,433	47,352	14,141	56,257	15,933	$ 229,206	$ 162,260	45.67%
42	9001 WOUND CARE		1.191172	-	-	2,488	55,236	2,829	288,408	1,343	76,826	1,311	102,045	$ 6,661	$ 420,470	34.95%
43	9100 EMERGENCY		0.508328	832,959	1,821,588	647,290	6,458,666	1,711,995	2,261,274	902,993	1,432,970	1,634,388	7,924,143	$ 4,095,237	$ 11,974,498	53.08%
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
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59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (10/01/2021-09/30/2022) SOUTH GEORGIA MEDICAL CENTER

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
61				-											$ -	$ -	-
62				-											$ -	$ -	
63				-											$ -	$ -	
64				-											$ -	$ -	
65				-											$ -	$ -	
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124				-											$ -	$ -	
125				-											$ -	$ -	
126				-											$ -	$ -	
127				-											$ -	$ -	
					$ 28,757,187	$ 30,517,128	$ 26,814,591	$ 60,737,905	$ 64,056,591	$ 69,070,950	$ 27,818,749	$ 27,800,836	$ 43,532,747	$ 63,444,582			

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

Cost Report Year (10/01/2021-09/30/2022) SOUTH GEORGIA MEDICAL CENTER

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges *(includes organ acquisition from Section J)***	$ 35,690,777	$ 30,517,128	$ 35,118,226	$ 60,737,905	$ 75,991,832	$ 69,070,950	$ 33,748,555	$ 27,800,836	$ 51,000,610 (Agrees to Exhibit A)	$ 63,444,582 (Agrees to Exhibit A)	$ 180,549,390	$ 188,126,819	38.90%
129	Total Charges per PS&R or Exhibit Detail	$ 35,690,777	$ 30,517,128	$ 35,118,226	$ 60,737,905	$ 75,991,832	$ 69,070,950	$ 33,748,555	$ 27,800,836	$ 51,000,610	$ 63,444,582			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 13,247,735	$ 6,844,576	$ 13,431,035	$ 13,367,011	$ 26,246,569	$ 14,409,918	$ 12,057,421	$ 6,073,816	$ 16,481,980	$ 13,685,436	$ 64,982,760	$ 40,695,321	42.51%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 9,833,897	$ 6,051,761			$ 835,334	$ 1,450,522	$ 54,869	$ 21,752			$ 10,724,100	$ 7,524,035	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 10,470,136	$ 9,864,117			$ 350,309	$ 320,169			$ 10,820,445	$ 10,184,286	
134	Private Insurance (including primary and third party liability)	$ 179,130	$ 6,262	$ 166,570	$ 186,509	$ 1,478	$ 5,203	$ 3,484,355	$ 3,658,772			$ 3,831,533	$ 3,856,746	
135	Self-Pay (including Co-Pay and Spend-Down)			$ 1,285	$ 9,369			$ 58,132	$ 8,977			$ 59,417	$ 18,346	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 10,013,027	$ 6,058,023	$ 10,637,991	$ 10,059,995									
137	Medicaid Cost Settlement Payments (See Note B)		$ 69,865									$ -	$ 69,865	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 19,400,158	$ 11,073,134	$ 4,069,145	$ 800,997			$ 23,469,303	$ 11,874,131	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 1,958,122	$ 2,178,364			$ 1,958,122	$ 2,178,364	
141	Medicare Cross-Over Bad Debt Payments					$ 284,225	$ 257,571					$ 284,225	$ 257,571	
142	Other Medicare Cross-Over Payments (See Note D)					$ 905,436	$ 20,651	$ 183,713	$ 1,191	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 1,089,149	$ 21,842	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 229,245	$ 1,196,517			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 3,234,708	$ 716,688	$ 2,793,044	$ 3,307,016	$ 4,819,938	$ 1,602,837	$ 1,898,776	$ (916,406)	$ 16,252,735	$ 12,488,919	$ 12,746,466	$ 4,710,135	
146	**Calculated Payments as a Percentage of Cost**	76%	90%	79%	75%	82%	89%	84%	115%	1%	9%	80%	88%	
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)**					37,626								
148	**Percent of cross-over days to total Medicare days from the cost report**					27%								

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 (10/01/2021-09/30/2022) 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	$ 937.56		34		234				449		717	
2	03100 INTENSIVE CARE UNIT	$ 1,711.97		6		151				348		505	
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	$ 763.94		1		4				-		5	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	41		389		-		797		1,227	
19	Total Days per PS&R or Exhibit Detail			41		389		-		797			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 48,510		$ 490,971				$ 1,001,264		$ 1,540,745	
21.01	Calculated Routine Charge Per Diem			$ 1,183.17		$ 1,262.14		$ -		$ 1,256.29		$ 1,255.70	
	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)		0.729247	2,606	13,557	14,499	52,850			51,892	99,490	$ 68,998	$ 165,897
23	5000 OPERATING ROOM		0.241913	13,610	7,425	114,515	103,530			172,211	82,951	$ 300,335	$ 193,906
24	5200 DELIVERY ROOM & LABOR ROOM		0.818847	13,166	-	29,980	5,582			19,613	20	$ 62,759	$ 5,602
25	5300 ANESTHESIOLOGY		0.064747	4,113	2,968	32,454	26,266			44,886	17,431	$ 81,453	$ 46,665
26	5400 RADIOLOGY-DIAGNOSTIC		0.247278	7,971	22,622	103,297	202,990			329,179	281,661	$ 440,447	$ 507,273
27	5700 CT SCAN		0.045078	4,749	55,391	148,111	469,969			342,476	293,769	$ 495,336	$ 819,130
28	5800 MRI		0.077690	-	-	20,808	28,697			29,303	40,163	$ 50,111	$ 68,860
29	6000 LABORATORY		0.155905	51,392	48,342	495,648	532,100			947,257	254,685	$ 1,494,297	$ 835,127
30	6300 BLOOD STORING PROCESSING & TRANS.		0.298251	2,159	-	38,709	4,695			111,150	6,036	$ 152,018	$ 10,731
31	6500 RESPIRATORY THERAPY		0.338666	872	1,596	92,493	20,401			301,586	7,569	$ 394,951	$ 29,566
32	6600 PHYSICAL THERAPY		0.749227	1,509	-	16,801	1,869			28,134	4,946	$ 46,444	$ 6,815
33	6700 OCCUPATIONAL THERAPY		0.539929	625	-	9,620	1,040			16,732	3,273	$ 26,977	$ 4,313
34	6800 SPEECH PATHOLOGY		0.520539	780	-	3,817	390			14,040	1,564	$ 18,637	$ 1,954
35	6900 ELECTROCARDIOLOGY		0.166111	2,581	4,704	60,389	47,426			116,446	51,758	$ 179,416	$ 103,888
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.162672	8,300	5,735	101,172	40,613			375,750	28,324	$ 485,222	$ 74,673
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.308586	-	-	15,710	15,731			126,818	15,403	$ 142,529	$ 31,134
38	7300 DRUGS CHARGED TO PATIENTS		0.172052	48,251	29,302	845,741	616,578			1,904,869	247,822	$ 2,798,861	$ 893,702
39	7400 RENAL DIALYSIS		0.485415	-	-	17,205	1,143			106,959	8,001	$ 124,164	$ 9,144
40	7501 IV THERAPY		0.164997	282	-	13,244	1,276			38,664	2,381	$ 52,191	$ 3,658
41	9000 CLINIC		3.107422	882	-	3,295	333			11,349	1,620	$ 15,526	$ 1,953
42	9001 WOUND CARE		1.191172	2	-	89	2,712			259	5,061	$ 350	$ 7,773
43	9100 EMERGENCY		0.508328	8,411	44,384	86,449	438,849			180,750	150,994	$ 275,610	$ 634,227
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2021-09/30/2022) 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	
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
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111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2021-09/30/2022) 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	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 172,261	$ 236,026	$ 2,264,047	$ 2,615,042	$ -	$ -	$ 5,270,323	$ 1,604,923		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 220,771	$ 236,026	$ 2,755,018	$ 2,615,042	$ -	$ -	$ 6,271,587	$ 1,604,923	$ 9,247,376	$ 4,455,991
129	Total Charges per PS&R or Exhibit Detail	$ 220,771	$ 236,026	$ 2,755,018	$ 2,615,042	$ -	$ -	$ 6,271,587	$ 1,604,923		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 89,309	$ 57,360	$ 961,302	$ 590,431	$ -	$ -	$ 2,167,795	$ 382,822	$ 3,218,406	$ 1,030,613
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 437	$ 3,493		$ 4,029			$ 43,452	$ 15,203	$ 43,889	$ 22,725
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 204,697	$ 147,210			$ 58,968	$ 17,526	$ 263,665	$ 164,736
134	Private Insurance (including primary and third party liability)		$ 9,281	$ 83,125	$ 81,656			$ 77,932	$ 82,836	$ 161,057	$ 173,773
135	Self-Pay (including Co-Pay and Spend-Down)				$ 45				$ 143	$ -	$ 188
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 437	$ 12,774	$ 287,822	$ 232,940						
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)							$ 1,000,324	$ 143,504	$ 1,000,324	$ 143,504
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 470,904	$ 44,630	$ 470,904	$ 44,630
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 88,872	$ 44,586	$ 673,480	$ 357,491	$ -	$ -	$ 516,215	$ 78,980	$ 1,278,567	$ 481,057
144	**Calculated Payments as a Percentage of Cost**	0%	22%	30%	39%	0%	0%	76%	79%	60%	53%

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (10/01/2021-09/30/2022) 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)*		$ 4,474,331		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	8301-8000-8710 & 7505-8000-8710	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 4,474,331	5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 4,474,331		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	382,379,576
19	Uninsured Hospital	**Charges Sec. G**	114,445,193
20	Total Hospital	**Charges Sec. G**	1,277,264,860
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		29.94%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.96%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		**$ -**

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

*** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.*