State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2020

DSH Version 6.00 2/17/2021

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2019	06/30/2020

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	10/01/2019	09/30/2020
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 (07/01/19 - 06/30/20)
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

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020** — $ 4,436,699
   (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 07/01/2019 - 06/30/2020**
   (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 Services07/01/2019 - 06/30/2020** — $ 4,436,699

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	Chief Financial Officer	11/15/2021
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	
Title	
Telephone Number	229-259-4162
E-Mail Address	
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

DSH Version 8.00 1/28/2021

D. General Cost Report Year Information 10/1/2019 - 9/30/2020

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

	10/1/2019 through 9/30/2020		
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: 5/18/2021

	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	

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: (10/01/2019 - 09/30/2020)

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)	$ 198,176	$ 991,529	$1,189,705
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,729,822	$ 7,204,672	$8,934,494
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)	$1,927,998	$8,196,201	$10,124,199
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	10.28%	12.10%	11.75%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?**
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, 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 (10/01/2019 - 09/30/2020)

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)	68,602	**(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	26,856,354
8.	Outpatient Hospital Charity Care Charges	26,352,610
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 53,208,964

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	$76,272,513.00			$ 52,423,020	$ -	$ -	$ 23,849,493
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	$419,342,876.00	$501,336,648.00		$ 288,219,425	$ 344,574,735	$ -	$ 287,885,365
20.	Outpatient Services		$58,878,852.00			$ 40,468,146	$ -	$ 18,410,706
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 15,117,009	-	-	$ 10,390,103	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$6,492,026.00			$ 4,462,048	
26.	Other	$22,639,833.00	$0.00	$45,713,716.00	$ 15,560,631	$ -	$ 31,419,589	$ 7,079,202
27.	Total	$ 518,255,222	$ 560,215,500	$ 67,322,751	$ 356,203,075	$ 385,042,881	$ 46,271,740	$ 337,224,766
28.	Total Hospital and Non Hospital		Total from Above	$ 1,145,793,473		Total from Above	$ 787,517,696	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,145,793,473	Total Contractual Adj. (G-3 Line 2)		781,479,656
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)				+	6,038,040
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					787,517,696
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2019-09/30/2020) 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	$ 36,022,445	$ -	$ 65,151	$0.00	$ 36,087,596	44,036	$43,540,314.00		$ 819.50
2	03100 INTENSIVE CARE UNIT	$ 27,855,928	$ -	$ -		$ 27,855,928	19,974	$34,028,525.00		$ 1,394.61
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	$ 3,825,399	$ -	$ -		$ 3,825,399	4,592	$4,422,222.00		$ 833.06
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 67,703,772	$ -	$ 65,151	$ -	$ 67,768,923	68,602	$ 81,991,061		
19	Weighted Average									$ 987.86

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)	-	-	-	$ -	$0.00	$0.00	$ -	-

Line #	Ancillary Cost Centers (from W/S C excluding Observation) (list below)	Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4		Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
21	5000 OPERATING ROOM	$27,707,873.00	$ -	$0.00		$ 27,707,873	$38,782,477.00	$55,206,336.00	$ 93,988,813	0.294800
22	5200 DELIVERY ROOM & LABOR ROOM	$4,630,012.00	$ -	$0.00		$ 4,630,012	$2,939,169.00	$1,714,866.00	$ 4,654,035	0.994838
23	5300 ANESTHESIOLOGY	$1,436,880.00	$ -	$0.00		$ 1,436,880	$6,259,225.00	$12,167,409.00	$ 18,426,634	0.077978
24	5400 RADIOLOGY-DIAGNOSTIC	$29,893,104.00	$ -	$0.00		$ 29,893,104	$29,563,423.00	$78,176,658.00	$ 107,740,081	0.277456
25	5700 CT SCAN	$4,357,658.00	$ -	$0.00		$ 4,357,658	$27,451,709.00	$73,478,102.00	$ 100,929,811	0.043175
26	5800 MRI	$1,564,330.00	$ -	$0.00		$ 1,564,330	$5,079,538.00	$12,946,125.00	$ 18,025,663	0.086783
27	6000 LABORATORY	$25,355,237.00	$ -	$0.00		$ 25,355,237	$68,983,678.00	$73,860,112.00	$ 142,843,790	0.177503
28	6300 BLOOD STORING PROCESSING & TRANS.	$2,880,478.00	$ -	$0.00		$ 2,880,478	$6,822,477.00	$2,422,703.00	$ 9,245,180	0.311565
29	6500 RESPIRATORY THERAPY	$5,375,396.00	$ -	$0.00		$ 5,375,396	$22,739,429.00	$3,883,832.00	$ 26,623,261	0.201906

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2019-09/30/2020) SOUTH GEORGIA MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
30	6600	PHYSICAL THERAPY	$3,173,981.00	$ -	$0.00		$ 3,173,981	$3,972,514.00	$1,157,218.00	$ 5,129,732	0.618742
31	6700	OCCUPATIONAL THERAPY	$1,596,501.00	$ -	$0.00		$ 1,596,501	$3,132,646.00	$40,637.00	$ 3,173,283	0.503107
32	6800	SPEECH PATHOLOGY	$1,024,804.00	$ -	$0.00		$ 1,024,804	$2,084,227.00	$45,476.00	$ 2,129,703	0.481196
33	6900	ELECTROCARDIOLOGY	$3,619,062.00	$ -	$0.00		$ 3,619,062	$10,331,309.00	$10,265,121.00	$ 20,596,430	0.175713
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$8,164,959.00	$ -	$0.00		$ 8,164,959	$20,800,386.00	$15,393,858.00	$ 36,194,244	0.225587
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$20,606,323.00	$ -	$0.00		$ 20,606,323	$26,330,139.00	$38,519,484.00	$ 64,849,623	0.317755
36	7300	DRUGS CHARGED TO PATIENTS	$41,593,951.00	$ -	$0.00		$ 41,593,951	$136,591,225.00	$121,472,088.00	$ 258,063,313	0.161177
37	7400	RENAL DIALYSIS	$1,444,535.00	$ -	$0.00		$ 1,444,535	$3,185,050.00	$244,541.00	$ 3,429,591	0.421197
38	7501	IV THERAPY	$639,186.00	$ -	$0.00		$ 639,186	$4,297,269.00	$342,082.00	$ 4,639,351	0.137775
39	9000	CLINIC	$1,860,403.00	$ -	$0.00		$ 1,860,403	$263,544.00	$803,513.00	$ 1,067,057	1.743490
40	9001	WOUND CARE	$1,474,212.00	$ -	$0.00		$ 1,474,212	$345,753.00	$1,703,023.00	$ 2,048,776	0.719557
41	9100	EMERGENCY	$23,373,226.00	$ -	$0.00		$ 23,373,226	$9,612,970.00	$33,170,956.00	$ 42,783,926	0.546309
42	9200	OBSERVATION	$7,394,673.00	$ -	$0.00		$ 7,394,673	$3,772,482.00	$7,907,271.00	$ 11,679,753	0.633119
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2019-09/30/2020) SOUTH GEORGIA MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 219,166,784	$ -	$ -		$ 219,166,784	$ 433,340,639	$ 544,921,411	$ 978,262,050	
127		**Weighted Average**									0.224037
128		**Sub Totals**	$ 286,870,556	$ -	$ 65,151		$ 286,935,707	$ 515,331,700	$ 544,921,411	$ 1,060,253,111	
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**					$ 286,935,707				
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 (10/01/2019-09/30/2020) 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	$ 819.50		3,836		3,138		4,228		4,181		4,123		15,383		45.40%
2	03100 INTENSIVE CARE UNIT	$ 1,394.61		1,860		328		2,260		1,795		1,975		6,243		42.67%
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	$ 833.06		212		2,414		-		252		382		2,878		71.04%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	5,908		5,880		6,488		6,228		6,480		24,504		46.32%
19	Total Days per PS&R or Exhibit Detail			5,908		5,880		6,488		6,228		6,480				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 7,125,740		$ 5,952,611		$ 8,614,850		$ 8,309,356		$ 8,327,580		$ 30,002,557		48.05%
21.01	Calculated Routine Charge Per Diem			$ 1,206.12		$ 1,012.35		$ 1,327.81		$ 1,334.19		$ 1,285.12		$ 1,224.39		
	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		0.294800	2,008,513	1,698,095	2,132,487	5,105,102	2,142,346	4,177,095	1,582,912	1,134,335	3,017,715	3,112,243	$ 7,866,258	$ 12,114,627	28.02%
24	5200 DELIVERY ROOM & LABOR ROOM		0.994838	178,144	5,306	2,427,745	3,506	12,809	-	584,541	-	165,506	-	$ 3,203,239	$ 8,812	73.14%
25	5300 ANESTHESIOLOGY		0.077978	455,637	469,838	588,555	1,352,064	530,301	978,397	390,716	271,474	690,051	708,052	$ 1,965,209	$ 3,071,773	35.30%
26	5400 RADIOLOGY-DIAGNOSTIC		0.277456	1,046,640	2,467,913	755,804	2,373,058	2,781,088	6,756,557	1,511,039	1,374,392	3,368,841	5,377,291	$ 6,094,571	$ 12,971,920	26.38%
27	5700 CT SCAN		0.043175	2,281,941	2,892,824	721,556	3,404,934	2,986,954	6,123,671	2,029,042	1,165,684	3,465,629	9,661,004	$ 8,019,493	$ 13,587,113	35.34%
28	5800 MRI		0.086783	437,026	242,862	85,664	281,922	566,879	845,758	368,217	219,821	712,178	735,704	$ 1,457,786	$ 1,590,363	25.40%
29	6000 LABORATORY		0.177503	5,771,568	3,549,625	3,937,948	4,667,788	6,889,183	4,728,775	6,251,084	3,676,782	7,054,780	9,634,194	$ 22,849,783	$ 16,622,970	40.33%
30	6300 BLOOD STORING PROCESSING & TRANS.		0.311565	360,782	67,624	156,837	47,527	560,693	240,057	687,504	29,016	567,272	198,666	$ 1,765,816	$ 384,224	32.07%
31	6500 RESPIRATORY THERAPY		0.201906	2,344,050	91,732	806,263	236,103	2,525,609	411,021	2,327,585	191,485	1,502,366	337,829	$ 8,003,507	$ 930,341	41.66%
32	6600 PHYSICAL THERAPY		0.618742	203,908	355	24,065	5,254	342,207	102,657	228,888	17,011	205,523	25,101	$ 799,068	$ 125,277	23.29%
33	6700 OCCUPATIONAL THERAPY		0.503107	102,379	-	11,145	8,865	153,648	51,834	97,084	10,815	102,749	15,651	$ 364,256	$ 71,514	18.06%
34	6800 SPEECH PATHOLOGY		0.481196	103,865	3,553	407,867	10,040	106,134	35,213	98,662	13,398	159,527	16,538	$ 716,528	$ 62,204	45.56%
35	6900 ELECTROCARDIOLOGY		0.175713	1,717,895	1,017,545	341,672	518,766	1,105,896	1,153,037	635,518	262,941	940,870	1,475,370	$ 3,800,981	$ 2,952,289	45.41%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.225587	1,578,559	454,522	1,454,723	1,533,561	1,999,811	1,545,064	1,749,350	258,286	1,747,228	781,796	$ 6,782,444	$ 3,791,433	37.02%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.317755	1,336,555	1,217,624	19,098	66,538	2,667,513	4,032,945	1,088,158	409,477	1,376,093	792,134	$ 5,111,324	$ 5,726,584	20.16%
38	7300 DRUGS CHARGED TO PATIENTS		0.161177	12,627,833	3,759,705	6,541,331	3,023,706	12,960,990	15,809,900	13,121,664	2,159,188	13,832,007	9,025,166	$ 45,251,817	$ 24,752,501	36.88%
39	7400 RENAL DIALYSIS		0.421197	254,858	-	1,195	-	547,563	111,458	574,463	13,904	31,070	3,585	$ 1,378,079	$ 125,362	45.96%
40	7501 IV THERAPY		0.137775	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
41	9000 CLINIC		1.743490	61,253	-	33,017	865,411	-	-	-	107	-	590	$ 94,270	$ 865,518	90.00%
42	9001 WOUND CARE		0.719557	-	-	-	2,805	-	45,340	-	3,943	958	19,940	$ -	$ 52,088	3.56%
43	9100 EMERGENCY		0.546309	872,420	1,906,006	213,677	3,897,166	1,281,086	2,091,899	1,130,774	567,271	1,480,429	7,686,954	$ 3,497,957	$ 8,462,342	50.76%
44	9200 OBSERVATION		0.633119	773,989	967,189	1,133,669	810,890	110,512	3,021,746	70,543	908,760	50,680	1,703,439	$ 2,088,712	$ 5,708,585	83.20%
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
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59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (10/01/2019-09/30/2020) 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			-											$ -	$ -	
66			-											$ -	$ -	
67			-											$ -	$ -	
68			-											$ -	$ -	
69			-											$ -	$ -	
70			-											$ -	$ -	
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124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 34,517,816	$ 20,812,318	$ 21,794,319	$ 28,215,008	$ 40,271,221	$ 52,262,424	$ 34,527,744	$ 12,688,090	$ 40,471,473	$ 51,311,247			

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

Cost Report Year (10/01/2019-09/30/2020) 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)***	$ 41,643,556	$ 20,812,318	$ 27,746,930	$ 28,215,008	$ 48,886,071	$ 52,262,424	$ 42,837,100	$ 12,688,090	$ 48,799,053 (Agrees to Exhibit A)	$ 51,311,247 (Agrees to Exhibit A)	$ 161,113,656	$ 113,977,840	36.20%
129	Total Charges per PS&R or Exhibit Detail	$ 41,643,556	$ 20,812,318	$ 27,746,930	$ 28,215,008	$ 48,886,071	$ 52,262,424	$ 42,837,100	$ 12,688,090	$ 48,799,053	$ 51,311,247			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 13,282,454	$ 4,972,642	$ 11,846,630	$ 8,446,264	$ 15,082,247	$ 12,140,178	$ 13,660,062	$ 3,005,797	$ 14,774,321	$ 12,253,969	$ 53,871,393	$ 28,564,881	39.01%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 10,999,125	$ 5,359,315			$ 328,486	$ 1,123,600	$ 22,429	$ 18,667			$ 11,350,040	$ 6,501,582	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 8,187,845	$ 5,242,074	$ -	$ -	$ 150,756	$ 107,366			$ 8,338,601	$ 5,349,440	
134	Private Insurance (including primary and third party liability)	$ 132,036	$ 5,680	$ 159,148	$ 99,444	$ 1,795	$ 467	$ 3,744,998	$ 2,187,772			$ 4,037,977	$ 2,293,363	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 213	$ 6,434	$ 1,755	$ 4,393	$ 263	$ 7,280	$ 202	$ 16,689			$ 2,433	$ 34,796	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 11,131,374	$ 5,371,429	$ 8,348,748	$ 5,345,911									
137	Medicaid Cost Settlement Payments (See Note B)		$ (639,808)									$ -	$ (639,808)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 14,557,894	$ 9,860,489	$ 5,435,395	$ 416,218			$ 19,993,289	$ 10,276,707	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 5,163,793	$ 864,151			$ 5,163,793	$ 864,151	
141	Medicare Cross-Over Bad Debt Payments					$ 754,298	$ 582,419			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 754,298	$ 582,419	
142	Other Medicare Cross-Over Payments (See Note D)					$ 424,546	$ (1,575)	$ 143,755	$ (59)			$ 568,301	$ (1,634)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 198,176	$ 991,529			
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)**	$ 2,151,080	$ 241,021	$ 3,497,882	$ 3,100,353	$ (985,035)	$ 567,498	$ (1,001,266)	$ (605,007)	$ 14,576,145	$ 11,262,440	$ 3,662,661	$ 3,303,865	
146	**Calculated Payments as a Percentage of Cost**	84%	95%	70%	63%	107%	95%	107%	120%	1%	8%	93%	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)**					25,698								
148	**Percent of cross-over days to total Medicare days from the cost report**					25%								

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

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2019-09/30/2020) 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	$ 819.50								485		485	
2	03100	INTENSIVE CARE UNIT	$ 1,394.61								304		304	
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	$ 833.06								2		2	
11			$ -										-	
12			$ -										-	
13			$ -										-	
14			$ -										-	
15			$ -										-	
16			$ -										-	
17			$ -										-	
18				**Total Days**	-		-		-		791		791	
19		Total Days per PS&R or Exhibit Detail			-		-		-		791			
20		Unreconciled Days (Explain Variance)			-		-		-		-			
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21		Routine Charges									$ 1,065,952		$ 1,065,952	
21.01		Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ 1,347.60		$ 1,347.60	
		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		0.294800							167,591	57,436	$ 167,591	$ 57,436
24	5200	DELIVERY ROOM & LABOR ROOM		0.994838							26,541	-	$ 26,541	$ -
25	5300	ANESTHESIOLOGY		0.077978							42,042	26,895	$ 42,042	$ 26,895
26	5400	RADIOLOGY-DIAGNOSTIC		0.277456							311,986	300,878	$ 311,986	$ 300,878
27	5700	CT SCAN		0.043175							346,500	592,502	$ 346,500	$ 592,502
28	5800	MRI		0.086783							50,192	31,638	$ 50,192	$ 31,638
29	6000	LABORATORY		0.177503							991,964	458,167	$ 991,964	$ 458,167
30	6300	BLOOD STORING PROCESSING & TRANS.		0.311565							45,616	3,150	$ 45,616	$ 3,150
31	6500	RESPIRATORY THERAPY		0.201906							302,677	15,271	$ 302,677	$ 15,271
32	6600	PHYSICAL THERAPY		0.618742							35,940	4,012	$ 35,940	$ 4,012
33	6700	OCCUPATIONAL THERAPY		0.503107							18,526	262	$ 18,526	$ 262
34	6800	SPEECH PATHOLOGY		0.481196							14,755	794	$ 14,755	$ 794
35	6900	ELECTROCARDIOLOGY		0.175713							120,081	63,986	$ 120,081	$ 63,986
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.225587							252,894	43,417	$ 252,894	$ 43,417
37	7200	IMPL. DEV. CHARGED TO PATIENTS		0.317755							61,419	8,243	$ 61,419	$ 8,243
38	7300	DRUGS CHARGED TO PATIENTS		0.161177							1,792,220	528,646	$ 1,792,220	$ 528,646
39	7400	RENAL DIALYSIS		0.421197							31,070	7,170	$ 31,070	$ 7,170
40	7501	IV THERAPY		0.137775							-	-	$ -	$ -
41	9000	CLINIC		1.743490							-	-	$ -	$ -
42	9001	WOUND CARE		0.719557							-	-	$ -	$ -
43	9100	EMERGENCY		0.546309							189,631	397,775	$ 189,631	$ 397,775
44	9200	OBSERVATION		0.633119							10,726	155,428	$ 10,726	$ 155,428
45				-									$ -	$ -
46				-									$ -	$ -
47				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2019-09/30/2020) 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	
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
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106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2019-09/30/2020) 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	
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ -	$ -	$ -	$ -	$ -	$ 4,812,371	$ 2,695,670		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,878,323	$ 2,695,670	$ 5,878,323	$ 2,695,670
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,878,323	$ 2,695,670		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,808,116	$ 646,819	$ 1,808,116	$ 646,819
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)							$ 119,559	$ 48,047	$ 119,559	$ 48,047
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)							$ 170,551	$ 81,234	$ 170,551	$ 81,234
134	Private Insurance (including primary and third party liability)							$ 135,050	$ 81,369	$ 135,050	$ 81,369
135	Self-Pay (including Co-Pay and Spend-Down)							$ 208	$ 1,574	$ 208	$ 1,574
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						
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)							$ 721,662	$ 148,094	$ 721,662	$ 148,094
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 240,926	$ 107,041	$ 240,926	$ 107,041
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)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 420,160	$ 179,460	$ 420,160	$ 179,460
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	77%	72%	77%	72%

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 (10/01/2019-09/30/2020) 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)*		$ 4,378,124		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	7505-8000-8710 & 8301-8000-8710	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 4,378,124	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		$ 4,378,124		

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**	283,665,489
19	Uninsured Hospital	**Charges Sec. G**	100,110,300
20	Total Hospital	**Charges Sec. G**	1,060,253,111
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		26.75%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		9.44%
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.*