

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2020	06/30/2021

2. Select Your Facility from the Drop-Down Menu Provided:

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	10/01/2020	09/30/2021
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:	000001163A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	111326

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:

1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?
- 3a. Was the hospital open as of December 22, 1987?
- 3b. What date did the hospital open?

DSH Examination Year (07/01/20 - 06/30/21)
Yes

No

No

Yes

7/1/1950

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2020 - 06/30/2021**
 (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.) \$ 41,569

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2020 - 06/30/2021**
 (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 Services 07/01/2020 - 06/30/2021** \$ 41,569

Certification:

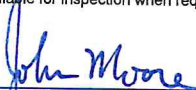
1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?**
 Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present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

Answer
Yes

Explanation for "No" answers:

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

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

 _____ Hospital CEO or CFO Signature	CFO _____ Title	_____ Date
John Moore _____ Hospital CEO or CFO Printed Name	229-259-4162 _____ Hospital CEO or CFO Telephone Number	john.moore@sgmc.org _____ 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 Stemenberg
Title	Partner
Firm Name	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	wstemenberg@draffin-tucker.com

D. General Cost Report Year Information **10/1/2020 - 9/30/2021**

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:

10/1/2020 through 9/30/2021		
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2. Select Cost Report Year Covered by this Survey (enter "X"):

X		
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3. Status of Cost Report Used for this Survey (Should be audited if available):

3a. Date CMS processed the HCRIS file into the HCRIS database:

Data	Correct?	If Incorrect, Proper Information
4. Hospital Name: SOUTH GEORGIA MED CTR - LANIER	Yes	
5. Medicaid Provider Number: 000001163A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab): 0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab): 0	Yes	
8. Medicare Provider Number: 111326	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal): Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban): Small Rural	Yes	

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

State Name	Provider No.

- 9. State Name & Number
 - 10. State Name & Number
 - 11. State Name & Number
 - 12. State Name & Number
 - 13. State Name & Number
 - 14. State Name & Number
 - 15. State Name & Number
- (List additional states on a separate attachment)*

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2020 - 09/30/2021)

- 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)	\$ 30	\$ 108,784	\$108,814
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 7,399	\$ 153,142	\$160,541
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)	\$7,429	\$261,926	\$269,355
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.40%	41.53%	40.40%

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 (10/01/2020 - 09/30/2021)

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) 304 (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	138,246
8. Outpatient Hospital Charity Care Charges	963,783
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	\$ 1,102,029

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)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$293,291.00			\$ 155,914	\$ -	\$ -	\$ 137,377
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$1,608,661.00			\$ 855,168	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$5,475,614.00			\$ 2,910,850	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$5,385,749.00	\$13,118,317.00		\$ 2,863,078	\$ 6,973,731	\$ -	\$ 8,667,257
20. Outpatient Services		\$3,626,600.00			\$ 1,927,910	\$ -	\$ 1,698,690
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$0.00			\$ -	
26. Other	\$0.00	\$0.00	\$106,663.00	\$ -	\$ -	\$ 56,702	\$ -
27. Total	\$ 5,679,040	\$ 16,744,917	\$ 7,190,938	\$ 3,018,992	\$ 8,901,641	\$ 3,822,721	\$ 10,503,324
28. Total Hospital and Non Hospital		Total from Above	\$ 29,614,895	Total from Above	\$ 15,743,354		

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	29,614,895	Total Contractual Adj. (G-3 Line 2)	14,529,392
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				1,213,962
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. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"				
35. Adjusted Contractual Adjustments				15,743,354
36. Unreconciled Difference	Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) SOUTH GEORGIA MED CTR - LANIER

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. 1, 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

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.

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 2,785,367	\$ -	\$ -	\$ 2,365,954.00	\$ 419,413	494	\$ 1,901,952.00	\$ 849.01
2	03100	INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
6	03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
10	04300	NURSERY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
11			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
12			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
13			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
14			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
15			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
16			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
17			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	
18		Total Routine	\$ 2,785,367	\$ -	\$ -	\$ 2,365,954	\$ 419,413	494	\$ 1,901,952	
19		Weighted Average								\$ 849.01

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)	190	-	\$ 161,312	\$ 14,976.00	\$ 235,702.00	\$ 250,678	0.643503

	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
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Ancillary Cost Centers (from W/S C excluding Observation) (list below)

21	5400	RADIOLOGY-DIAGNOSTIC	\$385,718.00	\$ -	\$ -	\$ 385,718	\$108,304.00	\$940,087.00	\$ 1,048,391	0.367914
22	5700	CT SCAN	\$410,360.00	\$ -	\$ -	\$ 410,360	\$180,405.00	\$4,274,352.00	\$ 4,454,757	0.092117
23	6000	LABORATORY	\$1,489,025.00	\$ -	\$ -	\$ 1,489,025	\$956,576.00	\$4,753,921.00	\$ 5,710,497	0.260752
24	6600	PHYSICAL THERAPY	\$1,133,354.00	\$ -	\$ -	\$ 1,133,354	\$1,156,112.00	\$854,990.00	\$ 2,011,102	0.563549
25	6900	ELECTROCARDIOLOGY	\$35,306.00	\$ -	\$ -	\$ 35,306	\$22,649.00	\$279,583.00	\$ 302,232	0.116818
26	7000	ELECTROENCEPHALOGRAPHY	\$819.00	\$ -	\$ -	\$ 819	\$0.00	\$3,325.00	\$ 3,325	0.246316
27	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$300,649.00	\$ -	\$ -	\$ 300,649	\$216,315.00	\$67,076.00	\$ 283,391	1.060898
28	7300	DRUGS CHARGED TO PATIENTS	\$700,222.00	\$ -	\$ -	\$ 700,222	\$2,745,388.00	\$1,944,983.00	\$ 4,690,371	0.149289
29	9100	EMERGENCY	\$2,227,416.00	\$ -	\$ -	\$ 2,227,416	\$70,986.00	\$3,304,936.00	\$ 3,375,922	0.659795
30			\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
31			\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) SOUTH GEORGIA MED CTR - LANIER

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
32		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
33		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
36		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
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	\$ -	-
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) SOUTH GEORGIA MED CTR - LANIER

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
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	\$ 6,682,869	\$ -	\$ -	\$ 6,682,869	\$ 5,471,711	\$ 16,658,955	\$ 22,130,666	
127	Weighted Average								0.309262
128	Sub Totals	\$ 9,468,236	\$ -	\$ -	\$ 7,102,282	\$ 7,373,663	\$ 16,658,955	\$ 24,032,618	
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)				\$808,316.00				
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				\$ 6,293,966				
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 (10/01/2020-09/30/2021) SOUTH GEORGIA MED CTR - LANIER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost <i>From Section G</i>	Medicaid Cost to Charge Ratio for Ancillary Cost <i>From Section G</i>	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (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	
				<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From Hospital's Own Internal Analysis</i>	<i>From Hospital's Own Internal Analysis</i>			
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	\$ 849.01		18				31		23		34		72		35.53%
2	03100 INTENSIVE CARE UNIT	\$ -														
3	03200 CORONARY CARE UNIT	\$ -														
4	03300 BURN INTENSIVE CARE UNIT	\$ -														
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -														
6	03500 OTHER SPECIAL CARE UNIT	\$ -														
7	04000 SUBPROVIDER I	\$ -														
8	04100 SUBPROVIDER II	\$ -														
9	04200 OTHER SUBPROVIDER	\$ -														
10	04300 NURSERY	\$ -														
11	\$ -															
12	\$ -															
13	\$ -															
14	\$ -															
15	\$ -															
16	\$ -															
17	\$ -															
18			Total Days	18				31		23		34		72		21.86%
19	Total Days per PS&R or Exhibit Detail			18				31		23		34		72		
20	Unreconciled Days (Explain Variance)															
21	Routine Charges															
21.01	Calculated Routine Charge Per Diem			\$ 17,721	\$ -	\$ 25,868	\$ 834.45	\$ 18,861	\$ 820.04	\$ 33,986	\$ 999.59	\$ 82,450	\$ 867.36		5.18%	
22	Ancillary Cost Centers (from WIS C) (from Section G):															
23	09200 Observation (Non-Distinct)	0.643503			7,843			5,909		29,136		6,115		38,505		35.11%
24	5400 RADIOLOGY-DIAGNOSTIC	0.367914		1,956	47,131			111,971		1,775		25,423		2,898		42.89%
25	5700 CT SCAN	0.092117		13,534	172,737			318,810		4,237		18,729		885,124		43.89%
26	6000 LABORATORY	0.260752		20,453	264,509			290,697		24,061		650,377		37,684		40.97%
27	6600 PHYSICAL THERAPY	0.563549		532	26,659			66,073		1,440		27,625		645		19.24%
28	6900 ELECTROCARDIOLOGY	0.116818		1,272	14,623			50,185		636		14,726		3,027		57.08%
29	7000 ELECTROENCEPHALOGRAPHY	0.246316		-	-			-		-		-		-		0.00%
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.060898		780	3,972			8,069		640		2,349		1,292		12.60%
31	7300 DRUGS CHARGED TO PATIENTS	0.149289		19,297	108,102			123,112		29,504		34,747		503,992		22.26%
32	9100 EMERGENCY	0.659795		9,228	150,760			619,268		4,889		114,285		11,409		61.32%
33																
34																
35																
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2020-09/30/2021) SOUTH GEORGIA MED CTR - LANIER

			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
64															
65															
66															
67															
68															
69															
70															
71															
72															
73															
74															
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125															
126															
127															
			\$ 67,049	\$ 796,357	\$ -	\$ 1,594,094	\$ 67,182	\$ 1,180,607	\$ 45,290	\$ 1,032,599	\$ 110,432	\$ 3,596,022			

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

Cost Report Year (10/01/2020-09/30/2021) SOUTH GEORGIA MED CTR - LANIER

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey
Totals / Payments														
128	Total Charges (includes organ acquisition from Section J)	\$ 84,770	\$ 796,357	\$ -	\$ 1,594,094	\$ 93,050	\$ 1,180,607	\$ 64,151	\$ 1,032,599	\$ 144,418	\$ 3,596,022	\$ 241,972	\$ 4,603,658	35.94%
129	Total Charges per PS&R or Exhibit Detail	\$ 84,770	\$ 796,357	\$ -	\$ 1,594,094	\$ 93,050	\$ 1,180,607	\$ 64,151	\$ 1,032,599	(Agrees to Exhibit A)	(Agrees to Exhibit A)	\$ 144,418	\$ 3,596,022	
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-	
131	Total Calculated Cost (includes organ acquisition from Section J)	\$ 32,825	\$ 243,839	\$ -	\$ 628,793	\$ 42,832	\$ 340,089	\$ 32,147	\$ 298,603	\$ 56,287	\$ 1,203,690	\$ 107,804	\$ 1,511,324	46.09%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 29,076	\$ 249,945			\$ 1,484	\$ 44,025		\$ 62			\$ 30,560	\$ 294,032	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				\$ 451,516				\$ 9,674			\$ -	\$ 461,190	
134	Private Insurance (including primary and third party liability)		\$ 175		\$ 5,205		\$ 382	\$ 1,408	\$ 62,640			\$ 1,408	\$ 68,402	
135	Self-Pay (including Co-Pay and Spend-Down)				\$ 2				\$ 131			\$ -	\$ 133	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 29,076	\$ 250,120	\$ -	\$ 456,723									
137	Medicaid Cost Settlement Payments (See Note B)		\$ (53,172)									\$ -	\$ (53,172)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											\$ -	\$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 75,945	\$ 460,719	\$ 50,897	\$ 183,511			\$ -	\$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								\$ 186,956			\$ 126,842	\$ 644,230	
141	Medicare Cross-Over Bad Debt Payments					\$ 7,264	\$ 28,784					\$ 7,264	\$ 28,784	
142	Other Medicare Cross-Over Payments (See Note D)					\$ (42,884)	\$ (199,488)					\$ (42,884)	\$ (199,488)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	\$ 30	\$ 108,784	
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)	\$ 3,749	\$ 46,891	\$ -	\$ 172,070	\$ 1,023	\$ 5,667	\$ (20,159)	\$ (144,371)	\$ 56,257	\$ 1,094,906	\$ (15,386)	\$ 80,257	
146	Calculated Payments as a Percentage of Cost	89%	81%	0%	73%	98%	98%	163%	148%	0%	9%	114%	95%	
147	Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)	189												
148	Percent of cross-over days to total Medicare days from the cost report	16%												

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with 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 pay)
 Note E - Medicaid Managed Care payments should include Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation pay

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) SOUTH GEORGIA MED CTR - LANIER

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	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-Over (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 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	\$ 849.01								2		2	
2	03100 INTENSIVE CARE UNIT	\$ -											
3	03200 CORONARY CARE UNIT	\$ -											
4	03300 BURN INTENSIVE CARE UNIT	\$ -											
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -											
6	03500 OTHER SPECIAL CARE UNIT	\$ -											
7	04000 SUBPROVIDER I	\$ -											
8	04100 SUBPROVIDER II	\$ -											
9	04200 OTHER SUBPROVIDER	\$ -											
10	04300 NURSERY	\$ -											
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
			Total Days							2		2	
19	Total Days per PS&R or Exhibit Detail									2			
20	Unreconciled Days (Explain Variance)												
21				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21.01	Routine Charges			\$ -		\$ -		\$ -		\$ 2,026		\$ 2,026	
	Calculated Routine Charge Per Diem									\$ 1,013.00		\$ 1,013.00	
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)	0.643503							507		507		
23	5400 RADIOLOGY-DIAGNOSTIC	0.367914		2,547					390		390		2,937
24	5700 CT SCAN	0.092117		1,530									1,530
25	6000 LABORATORY	0.260752		12,292				2,156	2,958		2,156		15,250
26	6600 PHYSICAL THERAPY	0.563549											
27	6900 ELECTROCARDIOLOGY	0.116818		424					212				636
28	7000 ELECTROENCEPHALOGRAPHY	0.246316											
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.060898		58				41	52		41		110
30	7300 DRUGS CHARGED TO PATIENTS	0.149289		6,082				566	792		566		6,874
31	9100 EMERGENCY	0.659795		14,789				841	3,649		841		18,438
32													
33													
34													
35													
36													
37													
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39													
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I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) SOUTH GEORGIA MED CTR - LANIER

		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										\$ -	\$ -
		\$ -	\$ 37,722	\$ -	\$ -	\$ -	\$ -	\$ 4,111	\$ 8,053	\$ -	\$ -
Totals / Payments											
128	Total Charges (includes organ acquisition from Section K)	\$ -	\$ 37,722	\$ -	\$ -	\$ -	\$ -	\$ 6,137	\$ 8,053	\$ 6,137	\$ 45,775
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ 37,722	\$ -	\$ -	\$ -	\$ -	\$ 6,137	\$ 8,053		
130	Unreconciled Charges (Explain Variance)										
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ -	\$ 15,060	\$ -	\$ -	\$ -	\$ -	\$ 3,269	\$ 3,521	\$ 3,269	\$ 18,581
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)									\$ -	\$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		\$ 2,598						\$ 225	\$ -	\$ 2,823
134	Private Insurance (including primary and third party liability)		\$ 464						\$ 284	\$ -	\$ 748
135	Self-Pay (including Co-Pay and Spend-Down)									\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ 3,062	\$ -	\$ -					\$ -	\$ -
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)							\$ 4,756	\$ 1,570	\$ 4,756	\$ 1,570
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									\$ -	\$ -
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)	\$ -	\$ 11,998	\$ -	\$ -	\$ -	\$ -	\$ (1,487)	\$ 1,442	\$ (1,487)	\$ 13,440
144	Calculated Payments as a Percentage of Cost	0%	20%	0%	0%	0%	0%	145%	59%	145%	28%

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 (10/01/2020-09/30/2021) SOUTH GEORGIA MED CTR - LANIER

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*		
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		(WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		(Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	CAH
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	\$ -	

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	4,897,541
19 Uninsured Hospital Charges Sec. G	3,740,440
20 Total Hospital Charges Sec. G	24,032,618
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	20.38%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	15.56%
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.