State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2021

DSH Version 6.01 2/10/2022

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2020	06/30/2021

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	10/01/2020	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:	000001724A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001724G
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110122

B. DSH Qualifying Information

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

During the DSH Examination Year:

	DSH Examination Year (07/01/20 - 06/30/21)
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 07/01/2020 - 06/30/2021** $ 4,571,995
   (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 07/01/2020 - 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 Services07/01/2020 - 06/30/2021** $ 4,571,995

Certification:

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

Explanation for "No" answers:

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

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

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

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

Hospital Contact:

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

Outside Preparer:

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

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D. General Cost Report Year Information 10/1/2020 - 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: SOUTH GEORGIA MEDICAL CENTER

	10/1/2020 through 9/30/2021		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/3/2022		

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

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

	State Name	Provider No.
9. State Name & Number		
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)	$ 1,814,122	$ 1,141,377	$2,955,499
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,324,564	$ 7,633,988	$8,958,552
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)	$3,138,686	$8,775,365	$11,914,051
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	57.80%	13.01%	24.81%

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)	80,220 (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	32,701,879
8.	Outpatient Hospital Charity Care Charges	33,704,678
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 66,406,557

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	$96,381,293.00			$ 68,214,607	$ -	$ -	$ 28,166,686
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	$503,789,373.00	$623,202,703.00		$ 356,560,830	$ 441,076,539	$ -	$ 329,354,706
20.	Outpatient Services		$67,634,350.00			$ 47,868,735	$ -	$ 19,765,615
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 17,980,832	-	-	$ 12,726,073	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$6,929,960.00			$ 4,904,733	
26.	Other	$18,451,123.00	$0.00	$14,260,690.00	$ 13,058,925	$ -	$ 10,093,114	$ 5,392,198
27.	Total	$ 618,621,789	$ 690,837,053	$ 39,171,482	$ 437,834,362	$ 488,945,274	$ 27,723,920	$ 382,679,206
28.	Total Hospital and Non Hospital		Total from Above	$ 1,348,630,324		Total from Above	$ 954,503,556	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,348,630,324	Total Contractual Adj. (G-3 Line 2)		946,646,677
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)				+	7,856,879
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					954,503,556
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 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	$ 50,037,507	$ -	$ 65,151	$0.00	$ 50,102,658	52,683	$53,580,389.00		$ 951.02
2	03100 INTENSIVE CARE UNIT	$ 37,762,376	$ -	$ -		$ 37,762,376	22,806	$42,800,904.00		$ 1,655.81
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 4,454,492	$ -	$ -		$ 4,454,492	4,800	$4,947,661.00		$ 928.02
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 92,254,375	$ -	$ 65,151	$ -	$ 92,319,526	80,289	$ 101,328,954		
19	Weighted Average									$ 1,149.84

Line #			*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)									
20	09200	Observation (Non-Distinct)	9,432	-	-	$ 8,970,021	$6,916,990.00	$6,905,581.00	$ 13,822,571	0.648940

Line #			*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below)										
21	5000	OPERATING ROOM	$30,786,191.00	$ -	$ -		$ 30,786,191	$41,040,109.00	$69,740,638.00	$ 110,780,747	0.277902
22	5200	DELIVERY ROOM & LABOR ROOM	$4,871,391.00	$ -	$ -		$ 4,871,391	$2,504,365.00	$487,820.00	$ 2,992,185	1.628038
23	5300	ANESTHESIOLOGY	$1,483,836.00	$ -	$ -		$ 1,483,836	$7,195,595.00	$15,114,913.00	$ 22,310,508	0.066508
24	5400	RADIOLOGY-DIAGNOSTIC	$29,961,596.00	$ -	$ -		$ 29,961,596	$36,591,442.00	$85,082,537.00	$ 121,673,979	0.246245
25	5700	CT SCAN	$4,405,135.00	$ -	$ -		$ 4,405,135	$33,095,938.00	$87,254,667.00	$ 120,350,605	0.036603
26	5800	MRI	$1,766,888.00	$ -	$ -		$ 1,766,888	$5,474,431.00	$18,454,422.00	$ 23,928,853	0.073839
27	6000	LABORATORY	$27,773,872.00	$ -	$ -		$ 27,773,872	$87,994,275.00	$104,764,801.00	$ 192,759,076	0.144086
28	6300	BLOOD STORING PROCESSING & TRANS.	$3,498,448.00	$ -	$ -		$ 3,498,448	$8,810,536.00	$3,567,571.00	$ 12,378,107	0.282632
29	6500	RESPIRATORY THERAPY	$6,962,977.00	$ -	$ -		$ 6,962,977	$24,904,319.00	$4,452,067.00	$ 29,356,386	0.237188
30	6600	PHYSICAL THERAPY	$2,831,483.00	$ -	$ -		$ 2,831,483	$2,867,137.00	$933,871.00	$ 3,801,008	0.744930
31	6700	OCCUPATIONAL THERAPY	$1,930,239.00	$ -	$ -		$ 1,930,239	$3,454,673.00	$37,455.00	$ 3,492,128	0.552740

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) 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
32	6800	SPEECH PATHOLOGY	$1,135,870.00	$ -	$ -		$ 1,135,870	$2,093,505.00	$39,972.00	$ 2,133,477	0.532403
33	6900	ELECTROCARDIOLOGY	$3,557,602.00	$ -	$ -		$ 3,557,602	$13,778,335.00	$11,762,334.00	$ 25,540,669	0.139292
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$9,489,238.00	$ -	$ -		$ 9,489,238	$26,496,063.00	$20,042,681.00	$ 46,538,744	0.203900
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$19,889,973.00	$ -	$ -		$ 19,889,973	$23,899,700.00	$46,588,289.00	$ 70,487,989	0.282175
36	7300	DRUGS CHARGED TO PATIENTS	$52,392,933.00	$ -	$ -		$ 52,392,933	$174,752,309.00	$153,720,733.00	$ 328,473,042	0.159505
37	7400	RENAL DIALYSIS	$1,904,097.00	$ -	$ -		$ 1,904,097	$4,005,678.00	$394,806.00	$ 4,400,484	0.432702
38	7501	IV THERAPY	$846,100.00	$ -	$ -		$ 846,100	$4,830,963.00	$763,126.00	$ 5,594,089	0.151249
39	9000	CLINIC	$3,083,983.00	$ -	$ -		$ 3,083,983	$306,478.00	$1,695,228.00	$ 2,001,706	1.540677
40	9001	WOUND CARE	$1,829,744.00	$ -	$ -		$ 1,829,744	$8,700.00	$1,571,308.00	$ 1,580,008	1.158060
41	9100	EMERGENCY	$24,180,577.00	$ -	$ -		$ 24,180,577	$14,821,592.00	$35,408,473.00	$ 50,230,065	0.481396
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 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
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**	$ 234,582,173	$ -	$ -		$ 234,582,173	$ 525,843,133	$ 668,783,293	$ 1,194,626,426	
127	**Weighted Average**									0.203873
128	**Sub Totals**	$ 326,836,548	$ -	$ 65,151		$ 326,901,699	$ 627,172,087	$ 668,783,293	$ 1,295,955,380	
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**					$ 326,901,699				
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 MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	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	$ 951.02		4,333		3,815		6,393		4,110		5,064		18,651		56.80%
2	03100 INTENSIVE CARE UNIT	$ 1,655.81		1,983		994		2,839		1,686		2,563		7,502		45.56%
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	$ 928.02		266		2,437				220		316		2,923		67.67%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	6,582		7,246		9,232		6,016		7,943		29,076		47.58%
19	Total Days per PS&R or Exhibit Detail			6,582		7,246		9,232		6,016		7,943				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 8,300,221		$ 8,023,659		$ 11,523,247		$ 7,395,621		$ 10,127,581		$ 35,242,748		46.21%
21.01	Calculated Routine Charge Per Dien			$ 1,261.05		$ 1,107.32		$ 1,248.19		$ 1,229.33		$ 1,275.03		$ 1,212.09		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct		0.648940	790,788	932,272	436,877	794,863	294,234	973,809	210,017	882,202	246,940	1,182,931	$ 1,731,917	$ 3,583,146	50.12%
23	5000 OPERATING ROOM		0.277902	1,974,609	1,969,642	2,537,835	9,806,523	3,609,843	5,354,303	2,111,019	1,413,959	3,659,053	3,485,226	$ 10,233,304	$ 18,544,427	32.67%
24	5200 DELIVERY ROOM & LABOR ROOM		1.628038	189,216	-	598,773	5,704	25,382	-	675,804	-	128,242	2,633	$ 1,489,175	$ 5,704	56.43%
25	5300 ANESTHESIOLOGY		0.066508	459,590	528,948	718,813	2,086,455	791,396	1,199,903	483,179	376,992	836,990	821,090	$ 2,452,978	$ 4,192,298	37.57%
26	5400 RADIOLOGY-DIAGNOSTIC		0.246245	1,050,520	2,429,723	2,262,091	5,846,691	2,086,456	7,556,860	1,368,157	2,028,600	1,677,810	5,881,888	$ 6,767,224	$ 17,861,874	26.94%
27	5700 CT SCAN		0.036603	2,488,229	2,997,246	1,253,424	5,223,250	4,188,278	7,486,600	2,110,989	2,198,592	4,035,544	11,445,806	$ 10,040,920	$ 17,905,687	37.31%
28	5800 MRI		0.073839	428,053	426,822	216,925	690,882	637,181	1,504,297	291,701	420,371	755,630	1,305,247	$ 1,573,860	$ 3,042,372	28.41%
29	6000 LABORATORY		0.144086	6,678,178	4,497,201	5,239,432	11,387,513	10,577,023	5,437,252	6,593,940	6,311,399	9,543,200	15,819,393	$ 29,088,573	$ 27,633,365	43.73%
30	6300 BLOOD STORING PROCESSING & TRANS.		0.282632	524,964	249,442	303,851	80,731	895,379	280,563	706,022	81,206	833,514	314,353	$ 2,430,216	$ 691,942	35.33%
31	6500 RESPIRATORY THERAPY		0.237188	2,312,981	118,458	999,038	265,980	3,623,719	290,438	2,095,048	371,563	2,097,231	274,925	$ 9,030,786	$ 1,046,439	43.87%
32	6600 PHYSICAL THERAPY		0.744930	234,149	-	62,744	22,775	458,032	125,837	201,645	51,713	290,651	44,567	$ 956,570	$ 200,325	40.41%
33	6700 OCCUPATIONAL THERAPY		0.552740	102,912	-	32,077	5,879	223,766	20,314	83,798	22,787	138,053	17,623	$ 442,553	$ 48,980	19.22%
34	6800 SPEECH PATHOLOGY		0.532403	115,431	339	423,303	3,031	126,283	34,196	85,708	14,379	128,837	21,448	$ 750,725	$ 51,945	45.76%
35	6900 ELECTROCARDIOLOGY		0.139292	1,685,587	881,497	769,634	1,059,843	3,270,034	2,703,612	1,379,604	1,051,310	4,163,623	2,958,477	$ 7,104,859	$ 5,696,262	80.03%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.203900	2,072,207	550,999	1,847,505	1,539,523	3,142,699	1,732,624	2,093,827	487,931	2,782,712	1,086,892	$ 9,156,239	$ 4,311,076	38.08%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.282175	1,098,941	1,596,544	486,655	1,100,898	2,135,734	4,967,134	579,195	856,609	1,713,087	926,163	$ 4,300,525	$ 8,521,186	22.11%
38	7300 DRUGS CHARGED TO PATIENTS		0.159505	15,486,702	8,281,931	9,532,932	7,548,028	19,623,866	21,703,119	12,195,712	4,393,342	19,456,472	9,515,776	$ 56,839,211	$ 41,926,421	39.83%
39	7400 RENAL DIALYSIS		0.432702	240,960	-	52,170	-	781,932	120,480	681,383	67,434	150,600	17,570	$ 1,756,445	$ 187,914	48.95%
40	7501 IV THERAPY		0.151249	-	-	344,060	21,338	438,209	88,133	319,634	29,376	363,366	47,473	$ 1,101,904	$ 138,847	30.37%
41	9000 CLINIC		1.540677	68,273	70,632	38,075	64,279	99,028	154,267	54,416	46,576	71,657	79,322	$ 259,793	$ 335,754	38.14%
42	9001 WOUND CARE		1.158060	-	-	850	60,281	1,083	248,977	790	82,986	898	134,110	$ 2,723	$ 392,244	34.00%
43	9100 EMERGENCY		0.481396	964,722	1,826,147	561,890	5,482,505	1,642,775	2,163,508	1,130,262	1,251,162	1,911,140	8,451,163	$ 4,299,649	$ 10,723,322	52.28%
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
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62			-											$ -	$ -	
63			-											$ -	$ -	

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

Cost Report Year (10/01/2020-09/30/2021 | 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		% Survey
64			-											$ -	$ -	
65			-											$ -	$ -	
66			-											$ -	$ -	
67			-											$ -	$ -	
68			-											$ -	$ -	
69			-											$ -	$ -	
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125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 38,967,010	$ 27,357,843	$ 28,718,954	$ 53,096,973	$ 58,672,333	$ 64,146,226	$ 35,451,850	$ 22,440,489	$ 54,985,249	$ 63,834,077			

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

Cost Report Year (10/01/2020-09/30/2021 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		% Survey
128	**Total Charges *(includes organ acquisition from Section J)***	$ 47,267,231	$ 27,357,843	$ 36,742,613	$ 53,096,973	$ 70,195,580	$ 64,146,226	$ 42,847,471	$ 22,440,489	$ 65,112,830 (Agrees to Exhibit A)	$ 63,834,077 (Agrees to Exhibit A)	$ 197,052,895	$ 167,041,531	38.99%
129	Total Charges per PS&R or Exhibit Detail	$ 47,267,231	$ 27,357,843	$ 36,742,613	$ 53,096,973	$ 70,195,580	$ 64,146,226	$ 42,847,471	$ 22,440,489	$ 65,112,830	$ 63,834,077			
130	Unreconciled Charges (Explain Variance	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 15,496,456	$ 5,668,397	$ 14,080,071	$ 11,607,013	$ 22,129,927	$ 12,726,658	$ 14,784,144	$ 4,672,988	$ 19,766,478	$ 13,020,100	$ 66,490,598	$ 34,675,056	42.06%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 11,803,173	$ 5,854,172			$ 642,887	$ 1,322,658	$ 36,331	$ 17,033			$ 12,482,391	$ 7,193,863	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 11,297,081	$ 10,009,617			$ 332,983	$ 157,747			$ 11,630,064	$ 10,167,364	
134	Private Insurance (including primary and third party liability)	$ 138,029	$ 6,324	$ 84,933	$ 62,615		$ 45	$ 3,560,372	$ 2,616,000			$ 3,783,334	$ 2,684,984	
135	Self-Pay (including Co-Pay and Spend-Down)			$ 71	$ 5,524			$ 58,124	$ 15,289			$ 58,195	$ 20,813	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 11,941,202	$ 5,860,496	$ 11,382,085	$ 10,077,756									
137	Medicaid Cost Settlement Payments (See Note B)		$ (533,680)									$ -	$ (533,680)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 18,152,983	$ 11,154,666	$ 4,955,048	$ 847,959			$ 23,108,031	$ 12,002,625	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 4,207,037	$ 2,071,181			$ 4,207,037	$ 2,071,181	
141	Medicare Cross-Over Bad Debt Payments					$ 408,381	$ 277,180			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 408,381	$ 277,180	
142	Other Medicare Cross-Over Payments (See Note D)					$ 301,921	$ 2,923	$ 72,356	$ 181			$ 374,277	$ 3,104	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 1,814,122	$ 1,141,377			
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)**	$ 3,555,254	$ 341,581	$ 2,697,986	$ 1,529,257	$ 2,623,755	$ (30,814)	$ 1,561,893	$ (1,052,402)	$ 17,952,356	$ 11,878,723	$ 10,438,888	$ 787,622	
146	**Calculated Payments as a Percentage of Cost**	77%	94%	81%	87%	88%	100%	89%	123%	9%	9%	84%	98%	
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)**					41,050								
148	**Percent of cross-over days to total Medicare days from the cost report**					22%								

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 s
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*all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payn

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) SOUTH GEORGIA MEDICAL CENTER

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid 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	$ 951.02		284						567		851	
2	03100 INTENSIVE CARE UNIT	$ 1,655.81		118						208		326	
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	$ 928.02		8						1		9	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	410		-		-		776		1,186	
19	Total Days per PS&R or Exhibit Detail			410		-		-		776			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 509,511						$ 943,655		$ 1,453,166	
21.01	Calculated Routine Charge Per Diem			$ 1,242.71		$ -		$ -		$ 1,216.05		$ 1,225.27	
	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)		0.648940	9,934	79,989					21,368	71,131	$ 31,302	$ 151,120
23	5000 OPERATING ROOM		0.277902	95,793	47,573					83,282	48,013	$ 179,075	$ 95,586
24	5200 DELIVERY ROOM & LABOR ROOM		1.628038	54,052	-					6,055	2,633	$ 60,107	$ 2,633
25	5300 ANESTHESIOLOGY		0.066508	23,823	16,683					28,968	8,542	$ 52,791	$ 25,225
26	5400 RADIOLOGY-DIAGNOSTIC		0.246245	105,358	204,173					153,538	130,747	$ 258,897	$ 334,920
27	5700 CT SCAN		0.036603	220,118	573,900					340,987	342,044	$ 561,104	$ 915,944
28	5800 MRI		0.073839	49,657	35,345					31,524	5,608	$ 81,181	$ 40,953
29	6000 LABORATORY		0.144086	590,681	508,551					890,984	222,506	$ 1,481,665	$ 731,057
30	6300 BLOOD STORING PROCESSING & TRANS.		0.282632	42,871	2,966					57,272	-	$ 100,143	$ 2,966
31	6500 RESPIRATORY THERAPY		0.237188	107,972	27,850					285,982	7,830	$ 393,954	$ 35,680
32	6600 PHYSICAL THERAPY		0.744930	12,502	2,214					25,224	4,021	$ 37,726	$ 6,235
33	6700 OCCUPATIONAL THERAPY		0.552740	8,648	775					12,347	2,343	$ 20,995	$ 3,118
34	6800 SPEECH PATHOLOGY		0.532403	8,670	1,149					10,658	2,892	$ 19,328	$ 4,041
35	6900 ELECTROCARDIOLOGY		0.139292	138,470	63,027					259,292	55,991	$ 397,762	$ 119,018
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.203900	103,469	37,954					223,734	18,824	$ 327,204	$ 56,778
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.282175	11,510	861					87,556	25,782	$ 99,066	$ 26,642
38	7300 DRUGS CHARGED TO PATIENTS		0.159505	871,490	487,135					1,548,715	195,856	$ 2,420,205	$ 682,991
39	7400 RENAL DIALYSIS		0.432702	10,040	-					30,012	1,255	$ 40,052	$ 1,255
40	7501 IV THERAPY		0.151249	13,833	899					30,892	1,640	$ 44,726	$ 2,538
41	9000 CLINIC		1.540677	3,059	1,802					9,455	2,646	$ 12,514	$ 4,447
42	9001 WOUND CARE		1.158060	34	2,539					76	4,632	$ 111	$ 7,171
43	9100 EMERGENCY		0.481396	108,116	409,437					193,759	164,783	$ 301,875	$ 574,220
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) 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	
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
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110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) SOUTH GEORGIA MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 2,590,101	$ 2,504,821	$ -	$ -	$ -	$ -	$ 4,331,680	$ 1,319,719		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 3,099,612	$ 2,504,821	$ -	$ -	$ -	$ -	$ 5,275,335	$ 1,319,719	$ 8,374,947	$ 3,824,539
129	Total Charges per PS&R or Exhibit Detail	$ 3,099,612	$ 2,504,821	$ -	$ -	$ -	$ -	$ 5,275,335	$ 1,319,719		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 1,020,638	$ 520,954	$ -	$ -	$ -	$ -	$ 1,708,723	$ 288,944	$ 2,729,361	$ 809,898
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 6,836	$ 6,755					$ -	$ 138	$ 6,836	$ 6,893
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ 218,635	$ 130,817					$ 60,637	$ 10,219	$ 279,272	$ 141,036
134	Private Insurance (including primary and third party liability)	$ 91,419	$ 59,841					$ 267,504	$ 64,343	$ 358,923	$ 124,184
135	Self-Pay (including Co-Pay and Spend-Down)		$ 97					$ 90	$ 320	$ 90	$ 417
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 316,890	$ 197,510	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ 3,378	$ 189							$ 3,378	$ 189
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 912,664	$ 74,254	$ 912,664	$ 74,254
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 302,495	$ 77,186	$ 302,495	$ 77,186
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)**	$ 700,370	$ 323,255	$ -	$ -	$ -	$ -	$ 165,333	$ 62,484	$ 865,703	$ 385,739
144	**Calculated Payments as a Percentage of Cost**	31%	38%	0%	0%	0%	0%	90%	78%	68%	52%

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 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)*		$ 4,334,043		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	8301-8000-8710 & 7505-8000-8710	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 4,334,043	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		$ 4,334,043		

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**	376,293,912
19	Uninsured Hospital	**Charges Sec. G**	128,946,907
20	Total Hospital	**Charges Sec. G**	1,295,955,380
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		29.04%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		9.95%
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.*