

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2024	08/30/2025

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	10/01/2022	09/30/2023
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 (07/01/24 - 08/30/25) |
|--|--|
| 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.) | <input type="text" value="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? | <input type="text" value="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? | <input type="text" value="No"/> |
| 3a. Was the hospital open as of December 22, 1987? | <input type="text" value="Yes"/> |
| 3b. What date did the hospital open? | <input type="text" value="7/1/1955"/> |

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025
(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.) \$ 6,472,631

2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2024 - 06/30/2025
(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.) \$ 11,355,653

3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2024 - 06/30/2025 \$ 17,828,284

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.

	CFO	2/12/2025
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 Sternberg
Title	Partner
Firm Name	Driffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	wsternberg@driffin-tucker.com

D. General Cost Report Year Information **10/1/2022 - 9/30/2023**

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:

2. Select Cost Report Year Covered by this Survey (enter "X"):

10/1/2022 through 9/30/2023		
X		

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 MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000001724A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001724G	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110122	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	

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

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2022 - 09/30/2023)

- Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Total Section 1011 Payments Related to Hospital Services (See Note 1)**
- Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**

\$-
\$-

8. **Out-of-State DSH Payments (See Note 2)**

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- Total Cash Basis Patient Payments from Uninsured (On Exhibit B)
- Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)
- Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)
- Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

	Inpatient	Outpatient	Total
	\$ 365,327	\$ 1,272,219	\$1,637,546
	\$ 2,863,254	\$ 9,984,174	\$12,847,428
	\$3,228,581	\$11,256,393	\$14,484,974
	11.32%	11.30%	11.31%

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.

Yes

- Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services
- Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services
- Total Medicaid managed care non-claims payments (see question 13 above) received

\$ 11,355,653	<--These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.
\$ -	
\$11,355,653	

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 (10/01/2022 - 09/30/2023)

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)

70,981 (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
- 8. Outpatient Hospital Charity Care Charges
- 9. Non-Hospital Charity Care Charges
- 10. Total Charity Care Charges

40,421,509
47,396,921
\$ 87,818,430

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	\$75,312,718.00			\$ 54,305,545	\$ -	\$ -	\$ 21,007,173
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	\$480,619,521.00	\$784,826,509.00		\$ 346,559,066	\$ 565,912,806	\$ -	\$ 352,974,158
20. Outpatient Services		\$84,227,115.00			\$ 60,733,426	\$ -	\$ 23,493,689
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ 13,899,444			\$ 9,878,222	
23. Outpatient Rehab Providers			\$0.00			\$ -	
24. ASC	\$0.00	\$0.00				\$ -	
25. Hospice			\$7,398,026.00			\$ 5,334,475	
26. Other	\$24,859,943.00	\$0.00	\$6,010,838.00	\$ 17,925,694	\$ -	\$ 4,334,219	\$ 6,934,249
27. Total	\$ 580,792,182	\$ 869,053,624	\$ 27,108,308	\$ 418,790,306	\$ 626,646,232	\$ 19,546,917	\$ 404,409,268
28. Total Hospital and Non Hospital		Total from Above	\$ 1,476,954,114	Total from Above	\$ 1,064,983,455		

29. Total Per Cost Report Total Patient Revenues (G-3 Line 1) 1,476,954,114

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)

Total Contractual Adj. (G-3 Line 2) 1,058,476,322

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)

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)"

36. Adjusted Contractual Adjustments

37. Unreconciled Difference Unreconciled Difference (Should be \$0) \$ -

Unreconciled Difference (Should be \$0) \$ 1,064,983,455

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) 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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col. 2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>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</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

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	\$ 38,884,245	\$ 996,418	\$ 65,150	\$ 0.00	\$ 39,945,813	42,850	\$42,550,525.00	\$ 932.22
2	03100	INTENSIVE CARE UNIT	\$ 33,696,925	\$ 197,032	\$ -	\$ -	\$ 33,893,957	23,473	\$32,762,193.00	\$ 1,443.96
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ 3,952,405	\$ -	\$ -	\$ -	\$ 3,952,405	4,658	\$10,644,118.00	\$ 848.52
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 76,533,575	\$ 1,193,450	\$ 65,150	\$ -	\$ 77,792,175	70,981	\$ 85,956,836	
19		Weighted Average								\$ 1,095.96

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
09200 Observation (Non-Distinct)	9,099	-	-	\$ 8,482,270	\$6,693,340.00	\$6,489,491.00	\$ 13,182,831	0.643433

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):

5000	OPERATING ROOM	\$33,224,143.00	\$ -	\$ -	\$ 33,224,143	\$55,168,949.00	\$140,197,255.00	\$ 195,366,204	0.170061
5200	DELIVERY ROOM & LABOR ROOM	\$5,369,367.00	\$ -	\$ -	\$ 5,369,367	\$9,723,409.00	\$1,155,265.00	\$ 10,878,694	0.493567
5300	ANESTHESIOLOGY	\$1,801,405.00	\$ -	\$ -	\$ 1,801,405	\$14,894,387.00	\$33,788,823.00	\$ 48,683,210	0.037003
5400	RADIOLOGY-DIAGNOSTIC	\$27,398,972.00	\$ 11,439	\$ -	\$ 27,410,411	\$44,830,678.00	\$113,371,645.00	\$ 158,202,323	0.173262
5700	CT SCAN	\$5,730,047.00	\$ -	\$ -	\$ 5,730,047	\$35,859,169.00	\$91,476,037.00	\$ 127,335,206	0.045000
5800	MRI	\$1,891,011.00	\$ -	\$ -	\$ 1,891,011	\$5,994,131.00	\$20,390,263.00	\$ 26,384,394	0.071672
6000	LABORATORY	\$29,186,398.00	\$ 10,649	\$ -	\$ 29,197,047	\$72,564,379.00	\$110,019,392.00	\$ 182,583,771	0.159910
6300	BLOOD STORING PROCESSING & TRANS.	\$3,422,246.00	\$ -	\$ -	\$ 3,422,246	\$9,462,608.00	\$3,643,366.00	\$ 13,105,974	0.261121
6500	RESPIRATORY THERAPY	\$8,109,968.00	\$ -	\$ -	\$ 8,109,968	\$19,036,138.00	\$5,646,196.00	\$ 24,682,334	0.328574
6600	PHYSICAL THERAPY	\$3,040,826.00	\$ -	\$ -	\$ 3,040,826	\$3,296,540.00	\$711,647.00	\$ 4,008,187	0.758654

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) 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 Routine		Total Charges	Medicaid Per Diem / Cost or Other Ratios
						I/P Days and I/P Ancillary Charges	Charges and O/P Ancillary Charges		
31	6700 OCCUPATIONAL THERAPY	\$1,626,112.00	\$ -	\$ -	\$ 1,626,112	\$2,766,030.00	\$9,890.00	\$ 2,775,920	0.585792
32	6800 SPEECH PATHOLOGY	\$947,089.00	\$ -	\$ -	\$ 947,089	\$1,674,834.00	\$5,616.00	\$ 1,680,450	0.563592
33	6900 ELECTROCARDIOLOGY	\$4,929,597.00	\$ -	\$ -	\$ 4,929,597	\$13,325,159.00	\$14,562,501.00	\$ 27,987,660	0.176766
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$10,734,417.00	\$ -	\$ -	\$ 10,734,417	\$32,757,466.00	\$24,150,593.00	\$ 56,908,059	0.188627
35	7200 IMPL. DEV. CHARGED TO PATIENTS	\$22,301,841.00	\$ -	\$ -	\$ 22,301,841	\$26,694,447.00	\$55,529,858.00	\$ 82,224,305	0.271232
36	7300 DRUGS CHARGED TO PATIENTS	\$49,682,700.00	\$ -	\$ -	\$ 49,682,700	\$126,138,172.00	\$168,557,979.00	\$ 294,696,151	0.168590
37	7400 RENAL DIALYSIS	\$1,739,233.00	\$ -	\$ -	\$ 1,739,233	\$2,990,422.00	\$187,523.00	\$ 3,177,945	0.547282
38	7501 IV THERAPY	\$729,918.00	\$ -	\$ -	\$ 729,918	\$3,442,603.00	\$1,422,640.00	\$ 4,865,243	0.150027
39	9000 CLINIC	\$882,204.00	\$ 100,403	\$ -	\$ 982,607	\$2,653.00	\$882,661.00	\$ 885,314	1.109897
40	9001 WOUND CARE	\$1,850,618.00	\$ -	\$ -	\$ 1,850,618	\$19,961.00	\$3,784,542.00	\$ 3,804,503	0.486428
41	9100 EMERGENCY	\$25,223,443.00	\$ 156,689	\$ 579,786	\$ 25,959,918	\$21,496,094.00	\$44,858,373.00	\$ 66,354,467	0.391231
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) SOUTH GEORGIA MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 239,821,555	\$ 279,180	\$ 579,786	\$ 240,680,521	\$ 508,831,569	\$ 840,841,576	\$ 1,349,673,145	
127	Weighted Average								0.184610
128	Sub Totals	\$ 316,355,130	\$ 1,472,630	\$ 644,936	\$ 318,472,696	\$ 594,788,405	\$ 840,841,576	\$ 1,435,629,981	
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				\$ 318,472,696				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.46%			

* 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: 10/01/2023-09/30/2023 SOUTH GEORGIA MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medical Expenses (not included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (not to be included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (includes all payers)		
				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)	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		Days				
1	03000 NURSING & RECEPTION	\$ 832,222		3,733		3,543		2,599		6,133		3,727				18,005		60.8%		
2	03100 INTENSIVE CARE UNIT	\$ 1,443,996		1,622		447		1,654		2,927		2,927				7,550		84.9%		
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	\$ 848,524		339		7,701				192		133			3,232			72.8%		
11		\$ -																		
12		\$ -																		
13		\$ -																		
14		\$ -																		
15		\$ -																		
16		\$ -																		
17		\$ -																		
18		\$ -																		
19	Total Days per PS&R or Exhibit Detail				5,824		8,688		4,253		9,952		6,222			26,287		48.9%		
20	Unreconciled Days (Explain Variance)				5,824		8,688		4,253		9,952		6,222			26,287				
21	Routine Charges				\$ 6,790,430		\$ 13,812,800		\$ 4,338,608		\$ 11,995,614		\$ 6,959,048			\$ 38,077,782		\$1.0%		
21.01	Calculated Routine Charge Per Diem				\$ 1,152.10		\$ 2,065.32		\$ 1,031.95		\$ 1,114.91		\$ 1,110.26			\$ 1,347.21				
22	Ancillary Cost Centers (from Section G):				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges			
22	09200 Observation (Non-Distinct)	\$ 0.643433		808,119	508,848	508,848	635,209	439,522	532,457	904,208	1,044,532	301,332	751,238	2,935,606	2,941,203	24.9%				
23	6000 OPERATING ROOM	\$ 0.170061		2,952,543	3,722,647	3,105,430	21,040,977	2,438,753	3,728,221	6,160,626	12,444,718	5,002,101	9,407,187	16,657,352	40,683,563	100.0%				
24	5200 DELIVERY ROOM & LABOR ROOM	\$ 0.493587		454,701	454,701	5,624,375	49,216	43,200	602	1,182,299	2,207	260,245	1,327	7,214,676	7,214,676	100.0%				
25	5300 ANESTHESIOLOGY	\$ 0.023501		893,204	1,195,004	1,474,184	4,485,424	705,491	654,815	1,892,274	2,830,014	1,835,872	3,292,023	4,731,256	9,213,257	100.0%				
26	5400 RADIOLOGY-DIAGNOSTIC	\$ 0.172382		803,252	2,716,312	1,051,001	4,972,099	1,051,001	2,647,328	2,239,236	8,592,604	1,904,947	6,183,977	5,665,463	19,028,431	18.7%				
27	5700 GT SCIM	\$ 0.045000		2,354,768	2,700,726	1,184,008	8,108,789	2,490,589	2,296,846	4,662,877	7,613,684	3,722,750	12,179,609	10,892,236	19,119,495	427.6%				
28	5800 MRI	\$ 0.071672		276,747	465,403	165,742	818,747	314,993	524,299	931,713	2,262,552	818,817	1,500,799	1,578,705	4,060,597	18.2%				
29	6000 LABORATORY	\$ 0.155910		2,529,083	4,591,224	5,126,823	14,233,909	5,052,823	2,892,217	11,516,684	8,960,581	6,795,829	12,363,513	27,895,214	30,659,718	26.6%				
30	6300 BLOOD STORING, PROCESSING & TRANS.	\$ 0.261121		511,736	107,456	284,269	100,431	108,481	108,445	341,357	203,439	800,850	369,887	2,236,323	544,810	23.6%				
31	6800 RESPIRATORY THERAPY	\$ 0.328574		1,731,732	87,711	708,232	248,690	1,778,692	81,992	3,436,548	319,740	1,327,819	165,148	7,555,245	714,136	36.9%				
32	6900 PHYSICAL THERAPY	\$ 0.758924		120,433	30,442	22,574	156,845	15,655	15,655	267,274	59,290	155,404	31,070	874,994	97,519	11.0%				
33	6700 OCCUPATIONAL THERAPY	\$ 0.565792		83,084	16,094	5,728	97,156	4,970	4,970	247,651	30,220	100,979	7,328	445,265	30,228	47.7%				
34	6800 SPEECH/PATHOLOGY	\$ 0.563992		97,684	490	421,240	48,912	3,422	3,422	128,034	12,027	72,729	7,703	694,850	26,179	31.2%				
35	6900 ELECTROCARDIOLOGY	\$ 0.126766		2,304,822	1,205,446	619,276	1,047,267	1,270,534	1,165,478	3,627,241	4,253,776	3,433,241	2,708,340	8,594,476	8,321,997	104.2%				
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 0.188627		2,413,791	747,780	1,875,049	1,641,180	2,504,823	530,756	4,813,724	7,179,545	2,608,569	1,436,920	11,667,387	5,099,660	104.4%				
37	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 0.271532		1,113,153	2,729,912	277,892	2,053,201	155,192	1,892,822	2,622,110	5,368,945	1,818,375	2,770,595	4,771,678	11,709,681	178.7%				
38	7300 DRUGS CHARGED TO PATIENTS	\$ 0.188590		10,468,295	9,788,808	6,662,141	9,624,819	9,927,459	8,999,255	17,287,191	17,696,103	11,927,148	9,202,267	43,070,927	43,855,188	104.8%				
39	7400 RENAL DIALYSIS	\$ 0.547282		263,250	3,000	912	508,059	38,880	716,816	60,090	110,907	21,384	1,492,216	105,848	105,848	12.7%				
40	7501 IV THERAPY	\$ 0.150027		-	456,479	45,198	157,310	58,655	321,369	197,078	171,977	93,392	865,184	200,930	1,066,114	1.0%				
41	8000 CLINIC	\$ 1.199892		-	33,629	49,252	67,269	87,269	101,422	79,704	56,293	192,200	105,798	192,200	104,325	0.1%				
42	9001 WOUND CARE	\$ 0.494428		4,204	13,846	3,269	17,147	2,222	17,466	2,413	482,226	1,118	278,430	10,610	804,154	24.9%				
43	9100 EMERGENCY	\$ 0.391231		1,009,268	2,487,667	743,001	8,204,231	1,437,804	1,209,099	2,674,821	4,083,540	2,008,747	9,811,676	5,858,294	18,584,634	71.4%				
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2022-09/30/2023) SOUTH GEORGIA MEDICAL CENTER

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicare Secondary)		In-State Other Medicaid Expenses (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Excluded and Non-Governor)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
71																
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			\$ 34,351,643	\$ 33,441,477	\$ 32,995,214	\$ 70,694,031	\$ 31,037,720	\$ 25,500,005	\$ 68,888,975	\$ 79,072,438	\$ -	\$ -	\$ 44,539,950	\$ 71,935,297		

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

Cost Report Year 11/01/2023-10/31/2024 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 Medicare Eligibles (that included Disallow & with Medicaid Secondary - Excludes Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (not to be included elsewhere)		Uninsured		Total In-State Medicaid (DASH) Includes Medicare FFS & MCO Exhausted and Non-Covered		% Survey to
128	Totals / Payments															
129	Total Charges (includes organ acquisition from Section J)	\$ 41,142,093	\$ 33,441,477	\$ 45,808,079	\$ 76,894,031	\$ 38,028,604	\$ 25,500,005	\$ 78,084,589	\$ 79,072,438	\$ -	\$ -	\$ 51,447,996	\$ 71,835,297	\$ 202,061,385	\$ 214,707,951	35.2%
130	Total Charges per PS&R or Exhibit Detail	\$ 41,142,093	\$ 33,441,477	\$ 45,808,079	\$ 76,894,031	\$ 38,028,604	\$ 25,500,005	\$ 78,084,589	\$ 79,072,438	\$ -	\$ -	\$ 51,447,996	\$ 71,835,297	\$ 202,061,385	\$ 214,707,951	
131	Unreconciled Charges (Explain Variance)															
132	Total Calculated Cost (includes organ acquisition from Section J)	\$ 13,316,286	\$ 6,409,765	\$ 14,120,784	\$ 14,101,455	\$ 11,094,471	\$ 4,585,948	\$ 24,601,538	\$ 14,092,893	\$ -	\$ -	\$ 15,255,001	\$ 13,287,646	\$ 83,133,038	\$ 39,180,081	47.2%
133	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 10,327,309	\$ 6,553,561	\$ 10,140,595	\$ 10,944,247	\$ 1,141,017	\$ 480,849	\$ 789,872	\$ 1,099,888					\$ 12,393,148	\$ 8,133,298	
134	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 10,140,595	\$ 10,944,247			\$ 1,411,801	\$ 1,058,094					\$ 11,552,876	\$ 12,002,331	
135	Private Insurance (including primary and third party liability)	\$ 101,706	\$ 6,451					\$ 3,895,445	\$ 4,997,716					\$ 4,097,211	\$ 5,004,167	
136	Self-Pay (including Co-Pay and Spend-Down)			\$ 400	\$ 6,775	\$ 8,555	\$ 12,108		\$ 39,093					\$ 18,300	\$ 50,066	
137	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 10,484,075	\$ 6,560,012	\$ 10,141,308	\$ 10,951,022											
138	Medicaid Cost Settlement Payments (See Note B)		\$ (486,110)												\$ (486,110)	
139	Other Medicaid Payments Reported on Cost Report Year (See Note C)															
140	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)					\$ 9,782,340	\$ 4,266,167	\$ 800,976	\$ 303,411					\$ 9,843,256	\$ 4,659,578	
141	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 14,011,500	\$ 9,379,023					\$ 14,011,500	\$ 9,359,083	
142	Medicare Cross-Over Bad Debt Payments					\$ 209,618	\$ 115,644							\$ 209,618	\$ 115,644	
143	Other Medicare Cross-Over Payments (See Note D)					\$ 893,072	\$ 304,483	\$ 57,319	\$ 94,901					\$ 950,341	\$ 489,384	
144	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													\$ 365,327	\$ 1,272,219	
145	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)													\$ -	\$ -	
146	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 2,832,181	\$ 335,883	\$ 3,979,386	\$ 3,150,433	\$ 19,018	\$ (683,393)	\$ 3,565,304	\$ (2,848,283)	\$ -	\$ -	\$ 14,889,674	\$ 12,015,327	\$ 10,386,779	\$ (145,380)	
147	Calculated Payments as a Percentage of Cost	79%	95%	72%	78%	100%	115%	86%	121%	0%	0%	2%	10%	64%	100%	
148	Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (CIR, WIS S-3, Pl. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					37,045										
149	Percent of cross-over days to total Medicare days from the cost report					11%										

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-Claims Specific payments. DSH payments should NOT be included. LIP payments made on a state fiscal year basis should be reported in Section C of the survey.
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.
 Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payer buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (10/01/2022-09/30/2023)

SOUTH GEORGIA MEDICAL CENTER

	Total Organ Acquisition Cost	Additional Add-In Intermittent Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over/ Uninsured Organs Sold	Total Usable Organs (Count)	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 & with Medicaid Secondary - Excludes Medicaid Exhausted and Fair-Ordered)		Medicaid FFS & MCO Exhausted and Fair-Ordered (not to be included Elsewhere)		Uninsured			
						Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)
						Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report WS D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below):																			
1	Lung Acquisition	\$ 0.00	\$ -	\$ -	0														
2	Kidney Acquisition	\$ 0.00	\$ -	\$ -	0														
3	Liver Acquisition	\$ 0.00	\$ -	\$ -	0														
4	Heart Acquisition	\$ 0.00	\$ -	\$ -	0														
5	Pancreas Acquisition	\$ 0.00	\$ -	\$ -	0														
6	Intestinal Acquisition	\$ 0.00	\$ -	\$ -	0														
7	Islet Acquisition	\$ 0.00	\$ -	\$ -	0														
8	Islet Acquisition	\$ 0.00	\$ -	\$ -	0														
9	Totals	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0		
20	Total Cost																		

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
 Note B - Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.
 Note C - Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (10/01/2022-09/30/2023)

SOUTH GEORGIA MEDICAL CENTER

	Total Organ Acquisition Cost	Additional Add-In Intermittent Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over/ Uninsured Organs Sold	Total Usable Organs (Count)	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 & with Medicaid Secondary)	
						Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)
						Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report WS D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -	0								
12	Kidney Acquisition	\$ -	\$ -	\$ -	0								
13	Liver Acquisition	\$ -	\$ -	\$ -	0								
14	Heart Acquisition	\$ -	\$ -	\$ -	0								
15	Pancreas Acquisition	\$ -	\$ -	\$ -	0								
16	Intestinal Acquisition	\$ -	\$ -	\$ -	0								
17	Islet Acquisition	\$ -	\$ -	\$ -	0								
18	Islet Acquisition	\$ -	\$ -	\$ -	0								
19	Totals	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
20	Total Cost												

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
 Note B - Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year: (10/01/2022-09/30/2023) 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)*	\$ 4,840,964	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	FY00-0000-0710 & 0701-0000-0710 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 4,840,964	5.82 (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-5 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-5 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	\$ 4,840,964	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:	
18 Medicaid Eligible*** Charges Sec. G	430,511,987
19 Uninsured Hospital Charges Sec. G	123,383,293
20 Total Hospital Charges Sec. G	1,435,629,081
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	29.99%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	8.59%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC including all Medicaid eligibles***	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	204,653,105
27 Uninsured Hospital Charges Sec. G	123,383,293
28 Total Hospital Charges Sec. G	1,435,629,081
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	14.26%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	8.59%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ -
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
33 Medicaid Primary 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.

***For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.