

D. General Cost Report Year Information

7/1/2017 - 6/30/2018

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:

MEDICAL COLLEGE OF GA HOSP & CLINICS

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

7/1/2017 through 6/30/2018 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:

1/31/2019

4. Hospital Name:

MEDICAL COLLEGE OF GA HOSP & CLINICS

5. Medicaid Provider Number:

00000723A

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

0

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

0

8. Medicare Provider Number:

110034

- Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):

State Govt.

- DSH Pool Classification (Small Rural, Non-Small Rural, Urban):

Urban

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

9. State Name & Number

South Carolina 315846

10. State Name & Number

South Carolina 358127

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: (07/01/2017 - 06/30/2018)

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)

\$ 5,682,301

9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)

\$ 297,558

10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)

\$ 1,512,270

11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)

\$ 1,809,828

12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

16.44%

Inpatient \$ 574,669

Outpatient \$ 2,384

Total \$872,227

\$1,514,654

\$2,386,881

36.54%

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, supplemental, 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 (07/01/2017 - 06/30/2018)**F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)**

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (CR, W/S S-3, Pt. 1, Col. B, Sum of Lins. 14, 16, 17, 18, 00-18.03, 30, 31 less lines 5 & 6)

120,457

(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 IP and OIP 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

2,281,393

73,214,757

65,808,123

139,022,880

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	\$174,967,782.00		\$ 128,500,195	\$ -	\$ -	\$ 46,467,587
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	\$1,027,562,416.00	\$0.00	\$ 754,654,481	\$ -	\$ -	\$ 272,897,935
20. Outpatient Services		\$1,259,082,925.00		\$ 924,698,244	\$ -	\$ 334,384,681
21. Home Health Agency		\$0.00			\$ -	
22. Ambulance		\$0.00			\$ -	
23. Outpatient Rehab Providers		\$0.00			\$ -	
24. ASC	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
25. Hospice		\$0.00			\$ -	
26. Other	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
27. Total	\$ 1,202,530,198	\$ 1,259,082,925	\$ 883,164,675	\$ 924,698,244	\$ -	\$ 653,750,204
28. Total Hospital and Non Hospital		Total from Above		Total from Above	\$ 1,807,862,919	
29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)		2,461,613,123	Total Contractual Adj. (G-3 Line 2)		1,807,862,919
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)						
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						1,807,862,919

Q. Cost Report - Cost / Days / Charges

Cost Report Year: 07/01/2017-06/30/2018 MEDICAL COLLEGE OF GA HOSP & CLINICS

Line #	Cost Center Description	Total Allowable Cost	Item & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	IP Days and IP Ancillary Charges	IP Routine Charges and OIP Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratio
All data in this section must be verified by the hospital. If already present in this section, it was completed using CMS cost report data. If the hospital has a more recent version of the report, the data should be updated to the hospital's version of the cost report. Formulas can be applied as needed to all data.									
		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Item & Resident Other ONLY)	Cost Report Worksheet C, Part I, Col. 2 and Col. 4	Swing-Bed Care Out - Cost Report Worksheet D-1, Part I, Line 26	Calculated	Days - Cost Report WGS D-1, Pt. I, Line 2 for Adults & Peds; WGS D-1, Pt. 2, Lines 42-47 for others	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Calculated Per Diem

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was compiled using CMS HCRB 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	\$ 111,309,904	\$ 17,896,107	\$ 518,893	\$0.00	\$ 129,634,904	94,785	\$73,419,513.00	\$ 1,367.67
2	03100 INTENSIVE CARE UNIT	\$ 11,639,621	\$ -	\$ -	\$ -	\$ 11,639,621	12,820	\$27,321,692.00	\$ 899.42
3	03200 CORONARY CARE UNIT	\$ 3,109,627	\$ -	\$ -	\$ -	\$ 3,109,627	1,639	\$2,293,496.00	\$ 1,699.66
4	03300 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$0.00	\$ -
5	04000 SURGICAL INTENSIVE CARE UNIT	\$ 6,009,847	\$ -	\$ -	\$ -	\$ 6,009,847	5,290	\$10,222,600.00	\$ 1,145.53
6	05000 OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$0.00	\$ -
7	06000 SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$0.00	\$ -
8	06100 SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$0.00	\$ -
9	06200 OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$0.00	\$ -
10	04300 NURSERY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$0.00	\$ -
11	1301 PEDIATRIC INTENSIVE CARE UNIT	\$ 9,541,190	\$ -	\$ -	\$ -	\$ 9,541,190	3,099	\$11,487,891.00	\$ 3,079.79
12	1401 TRAUMA INTENSIVE CARE UNIT	\$ 9,943,029	\$ -	\$ -	\$ -	\$ 9,943,029	3,157	\$10,852,253.00	\$ 1,882.49
13	1402 NEONATAL INTENSIVE CARE UNIT	\$ 16,377,435	\$ 493,892	\$ -	\$ -	\$ 16,871,297	10,955	\$38,670,455.00	\$ 1,997.47
14		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$0.00	\$ -
15		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$0.00	\$ -
16		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$0.00	\$ -
17		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$0.00	\$ -
18	Total Routine	\$ 163,870,549	\$ 18,289,969	\$ 518,893	\$ -	\$ 182,679,411	131,344	\$ 174,967,782	\$ -
19	Weighted Average								\$ 1,990.85

Observation Data (Non-Distinct)

09200	Observation (Non-Distinct)	10,887	.	.	\$ 14,889,823	\$796,296.00	\$8,494,242.00	\$ 9,200,538	1.618364
-------	----------------------------	--------	---	---	---------------	--------------	----------------	--------------	----------

Ancillary Cost Centers (from WIS C excluding Observation) (list below):

5200	OPERATING ROOM	\$76,962,835.00	\$ 6,774,062	\$209,831.00	\$ -	\$83,946,728	\$76,532,982.00	\$95,680,432.00	\$ 171,213,414	0.490305
5300	DELIVERY ROOM & LABOR ROOM	\$6,291,151.00	\$ 2,032,218	\$80,240.00	\$ -	\$8,403,609	\$6,461,766.00	\$444,260.00	\$ 6,906,026	1.213338
5300	ANESTHESIOLOGY	\$3,098,847.00	\$ 4,394,736	\$25,798.00	\$ -	\$7,519,381	\$28,326,959.00	\$29,367,448.00	\$ 66,694,307	0.130923
5400	RADIOLOGY-DIAGNOSTIC	\$26,116,623.00	\$ 1,935,446	\$58,729.00	\$ -	\$28,110,798	\$58,238,773.00	\$66,138,116.00	\$ 124,397,487	0.229193
5500	RADIOLOGY-THERAPEUTIC	\$9,556,871.00	\$ -	\$6,107.00	\$ -	\$9,563,028	\$1,377,573.00	\$48,569,555.00	\$ 49,942,128	0.171416
5600	RADIOLOGY-OTOLARYNGIC	\$2,802,184.00	\$ -	\$0.00	\$ -	\$2,802,184	\$1,704,040.00	\$26,259,763.00	\$ 27,963,803	0.100208
5700	CT SCAN	\$2,987,096.00	\$ -	\$0.00	\$ -	\$2,987,096	\$37,772,831.00	\$69,201,075.00	\$ 106,973,906	0.027029
5800	MRI	\$3,006,699.00	\$ -	\$0.00	\$ -	\$3,006,699	\$12,639,291.00	\$40,019,827.00	\$ 52,659,118	0.058174
5900	CARDIAC CATHETERIZATION	\$7,524,772.00	\$ -	\$0.00	\$ -	\$7,524,772	\$32,813,299.00	\$29,189,534.00	\$ 62,103,233	0.121166
6000	LABORATORY	\$33,258,666.00	\$ 1,964,496	\$19,710.00	\$ -	\$35,242,872	\$168,172,847.00	\$120,241,017.00	\$ 297,513,884	0.113430
6200	WHOLE BLOOD & PACKED RED BLOOD CELL	\$7,493,705.00	\$ -	\$0.00	\$ -	\$7,493,705	\$11,848,003.00	\$3,117,807.00	\$ 15,260,940	0.484982
6500	RESPIRATORY THERAPY	\$14,610,298.00	\$ -	\$0.00	\$ -	\$14,610,298	\$76,265,282.00	\$7,861,070.00	\$ 86,126,352	0.169637
6600	PHYSICAL THERAPY	\$5,117,845.00	\$ -	\$0.00	\$ -	\$5,117,845	\$7,103,820.00	\$8,902,709.00	\$ 16,006,529	0.332217
6700	OCCUPATIONAL THERAPY	\$3,135,837.00	\$ -	\$0.00	\$ -	\$3,135,837	\$4,038,068.00	\$3,878,104.00	\$ 7,916,172	0.396130
6800	SPEECH PATHOLOGY	\$1,380,991.00	\$ -	\$0.00	\$ -	\$1,380,991	\$2,889,872.00	\$2,060,323.00	\$ 4,950,195	0.278977
6900	ELECTROCARDIOLOGY	\$17,328,934.00	\$67,723	\$0.00	\$ -	\$17,396,657	\$18,627,430.00	\$49,389,749.00	\$ 67,813,704	0.260368
7000	ELECTROENCEPHALOGRAPHY	\$2,696,109.00	\$ -	\$0.00	\$ -	\$2,696,109	\$9,486,967.00	\$13,658,157.00	\$ 23,146,724	0.112591
7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$15,684,916.00	\$ -	\$0.00	\$ -	\$15,684,916	\$115,060,443.00	\$47,156,644.00	\$ 162,205,887	0.097931
7200	IMPL. DEV. CHARGED TO PATIENTS	\$45,796,883.00	\$ -	\$0.00	\$ -	\$45,796,883	\$111,073,038.00	\$99,367,056.00	\$ 205,450,944	0.212786
7300	DRUGS CHARGED TO PATIENTS	\$77,218,175.00	\$ -	\$0.00	\$ -	\$77,218,175	\$200,314,810.00	\$290,496,871.00	\$ 490,771,681	0.157349
7400	RENAL DIALYSIS	\$3,246,466.00	\$ -	\$0.00	\$ -	\$3,246,466	\$3,279,932.00	\$243,272.00	\$ 3,523,694	0.095922
9000	CLINIC	\$62,299,798.00	\$ 2,322,536	\$26,251.00	\$ -	\$64,648,496	\$2,501,142.00	\$114,327,209.00	\$ 116,828,351	0.553021
9100	EMERGENCY	\$29,298,884.00	\$ 3,967,669	\$218,717.00	\$ -	\$33,485,266	\$30,162,398.00	\$81,696,160.00	\$ 111,848,564	0.299581
10000	XRAY ACQUISITION	\$7,092,922.00	\$ -	\$0.00	\$ -	\$7,092,922	\$ -	\$0.00	\$ -	\$ -
10900	PANCREAS ACQUISITION	\$104,623.00	\$ -	\$0.00	\$ -	\$104,623	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$0.00	\$ -	\$ -
		\$0.00	\$ -	\$						

Cost Report Year (07/01/2017-06/30/2018)	MEDICAL COLLEGE OF GA HOSP & CLINCS
--	-------------------------------------

Percent of cross-over days to total Medicare days from the cost report

Note A - These amounts must agree to your inpatient and outpatient Medicare paid claims summary. For Managed Care, Cross-over day, and other eligibles, use the hospital's logs if PSAR summaries are not available (submit logs with survey).
Note B - Medicare cost settlement payments refer to payments made by Medicare during a cost report settlement that are not reflected on the claims paid summary (PA summary or PSAR).
Note C - Other Medicare Payments such as Outliers and Non-Cover-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 - Medicare Managed Care payments should include all Medicare Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

I. Out-of-State Medicaid Data:

Cost Report Year 07/01/2017-06/30/2018 MEDICAL COLLEGE OF GA HOSP & CLINICS

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FPS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicaid PPS Cross-Over (with Medicaid Secondary)		Out-of-State Medicaid Eligible (Not Included) (Excludes)		Total Out-Of-State Medicaid			
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient		
					From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
Routine Cost Centers (Net below):					Days										Days	
03000	ADULT & PEDIATRICS	\$	1,907.87		1,797		2,361		2,096		649		6,863			
03000	INTENSIVE CARE UNIT	\$	899.42		435		281		367		29		1,112			
03000	CORONARY CARE UNIT	\$	1,899.06		11		21		49		81		1,112			
03000	BURN INTENSIVE CARE UNIT	\$	-		-		-		-		-		-			
03000	SURGICAL INTENSIVE CARE UNIT	\$	1,146.53		-		92		192		18		262			
03000	OTHER SPECIAL CARE UNIT	\$	-		-		-		-		-		-			
04000	SUBPROVIDER I	\$	-		-		-		-		-		-			
04000	SUBPROVIDER II	\$	-		-		-		-		-		-			
04000	OTHER SUBPROVIDER	\$	-		-		-		-		-		-			
04000	NURSERY	\$	-		-		-		-		-		-			
3101	PEDIATRIC INTENSIVE CARE UNIT	\$	3,079.79		-		271		271		70		341			
3401	TRAUMA INTENSIVE CARE UNIT	\$	1,699.47		-		-		-		-		-			
3402	NEONATAL INTENSIVE CARE UNIT	\$	1,699.47		711		896		29		438		2,035			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			
		\$	-		-		-		-		-		-			

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

Cost Report Year: 07/01/2017-06/30/2018

MEDICAL COLLEGE OF GAYHOP & CLINICS

	Total			Revenue for Medicaid Cases Over / Uninsured Organs Sold	Total Medicaid Organs (Count)	In-State Medicaid Facility Revenue		Out-of-State Medicaid Facility Revenue		In-State Medicaid Facility Revenue		Out-of-State Medicaid Facility Revenue		Uninsured	
	Organ Acquisition Cost	Additional Add-In Intermittent Cost	Total Adjusted Organ Acquisition Cost			Charges	Usuable Organs (Count)	Charges	Usuable Organs (Count)	Charges	Usuable Organs (Count)	Charges	Usuable Organs (Count)	Charges	Usuable Organs (Count)
	Cost Report Worksheet D-4, Pt. II, Col. 1, L4-E1	Add-On Cost Factor on Section G, Line 123 & Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report B05 D-4 Pt. II, Col. 1, L4-E1 Substitute Medians with Medicaid Cases Over & Uninsured: See Note C below	Cost Report Worksheet D-4, Pt. II, Line B2	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 Hospital's Cost Internal Analysis	From Hospital's Cost Internal Analysis
1	Liver Acquisition	\$0.00	\$		0										
2	Kidney Acquisition	\$9,201,200.00	\$	\$1,045	0	\$	491,305		2			\$	1,375,927	14	
3	Liver Acquisition	\$0.00	\$		0										
4	Heart Acquisition	\$0.00	\$		0										
5	Pancreas Acquisition	\$105,975.00	\$	7,121	0										
6	Intestine Acquisition	\$0.00	\$		0										
7	Small Intestine Acquisition	\$0.00	\$		0										
8	Small Intestine Acquisition	\$0.00	\$		0										
9	Totals	\$	\$,005,213	\$	\$78,805	\$	9,227,178	\$	99	\$	491,305	\$	1,375,927	\$	139,185
10	Total Cost						100,000						1,336,242		\$0,445

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

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

Cost Report Year: 07/01/2017-06/30/2018

MEDICAL COLLEGE OF GAYHOP & CLINICS

	Total			Revenue for Medicaid Cases Over / Uninsured Organs Sold	Total Medicaid Organs (Count)	Out-of-State Medicaid Facility Revenue		Out-of-State Medicaid Facility Revenue		Out-of-State Medicaid Facility Revenue		Out-of-State Medicaid Facility Revenue		Uninsured	
	Organ Acquisition Cost	Additional Add-In Intermittent Cost	Total Adjusted Organ Acquisition Cost			Charges	Usuable Organs (Count)	Charges	Usuable Organs (Count)	Charges	Usuable Organs (Count)	Charges	Usuable Organs (Count)	Charges	Usuable Organs (Count)
	Cost Report Worksheet D-4, Pt. II, Col. 1, L4-E1	Add-On Cost Factor on Section G, Line 123 & Total Cost Report Organ Acquisition Cost and the Add-On Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report B05 D-4 Pt. II, Col. 1, L4-E1 Substitute Medians with Medicaid Cases Over & Uninsured: See Note C below	Cost Report Worksheet D-4, Pt. II, Line B2	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 Hospital's Cost Internal Analysis	From Hospital's Cost Internal Analysis
1	Liver Acquisition	\$	\$		0										
2	Kidney Acquisition	\$	\$,201,200	\$	\$1,045		0					\$	754,927	7	\$
3	Liver Acquisition	\$			0										
4	Heart Acquisition	\$			0										
5	Pancreas Acquisition	\$	105,975	\$	7,121		0								
6	Intestine Acquisition	\$			0										
7	Small Intestine Acquisition	\$			0										
8	Small Intestine Acquisition	\$			0										
9	Totals	\$	\$,005,213	\$	\$78,805	\$	9,227,178	\$	99	\$	491,305	\$	754,927	\$	139,185
10	Total Cost												689,151		\$0,445

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 Out-of-State Medicaid total payments.

Total
0
0
0
0
0
0
0
0

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 (07/01/2017-06/30/2018)

MEDICAL COLLEGE OF GA HOSP & CLINICS

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*		
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		(WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		(Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
8 Reason for adjustment		(Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
12 Reason for adjustment		
13 Reason for adjustment		
14 Reason for adjustment		
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ -	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:	
18 Medicaid Hospital Charges Sec. G	792,764,878
19 Uninsured Hospital Charges Sec. G	181,701,430
20 Total Hospital Charges Sec. G	2,452,460,373
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	32.33%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	7.41%
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.