

Medicaid DSH Survey

Attached is the 2017 Medicaid DSH Survey

A. General DSH Year Information

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

| | | | |
|--------------------------|------------|-----|------------|
| Begin | 07/01/2016 | End | 06/30/2017 |
| LASPER MEMORIAL HOSPITAL | | | |

Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1
4. Cost Report Year 2 (if applicable)
5. Cost Report Year 3 (if applicable)

| | |
|---------------|-------------|
| Cost Report | Cost Report |
| Begin Date(s) | End Date(s) |
| 10/01/2016 | 09/30/2017 |

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART 1 FILES

6. Medicaid Provider Number:
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
9. Medicare Provider Number:

| | |
|------|------------|
| Data | 000000998A |
| | 0 |
| | 0 |
| | 11303 |

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

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 non-emergency obstetric procedures.)
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

3a. Was the hospital open as of December 22, 1987?

3b. What date did the hospital open?

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have 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 non-emergency obstetric procedures.)

List the names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

| |
|--|
| |
| |

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
6. Is 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?

| | |
|----------------------|--------------------------|
| DSH Examination Year | 07/01/16 - 06/30/17 |
| No | <input type="checkbox"/> |
| Yes | <input type="checkbox"/> |

| | |
|------------|--------------------------|
| No | <input type="checkbox"/> |
| Yes | <input type="checkbox"/> |
| 12/20/1951 | <input type="checkbox"/> |

| | |
|------------------|--------------------------|
| DSH Payment Year | 07/01/16 - 06/30/19 |
| No | <input type="checkbox"/> |

| | |
|-----|--------------------------|
| No | <input type="checkbox"/> |
| Yes | <input type="checkbox"/> |

1. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017
(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

\$ 21,220

Certification:

Answer:
Yes

1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Retaining the federal share with an IGTCPE 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.

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 payment provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Hospital CEO or CFO Signature

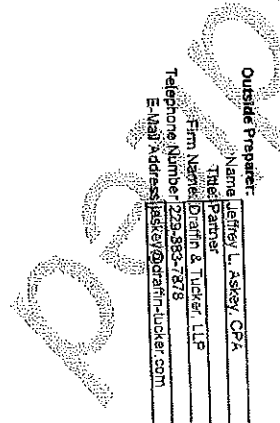
Stuart Abrey

CFO Title
706-468-4380
Hospital CEO or CFO Telephone Number
stuart@jaspememorial.com
Hospital CEO or CFO E-Mail

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

Hospital Contact:
Name: Stuart Abrey
Title: Controller
Telephone Number: 706-468-4380
E-Mail Address: stuart@jaspememorial.com
Mailing Street Address: 898 College St
Mailing City, State, Zip: Monticello, GA 31064

Outside Preparer:
Name: Jeffrey L. Askey, CPA
Title: Partner
Firm Name: Draffin & Tucker, LLP
Telephone Number: 229-383-7878
E-Mail Address: jaskey@draffin-tucker.com



1. **General Cost Report Year Information**
 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.

10/1/2016 through 9/30/2017

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

JASPER MEMORIAL HOSPITAL

10/1/2016 through 9/30/2017

1 - Yes Submitted

3/23/2018

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

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

3a. Date CMS Processed the HCRRIS file into the HCRRIS database:

| 1 - Yes Submitted | Date | Correct? | If Incorrect, Proper Information |
|-------------------|--------------------------|----------|----------------------------------|
| | JASPER MEMORIAL HOSPITAL | Yes | |
| | 0000009986A | Yes | |
| | 0 | Yes | |
| | 11303 | Yes | |
| | Non-State Govt | Yes | |
| | Small Rural | Yes | |

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
 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)

3. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2016 - 09/30/2017)

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) | \$ - | \$ 27,926 | \$27,926 |
| 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B) | \$ 6,287 | \$ 197,910 | \$204,197 |
| 11. Total Cash Basis Patient Payments Reported on Exhibit B, less physician and non-hospital portion of payments | \$5,287 | \$225,836 | \$232,123 |
| 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments: | 0.00% | 12.87% | 12.03% |

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 | \$ - |

one 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.

one 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.

MUR / LUR Qualifying Data from the Cost Report (10/01/2016 - 09/30/2017)

F.1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MUR)
 1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S.S., P.L. Col. & Sum of Lns. 14, 16, 17, 18, 20-18, 20, 30, 31 less lines 4 & 6) 137 (See Note in Section F-2, below)

F.2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-income Utilization Ratio (LUR) Calculations):

| | |
|---|---------|
| 2. Inpatient Hospital Subsidies | |
| 3. Outpatient Hospital Subsidies | |
| 4. Unspecified I/P and O/P Hospital Subsidies | \$ |
| 5. Non-Hospital Subsidies | 26,982 |
| 6. Total Hospital Subsidies | 267,585 |
| 7. Inpatient Hospital Charity Care Charges | |
| 8. Outpatient Hospital Charity Care Charges | 294,577 |
| 9. Non-Hospital Charity Care Charges | |
| 10. Total Charity Care Charges | |

F.3. Calculation of Net Hospital Revenue from Patient Services (Used for LUR) (W/S Section G-3, and 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 HCRRIS 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.

| | Inpatient Hospital | Outpatient Hospital | Non-Hospital | Inpatient Hospital | Outpatient Hospital | Non-Hospital | Net Hospital Revenue |
|---|--------------------|---------------------|----------------|--------------------|---------------------|--------------|----------------------|
| 11. Hospital | \$69,981.00 | | | \$ 18,665 | | | \$ 51,316 |
| 12. Subprovider I (Psych or Rehab) | \$0.00 | | | \$ - | | | \$ - |
| 13. Subprovider II (Psych or Rehab) | \$0.00 | | | \$ - | | | \$ - |
| 14. Swing Bed - SNF | | | \$3,823,433.99 | \$ - | | | \$ 105,083 |
| 15. Swing Bed - NF | | | \$0.00 | \$ - | | | \$ 1,019,149 |
| 16. Skilled Nursing Facility | | \$4,948,469.00 | \$0.00 | \$ - | | | \$ - |
| 17. Nursing Facility | \$1,375,145.00 | \$2,453,510.00 | \$0.00 | \$ 367,832 | \$ 1,320,076 | | \$ 4,640,707 |
| 18. Other Long-Term Care | | | \$0.00 | \$ - | \$ 834,483 | | \$ 1,799,427 |
| 19. Ancillary Services | | | \$0.00 | \$ - | | | \$ - |
| 20. Outpatient Services | | \$0.00 | \$0.00 | \$ - | | | \$ - |
| 21. Home Health Agency | | | \$0.00 | \$ - | | | \$ - |
| 22. Ambulance | | \$0.00 | \$0.00 | \$ - | | | \$ - |
| 23. Outpatient Rehab Providers | | \$0.00 | \$0.00 | \$ - | | | \$ - |
| 24. ASC | | \$0.00 | \$0.00 | \$ - | | | \$ - |
| 25. Hospice | | \$0.00 | \$0.00 | \$ - | | | \$ - |
| 26. Other | | | | \$ - | | | \$ - |
| 27. Total | \$ 1,449,126 | \$ 7,403,379 | \$ 4,217,431 | \$ 366,467 | \$ 1,974,558 | \$ 1,124,833 | \$ 6,481,450 |
| 28. Total Hospital and Non Hospital | | | \$ 13,059,936 | | | | |
| 29. Total Per Cost Report | | | | | | | |
| 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 W/MS-OTIS 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 an increase in net patient revenue) | | | | | | | |
| 33. 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) | | | | | | | |
| 34. Blank Reason 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 | | | | | | | |

| | |
|-------------------------------------|------------|
| Total Patient Revenues (G-3 Line 1) | 13,059,936 |
| Total Contractual Adj. (G-3 Line 2) | 3,485,888 |
| | 3,485,888 |

G. Cost Report - Cost / Days / Charges

JASPER MEMORIAL HOSPITAL

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 HCRRIS 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 | J/P Days and J/P Ancillary Charges | J/P Routine Charges and D/P Ancillary Charges | Total Charges | Medical Per Diem / Cost of Other Rates |
|--------|------------------------------------|----------------------|--|--|-----------------|------------------------------------|---|---------------|--|
| 1 | 03000 ADULTS & PEDIATRICS | \$ 1,271,808 | | | \$ 1,031,988.00 | 237 | \$435,899.00 | \$ 1,071.90 | |
| 2 | 03100 INTENSIVE CARE UNIT | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 3 | 03200 CORONARY CARE UNIT | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 4 | 03300 BURN INTENSIVE CARE UNIT | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 5 | 03400 SURGICAL INTENSIVE CARE UNIT | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 6 | 03500 OTHER SPECIAL CARE UNIT | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 7 | 04000 SUBPROVIDER I | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 8 | 04100 SUBPROVIDER II | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 9 | 04200 OTHER SUBPROVIDER | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 10 | 04300 NURSERY | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 11 | | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 12 | | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 13 | | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 14 | | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 15 | | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 16 | | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 17 | | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 18 | | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 19 | | \$ - | | | \$ - | | \$0.00 | \$ - | |
| 20 | | \$ - | | | \$ - | | \$0.00 | \$ - | |
| | Total Routine | \$ 1,271,808 | \$ - | \$ - | \$ 1,031,988 | 237 | \$435,899 | \$ 1,071.90 | |
| | Weighted Average | | | | | | | | |

| Observation Date (Non-Distinct) | Observation (Non-Distinct) | Hospital Observation Days - Cost Report W/S - 3. Pt. 1, Line 28. Col. 6 | Subprovider I Observation Days - Cost Report W/S - 3. Pt. 1, Line 28.01. Col. 8 | Subprovider II Observation Days - Cost Report W/S - 3. Pt. 1, Line 28.02. Col. 8 | Calculated Days Above Multiplied by Day(s) | Inpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 5 | Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7 | Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8 | Medical Calculated Cost-to-Charge Ratio |
|---------------------------------|----------------------------|---|---|--|--|--|---|--|---|
| 09/20/00 | Observation | 100 | - | - | 101.190 | \$19,380.00 | \$44,150.00 | \$ 63,530 | 1.592791 |

| Line # | Cost Center Description | Total Allowable Cost | Intern & Resident Costs Removed on Cost Report | RCE and Therapy Add-Back (if Applicable) | Total Cost | J/P Days and J/P Ancillary Charges | J/P Routine Charges and D/P Ancillary Charges | Total Charges | Medical Per Diem / Cost of Other Rates |
|--------|------------------------------------|----------------------|--|--|--------------|------------------------------------|---|---------------|--|
| 21 | 04000 ADULTS & PEDIATRICS | \$431,191.00 | | | \$431,191.00 | 237 | \$173,415.00 | \$ 685.540 | 0.619937 |
| 22 | 04100 INTENSIVE CARE UNIT | \$254,320.00 | | | \$254,320.00 | | \$1,190,522.00 | \$ 1,231.860 | 0.2066435 |
| 23 | 04200 CORONARY CARE UNIT | \$3,628.00 | | | \$3,628.00 | | \$8,986.00 | \$ 8.986 | 0.406171 |
| 24 | 04300 BURN INTENSIVE CARE UNIT | \$690,717.00 | | | \$690,717.00 | | \$1,614,231.00 | \$ 1,785.073 | 0.396940 |
| 25 | 04400 SURGICAL INTENSIVE CARE UNIT | \$50,382.00 | | | \$50,382.00 | | \$21,156.00 | \$ 53.053 | 0.949475 |
| 26 | 04500 OTHER SPECIAL CARE UNIT | \$441,649.00 | | | \$441,649.00 | | \$615,480.00 | \$ 718.288 | 0.451451 |
| 27 | 04600 SUBPROVIDER I | \$382,908.00 | | | \$382,908.00 | | \$114,876.00 | \$ 251.405 | 0.231456 |
| 28 | 04700 SUBPROVIDER II | \$136,538.00 | | | \$136,538.00 | | \$415,386.00 | \$ 1,033.231 | 0.478359 |
| 29 | 04800 OTHER SUBPROVIDER | \$67,843.00 | | | \$67,843.00 | | \$58,282.00 | \$ 80.216 | 0.697472 |
| 30 | 04900 NURSERY | \$523,727.00 | | | \$523,727.00 | | \$58,282.00 | \$ 80.216 | 0.697472 |

G. Cost Report - Cost / Days / Charges

Cost Report for 10/01/2015-09/30/2017 JASPER MEMORIAL HOSPITAL

| 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 C/P Ancillary Charges | Total Charges | Medical Per Diem / Cost of Other Ratios |
|--------|-------------------------|----------------------|--|--|------------|------------------------------------|---|---------------|---|
| 30 | 9100 EMERGENCY | \$1,385,981.00 | \$ | \$0.00 | \$ | \$802.00 | \$1,343,932.00 | \$ | 1.030595 |
| 31 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 32 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 33 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 34 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 35 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 36 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 37 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 38 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 39 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 40 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 41 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 42 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 43 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 44 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 45 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 46 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 47 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 48 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 49 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 50 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 51 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 52 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 53 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 54 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 55 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 56 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 57 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 58 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 59 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 60 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 61 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 62 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 63 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 64 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 65 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 66 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 67 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 68 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 69 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 70 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 71 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 72 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 73 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 74 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 75 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 76 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 77 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 78 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 79 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 80 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 81 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 82 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 83 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 84 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 85 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 86 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 87 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 88 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 89 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |

G. Cost Report - Cost / Days / Charges

JASPER MEMORIAL HOSPITAL

| 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 I/P Ancillary Charges | Total Charges | Medicaid Per Diem / Cost or Other Rates |
|--------|-------------------------|----------------------|--|--|------------|------------------------------------|---|---------------|---|
| 30 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 31 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 32 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 33 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 34 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 35 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 36 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 37 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 38 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 39 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 40 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 41 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 42 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 43 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 44 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 45 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 46 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 47 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 48 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 49 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 50 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 51 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 52 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 53 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 54 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 55 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 56 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 57 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 58 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 59 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 60 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 61 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 62 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 63 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 64 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 65 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 66 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 67 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 68 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 69 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 70 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 71 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 72 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 73 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 74 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 75 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 76 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 77 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 78 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 79 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 80 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 81 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 82 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 83 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 84 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 85 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 86 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 87 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 88 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 89 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 90 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 91 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 92 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 93 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 94 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 95 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 96 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 97 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 98 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 99 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 100 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 101 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 102 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 103 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 104 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 105 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 106 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 107 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 108 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 109 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 110 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 111 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 112 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 113 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 114 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 115 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 116 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 117 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 118 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 119 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 120 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 121 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 122 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 123 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 124 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 125 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 126 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 127 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 128 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 129 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 130 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 131 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 131.01 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 132 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |
| 133 | | \$0.00 | \$ | \$0.00 | \$ | \$0.00 | \$0.00 | \$ | |

Sub Totals \$ 5,610,797 \$ - \$ - \$ 5,610,797

Weighted Average \$ 4,338,989 \$ - \$ - \$ 4,338,989

Total Ancillary \$ 4,338,989 \$ - \$ - \$ 4,338,989

Total Charges \$ 7,941,728

Medicaid Per Diem / Cost or Other Rates 0.591554

* 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.

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: (10/01/2015-09/30/2017) JASPER MEMORIAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

- 1 Hospital Gross Provider Tax Assessment (from general ledger)
- 2 Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment
- 3 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (WIS A, Col. 2)
- 4 Difference (Explain Here ->)

Jasper Memorial is at OCH and exempt from the provider tax program.

| Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report) | Dollar Amount | WISA Cost Center Line | (WTR Account #) (Where is the cost included on w/s A?) |
|--|---------------|-----------------------|---|
| 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) | Dollar Amount | WISA Cost Center Line | (Adjusted to / (from)) |
|--|---------------|-----------------------|------------------------|
| 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) | Dollar Amount | WISA Cost Center Line | (Adjusted to / (from)) |
|--|---------------|-----------------------|------------------------|
| 12 Reason for adjustment | | | (Adjusted to / (from)) |
| 13 Reason for adjustment | | | (Adjusted to / (from)) |
| 14 Reason for adjustment | | | (Adjusted to / (from)) |
| 15 Reason for adjustment | | | (Adjusted to / (from)) |

| DSH UCC Provider Tax Assessment Adjustment: | Dollar Amount | WISA Cost Center Line | (Adjusted to / (from)) |
|--|---------------|-----------------------|------------------------|
| 16 Total Net Provider Tax Assessment Expense Included in the Cost Report | | | (Adjusted to / (from)) |
| 17 Gross Allowable Assessment Not Included in the Cost Report | | | (Adjusted to / (from)) |

* Assessment must exclude any non-hospital assessment such as Nursing Facility