

**A. General DSH Year Information**

1. DSH Year: 

Begin	End
07/01/2018	06/30/2019

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	10/01/2018	09/30/2019
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:	000000998A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	111303

**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:**

- |   |   |   |    |    |     |     |            |
|---|---|---|----|----|-----|-----|------------|
| <p>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.)</p> <p>2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?</p> <p>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?</p> <p>3a. Was the hospital open as of December 22, 1987?</p> <p>3b. What date did the hospital open?</p> | <table border="1" style="background-color: #cccccc; text-align: center; width: 100px;"> <tr> <td><b>DSH Examination Year (07/01/18 - 06/30/19)</b></td> </tr> <tr> <td>No</td> </tr> <tr> <td>No</td> </tr> <tr> <td>Yes</td> </tr> <tr> <td>Yes</td> </tr> <tr> <td>12/30/1951</td> </tr> </table> | <b>DSH Examination Year (07/01/18 - 06/30/19)</b> | No | No | Yes | Yes | 12/30/1951 |
| <b>DSH Examination Year (07/01/18 - 06/30/19)</b>   |   |   |    |    |     |     |            |
| No  |   |   |    |    |     |     |            |
| No  |   |   |    |    |     |     |            |
| Yes   |   |   |    |    |     |     |            |
| Yes   |   |   |    |    |     |     |            |
| 12/30/1951  |   |   |    |    |     |     |            |

**C. Disclosure of Other Medicaid Payments Received:**

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** \$ 9,052  
 (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2018 - 06/30/2019** [ ]  
 (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.  
 NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2018 - 06/30/2019** \$ 9,052

**Certification:**

1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?** Answer [ ]  
 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.

Explanation for "No" answers:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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

  
 Hospital CEO or CFO Signature  
 \_\_\_\_\_  
 Stuart Abney  
 Hospital CEO or CFO Printed Name

Controller  
 Title  
 \_\_\_\_\_  
 706-468-4580  
 Hospital CEO or CFO Telephone Number

10-28-2020  
 Date  
 \_\_\_\_\_  
 stuart@jaspermemorial.com  
 Hospital CEO or CFO E-Mail

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

Hospital Contact:	
Name	Stuart Abney
Title	Controller
Telephone Number	706-468-4580
E-Mail Address	stuart@jaspermemorial.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	229-883-7878
E-Mail Address	jaskey@draffin-tucker.com

**D. General Cost Report Year Information** 10/1/2018 - 9/30/2019

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"):  

10/1/2018 through 9/30/2019		
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: JASPER MEMORIAL HOSPITAL	Yes	
5. Medicaid Provider Number: 000000998A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab): 0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab): 0	Yes	
8. Medicare Provider Number: 111303	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal): Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban): Small Rural	Yes	

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

State Name	Provider No.

(List additional states on a separate attachment)

**E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2018 - 09/30/2019)**

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)	\$ -	\$ 17,715	\$17,715
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 128	\$ 172,294	\$172,422
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)	\$128	\$190,009	\$190,137
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.00%	9.32%	9.32%

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

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

16. Total Medicaid managed care non-claims payments (see question 13 above) received

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

**F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2018 - 09/30/2019)**

**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)

14 (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

	14,941
	158,030
\$	172,971

**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)			
11. Hospital	\$594,323.00			\$ 144,575	\$ -	\$ -	\$ 449,748
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			\$4,252,602.00			\$ 1,034,486	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$1,460,750.00	\$4,988,240.00		\$ 355,341	\$ 1,213,437	\$ -	\$ 4,880,211
20. Outpatient Services		\$2,730,959.00			\$ 664,332	\$ -	\$ 2,066,627
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00			\$ -	
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$0.00			\$ -	
26. Other	\$0.00	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
27. Total	\$ 2,055,073	\$ 7,719,199	\$ 4,252,602	\$ 499,916	\$ 1,877,769	\$ 1,034,486	\$ 7,396,586

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	14,026,874	Total Contractual Adj. (G-3 Line 2)	3,034,267
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)				377,905
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				3,412,172
36. Unreconciled Difference	Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (10/01/2018-09/30/2019) 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 O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26	Calculated	Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Calculated Per Diem

**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	\$ 1,173,579	\$ -	\$ -	\$ 1,131,297.00	\$ 42,282	48	\$ 472,562.00	\$ 880.88
2	03100	INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
10	04300	NURSERY	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
18		Total Routine	\$ 1,173,579	\$ -	\$ -	\$ 1,131,297	\$ 42,282	48	\$ 472,562	\$ 880.88
19		Weighted Average								\$ 880.88

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio	
20	09200	Observation (Non-Distinct)	34	-	\$ 29,950	\$ 7,761.00	\$ 98,698.00	\$ 106,459	0.281329

Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
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**Ancillary Cost Centers (from W/S C excluding Observation) (list below)**

21	5400	RADIOLOGY-DIAGNOSTIC	\$607,943.00	\$ -	\$ 0.00	\$ 607,943	\$54,531.00	\$552,997.00	\$ 607,528	1.000683
22	5700	CT SCAN	\$31,299.00	\$ -	\$ 0.00	\$ 31,299	\$29,336.00	\$1,289,663.00	\$ 1,318,999	0.023729
23	6000	LABORATORY	\$901,303.00	\$ -	\$ 0.00	\$ 901,303	\$151,818.00	\$1,796,074.00	\$ 1,947,892	0.462707
24	6500	RESPIRATORY THERAPY	\$43,509.00	\$ -	\$ 0.00	\$ 43,509	\$16,558.00	\$17,268.00	\$ 33,826	1.286259
25	6600	PHYSICAL THERAPY	\$603,685.00	\$ -	\$ 0.00	\$ 603,685	\$503,002.00	\$707,283.00	\$ 1,210,285	0.498796
26	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$66,544.00	\$ -	\$ 0.00	\$ 66,544	\$128,317.00	\$85,234.00	\$ 213,551	0.311607
27	7300	DRUGS CHARGED TO PATIENTS	\$466,544.00	\$ -	\$ 0.00	\$ 466,544	\$628,257.00	\$559,899.00	\$ 1,188,156	0.392662
28	9000	CLINIC	\$638,371.00	\$ -	\$ 0.00	\$ 638,371	\$1,375.00	\$155,484.00	\$ 156,859	4.069712
29	9100	EMERGENCY	\$1,689,205.00	\$ -	\$ 0.00	\$ 1,689,205	\$51,379.00	\$1,425,622.00	\$ 1,477,001	1.143672

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (10/01/2018-09/30/2019) 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 O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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	\$ -	-

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (10/01/2018-09/30/2019) 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 O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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	<b>Total Ancillary</b>	\$ 5,048,403	\$ -	\$ -	\$ 5,048,403	\$ 1,572,334	\$ 6,688,222	\$ 8,260,556	
127	<b>Weighted Average</b>								0.614771
128	<b>Sub Totals</b>	\$ 6,221,982	\$ -	\$ -	\$ 5,090,685	\$ 2,044,896	\$ 6,688,222	\$ 8,733,118	
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)				\$401,529.00				
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	<b>Grand Total</b>				\$ 4,689,156				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				0.00%				

\* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using



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

Cost Report Year (10/01/2018-09/30/2019) JASPER MEMORIAL HOSPITAL

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-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
				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			
<b>Routine Cost Centers (from Section G):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		
1	03000 ADULTS & PEDIATRICS	\$ 880.88			4							2		4		42.86%
2	03100 INTENSIVE CARE UNIT	\$ -														
3	03200 CORONARY CARE UNIT	\$ -														
4	03300 BURN INTENSIVE CARE UNIT	\$ -														
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -														
6	03500 OTHER SPECIAL CARE UNIT	\$ -														
7	04000 SUBPROVIDER I	\$ -														
8	04100 SUBPROVIDER II	\$ -														
9	04200 OTHER SUBPROVIDER	\$ -														
10	04300 NURSERY	\$ -														
11		\$ -														
12		\$ -														
13		\$ -														
14		\$ -														
15		\$ -														
16		\$ -														
17		\$ -														
18					4							2		4		12.50%
19	Total Days per PS&R or Exhibit Detail				4							2		4		
20	Unreconciled Days (Explain Variance)															
21	Routine Charges	\$ 1,464										\$ 732		\$ 1,464		0.46%
21.01	Calculated Routine Charge Per Diem	\$ 366.00										\$ 366.00		\$ 366.00		
<b>Ancillary Cost Centers (from W/S C) (from Section G):</b>				<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	
22	09200 Observation (Non-Distinct)		0.281329		-	675			4,469			1,027			5,144	5.80%
23	5400 RADIOLOGY-DIAGNOSTIC		1,00663		-	19,466		64,016	49,624		9,774	-	61,401		142,879	33.62%
24	5700 CT SCAN		0.023729		-	31,431		99,975	100,196		15,612	-	223,234		247,213	35.07%
25	6000 LABORATORY		0.462707		1,803	96,649		106,897	134,661		132,383	682	181,781	1,603	470,589	33.81%
26	6500 RESPIRATORY THERAPY		1.286259		-	6,487		4,495	775		86	-	2,434		11,843	42.21%
27	6600 PHYSICAL THERAPY		0.498796		-	1,198		24,652	32,400		12,504	-	3,728		70,753	6.15%
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.311607		49	4,066		9,861	6,828		510	24	17,673	49	21,265	18.27%
29	7300 DRUGS CHARGED TO PATIENTS		0.392662		9,108	15,428		25,927	56,669		9,066	2,612	83,358	9,108	107,091	17.02%
30	9000 CLINIC		4.069712		-	-		-	9,849		3,391	-	2,364		13,240	9.95%
31	9100 EMERGENCY		1.143672		471	76,228		271,578	75,883		13,219	-	379,797	471	436,906	55.33%
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**H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:**

Cost Report Year (10/01/2018-09/30/2019) JASPER MEMORIAL HOSPITAL

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
61															
62															
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65															
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124															
125															
126															
127															
			\$ 11,231	\$ 251,625	\$ -	\$ 607,401	\$ -	\$ 471,354	\$ -	\$ 196,545	\$ 3,318	\$ 956,797			

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

Cost Report Year (10/01/2018-09/30/2019) JASPER MEMORIAL HOSPITAL

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
<b>Totals / Payments</b>													
128 <b>Total Charges (includes organ acquisition from Section J)</b>	\$ 12,695	\$ 251,625	\$ -	\$ 607,401	\$ -	\$ 471,354	\$ -	\$ 196,545	\$ 4,050	\$ 956,797	\$ 12,695	\$ 1,526,925	28.63%
									(Agrees to Exhibit A)	(Agrees to Exhibit A)			
129 Total Charges per PS&R or Exhibit Detail	\$ 12,695	\$ 251,625	\$ -	\$ 607,401	\$ -	\$ 471,354	\$ -	\$ 196,545	\$ 4,050	\$ 956,797			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 <b>Total Calculated Cost (includes organ acquisition from Section J)</b>	\$ 8,396	\$ 168,579	\$ -	\$ 457,821	\$ -	\$ 284,008	\$ -	\$ 110,391	\$ 3,110	\$ 638,353	\$ 8,396	\$ 1,020,799	35.63%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 5,392	\$ 125,655				\$ 30,024		\$ 4,109			\$ 5,392	\$ 159,788	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				\$ 316,381								\$ 316,381	
134 Private Insurance (including primary and third party liability)		\$ 217		\$ 6,773				\$ 17,883				\$ 24,873	
135 Self-Pay (including Co-Pay and Spend-Down)		\$ 588		\$ 474		\$ 465		\$ 19				\$ 1,546	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 5,392	\$ 126,460	\$ -	\$ 323,628									
137 Medicaid Cost Settlement Payments (See Note B)		\$ (203)										\$ (203)	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)													
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)						\$ 245,121		\$ 48,301				\$ 293,422	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								\$ 35,194				\$ 35,194	
141 Medicare Cross-Over Bad Debt Payments						\$ 8,862						\$ 8,862	
142 Other Medicare Cross-Over Payments (See Note D)						\$ (5,667)						\$ (5,667)	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ -	\$ 17,715			
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									\$ -	\$ -			
145 <b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 3,004	\$ 42,322	\$ -	\$ 134,193	\$ -	\$ 5,203	\$ -	\$ 4,885	\$ 3,110	\$ 620,638	\$ 3,004	\$ 186,603	
146 <b>Calculated Payments as a Percentage of Cost</b>	64%	75%	0%	71%	0%	98%	0%	96%	0%	3%	64%	82%	
147 <b>Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 &amp; 6)</b>						\$							
148 <b>Percent of cross-over days to total Medicare days from the cost report</b>						0%							

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).  
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).  
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.  
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).  
 Note E - Medicaid Managed Care payments should include Medicaid 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.**  
**NOTE: Outpatient uninsured payment rate is outside normal ranges, please verify this is correct.**