DSH Version 6.00 2/21/2020

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2018	06/30/2019

2. Select Your Facility from the Drop-Down Menu Provided: JEFFERSON HOSPITAL

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	01/01/2019	12/31/2019
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:	000001031A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110100

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:	DSH Examination Year (07/01/18 - 06/30/19)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	1/29/1971

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** $ 88,711
   (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 Services07/01/2018 - 06/30/2019** $ 88,711

Certification:

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

Explanation for "No" answers:

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

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

	Chief Financial Officer	
Hospital CEO or CFO Signature	Title	Date
James Harrison	478-625-7000 x1207	jharrison@jeffersonhosp.com
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Jim Harrison
Title	CFO
Telephone Number	478-625-7000 x 1207
E-Mail Address	jharrison@jeffersonhosp.com
Mailing Street Address	1067 Peachtree Street
Mailing City, State, Zip	Jefferson, GA 30434

Outside Preparer:

Name	Keith Williams
Title	President
Firm Name	Keith Williams & Associates, Inc.
Telephone Number	615-390-8006
E-Mail Address	kgwhcadvisors@comcast.net

DSH Survey Submission Checklist

Please indicate with an "X" each item included or a "N/A" if not included. Consider a separate cover letter to explain any "N/A" answers to avoid additional documentation requests.

X	1.	Electronic copy of the DSH Survey Part I - DSH Year Data - 07/01/2018 - 06/30/2019
X	2.	Electronic copy of the DSH Survey Part II - Cost Report Data - Cost Report Year 01/01/2019 - 12/31/2019
N/A	3.	N/A
N/A	4.	N/A
X	5 (a).	Electronic copy of Exhibit A - Uninsured Charges / Days - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)
X	5 (b).	Description of logic used to compile Exhibit A. Include a copy of all financial classes and payer plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
X	6 (a).	Electronic copy of Exhibit B - Self-Pay Payments - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).
X	6 (b).	Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.
X	7 (a).	Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare crossover, Medicaid MCO, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report) - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).
X	7 (b).	Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payer plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
N/A	8.	Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	9.	Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
X	10.	Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	11.	Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B
N/A	12.	Documentation supporting out-of-state DSH payments received
	13.	- Examples may include remittances, detailed general ledgers, or add-on rates.
X	14.	Financial statements or other documentation to support total charity care charges and subsidies reported on Section F of DSH Survey Part II
X	15.	Revenue code cross-walk used to prepare cost report, or supporting grouping schedules
X	15a.	A detailed working trial balance used to prepare each cost report (including revenues)
N/A	15b.	A detailed revenue working trial balance by payer/contract. The schedule should show charges, contractual adjustments, and revenues by payer plan and contract (e.g., Medicare, each Medicaid agency payer, each Medicaid Managed care contract)
X	16.	Electronic copy of all cost reports used to prepare each DSH Survey Part II
X	17.	Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligible cost report payments)
N/A	18.	Documentation supporting Medicaid Managed Care Quality Incentive Payments, or any other Medicaid Managed Care lump sum payments

Please upload all checklist items above to the Myers and Stauffer Web Portal. If you are unable to access the Web Portal, please call or email.
Web Portal Address:

https://dsh.mslc.com

All electronic (CD or DVD - CDs or DVDs must be encrypted and/or password protected) and paper documentation can be mailed (using certified or other traceable delivery) to:

Myers and Stauffer LC
ATTN: DSH Examinations
700 W. 47th Street, Suite 1100
Kansas City, Missouri 64112
Fax: (816) 945-5301
Phone: (800) 374-6858
E-Mail: GADSH@mslc.com

Please Call Myers and Stauffer if you have any questions on completing the DSH survey.

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D. General Cost Report Year Information 1/1/2019 - 12/31/2019

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: JEFFERSON HOSPITAL

	1/1/2019 through 12/31/2019		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):			
3a. Date CMS processed the HCRIS file into the HCRIS database:			

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	JEFFERSON HOSPITAL	Yes	
5. Medicaid Provider Number:	000001031A	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:	110100	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.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. 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: (01/01/2019 - 12/31/2019)

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)	$ 493	$ 105,237	$105,730
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 27,235	$ 405,418	$432,653
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)	$27,728	$510,655	$538,383
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	1.78%	20.61%	19.64%

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 (01/01/2019 - 12/31/2019)

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) — 1,149 **(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	$ -

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	$ 514,152				$ 310,470	$ -	$ -	$ 203,682
12.	Subprovider I (Psych or Rehab)	$ -				$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$ -				$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ -				$ -	
15.	Swing Bed - NF			$ -				$ -	
16.	Skilled Nursing Facility			$ -				$ -	
17.	Nursing Facility			$ -				$ -	
18.	Other Long-Term Care			$ -				$ -	
19.	Ancillary Services	$ 2,451,345	$ 10,479,281			$ 1,480,240	$ 6,327,893	$ -	$ 5,122,493
20.	Outpatient Services		$ 2,204,001				$ 1,330,882	$ -	$ 873,119
21.	Home Health Agency			$ -				$ -	
22.	Ambulance	-	-	$ -		-	-	$ -	-
23.	Outpatient Rehab Providers			$ -		$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -			$ -	$ -	$ -	$ -
25.	Hospice			$ -				$ -	
26.	Other	$ 8,916	$ 3,418,133	$ 6,809,410		$ 5,384	$ 2,064,033	$ 4,111,849	$ 1,357,632
27.	Total	$ 2,974,413	$ 16,101,415	$ 6,809,410		$ 1,796,093	$ 9,722,807	$ 4,111,849	$ 7,556,928

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	25,885,238	Total Contractual Adj. (G-3 Line 2)	15,630,749
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)			+	
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				15,630,749
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2019-12/31/2019) JEFFERSON 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 HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 1,456,142	$ -	$ -	$ -	$ 1,456,142	1,283	$ -		$ 1,134.95
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	Total Routine	$ 1,456,142	$ -	$ -	$ -	$ 1,456,142	1,283	$ -		
19	Weighted Average									$ 1,134.95

	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)	134	-	-	$ 152,083	$ 13,223	$ 139,389	$ 152,612	0.996534

		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	50.00 Operating Room	$ 302,059	$ -	$ -		$ 302,059	$ 4,483	$ 706,757	$ 711,240	0.424693
22	53.00 Anesthesiology	$ 78,588	$ -	$ -		$ 78,588	$ 729	$ 225,758	$ 226,487	0.346987
23	54.00 Radiology-Diagnostic	$ 805,188	$ -	$ -		$ 805,188	$ 197,210	$ 3,133,676	$ 3,330,886	0.241734
24	60.00 Laboratory	$ 1,083,344	$ -	$ -		$ 1,083,344	$ 552,777	$ 3,501,545	$ 4,054,322	0.267207
25	65.00 Respiratory Therapy	$ 391,410	$ -	$ -		$ 391,410	$ 210,750	$ 366,295	$ 577,045	0.678301
26	66.00 Physical Therapy	$ 857,589	$ -	$ -		$ 857,589	$ 176,173	$ 1,254,021	$ 1,430,194	0.599631
27	71.00 Medical Supplies Charges to Patients	$ 129,649	$ -	$ -		$ 129,649	$ 305,466	$ 321,138	$ 626,604	0.206907
28	73.00 Drugs Charged to Patients	$ 585,498	$ -	$ -		$ 585,498	$ 646,981	$ 702,989	$ 1,349,970	0.433712
29	76.00 Sleep Lab	$ 70,288	$ -	$ -		$ 70,288	$ -	$ 205,493	$ 205,493	0.342046
30	90.00 Clinic	$ 104,678	$ -	$ -		$ 104,678	$ -	$ 9,949	$ 9,949	10.521459

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2019-12/31/2019) JEFFERSON 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
31	91.00	Emergency Room	$ 2,379,144	$ -	$ -	$ 2,379,144	$ 387,871	$ 2,054,663	$ 2,442,534	0.974047
32			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
33			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
34			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
35			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
36			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
37			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
38			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
39			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
40			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
41			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
42			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
43			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
44			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
45			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
46			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
47			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
48			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
49			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
50			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
51			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
52			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
53			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
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58			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
59			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
60			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
61			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
62			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
63			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
64			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
65			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
66			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
67			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
68			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
69			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
70			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
71			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
72			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
73			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
74			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
75			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
76			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
77			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
78			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
79			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
80			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
81			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
82			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
83			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
84			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
85			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
86			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
87			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
88			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
89			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
90			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2019-12/31/2019) JEFFERSON 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
91			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
92			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
93			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
94			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
95			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
96			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
97			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
98			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
99			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
100			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
101			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
102			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
103			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
104			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
105			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
106			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
107			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
108			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
109			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
110			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
111			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
112			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
113			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
114			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
115			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
116			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
117			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
118			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
119			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
120			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
121			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
122			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
123			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
124			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
125			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
126		**Total Ancillary**	$ 6,787,435	$ -	$ -	$ 6,787,435	$ 2,495,663	$ 12,621,673	$ 15,117,336	
127		**Weighted Average**								0.459044
128		**Sub Totals**	$ 8,243,577	$ -	$ -	$ 8,243,577	$ 2,495,663	$ 12,621,673	$ 15,117,336	
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)*				$ -				
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)*				$ -				
131		NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*								
131.01		Other Cost Adjustments (support must be submitted)								
132		**Grand Total**				$ 8,243,577				
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 (01/01/2019-12/31/2019) JEFFERSON 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 Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,134.95		85		13		222		136		3		456		39.95%
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			**Total Days**	85		13		222		136		3		456		35.78%
19	Total Days per PS&R or Exhibit Detail			85		13		222		136		3				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 35,720		$ 4,893		$ 124,002		$ 67,105		$ 1,468		$ 231,720		
21.01	Calculated Routine Charge Per Diem			$ 420.24		$ 376.38		$ 558.57		$ 493.42		$ 489.33		$ 508.16		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.996534	170	2,772	-	1,570	702	8,751	785	7,407	-	2,142	$ 1,657	$ 20,500	15.92%
23	50 Operating Room		0.424693	-	60,925	-	55,658	-	83,314	233	35,858	-	30,200	$ 233	$ 235,755	37.43%
24	53 Anesthesiology		0.346987	-	3,884	-	2,458	-	7,326	-	3,660	-	1,315	$ -	$ 17,328	8.23%
25	54 Radiology-Diagnostic		0.241734	11,311	101,203	1,512	511,974	41,961	323,327	24,202	202,041	806	258,169	$ 78,986	$ 1,138,545	44.33%
26	60 Laboratory		0.267207	1,084	218,833	5,444	316,187	139,081	274,868	75,694	205,103	916	367,918	$ 221,303	$ 1,014,991	39.59%
27	65 Respiratory Therapy		0.678301	17,518	21,809	8,541	21,420	64,533	67,080	45,686	33,114	1,847	53,848	$ 136,278	$ 143,423	58.12%
28	66 Physical Therapy		0.599631	238	17,705	-	30,960	3,870	78,700	3,986	43,364	-	9,773	$ 8,094	$ 170,729	13.19%
29	71 Medical Supplies Charges to Patients		0.206907	28,331	29,267	2,662	44,959	59,513	41,053	37,043	23,312	1,715	52,639	$ 127,549	$ 138,591	51.15%
30	73 Drugs Charged to Patients		0.433712	91,799	26,007	6,114	51,423	127,663	72,861	79,994	67,272	1,224	53,457	$ 305,570	$ 217,563	42.80%
31	76 Sleep Lab		0.342046	-	-	-	-	-	9,485	-	2,483	-	13,557	$ -	$ 11,968	12.42%
32	90 Clinic		10.521459	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
33	91 Emergency Room		0.974047	35,691	264,028	6,224	330,600	87,069	453,940	49,456	283,513	1,751	704,239	$ 178,440	$ 1,332,081	90.75%
34			-											$ -	$ -	
35			-											$ -	$ -	
36			-											$ -	$ -	
37			-											$ -	$ -	
38			-											$ -	$ -	
39			-											$ -	$ -	
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
49			-											$ -	$ -	
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
54			-											$ -	$ -	
55			-											$ -	$ -	
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58			-											$ -	$ -	
59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (01/01/2019-12/31/2019) JEFFERSON 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			-											$ -	$ -
63			-											$ -	$ -
64			-											$ -	$ -
65			-											$ -	$ -
66			-											$ -	$ -
67			-											$ -	$ -
68			-											$ -	$ -
69			-											$ -	$ -
70			-											$ -	$ -
71			-											$ -	$ -
72			-											$ -	$ -
73			-											$ -	$ -
74			-											$ -	$ -
75			-											$ -	$ -
76			-											$ -	$ -
77			-											$ -	$ -
78			-											$ -	$ -
79			-											$ -	$ -
80			-											$ -	$ -
81			-											$ -	$ -
82			-											$ -	$ -
83			-											$ -	$ -
84			-											$ -	$ -
85			-											$ -	$ -
86			-											$ -	$ -
87			-											$ -	$ -
88			-											$ -	$ -
89			-											$ -	$ -
90			-											$ -	$ -
91			-											$ -	$ -
92			-											$ -	$ -
93			-											$ -	$ -
94			-											$ -	$ -
95			-											$ -	$ -
96			-											$ -	$ -
97			-											$ -	$ -
98			-											$ -	$ -
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101			-											$ -	$ -
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103			-											$ -	$ -
104			-											$ -	$ -
105			-											$ -	$ -
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116			-											$ -	$ -
117			-											$ -	$ -
118			-											$ -	$ -
119			-											$ -	$ -
120			-											$ -	$ -
121			-											$ -	$ -
122			-											$ -	$ -
123			-											$ -	$ -
124			-											$ -	$ -
125			-											$ -	$ -
126			-											$ -	$ -
127			-											$ -	$ -
				$ 186,142	$ 746,433	$ 30,497	$ 1,367,209	$ 524,392	$ 1,420,705	$ 317,079	$ 907,127	$ 8,259	$ 1,547,257		

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

Cost Report Year (01/01/2019-12/31/2019) JEFFERSON 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		%
	Totals / Payments													
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 221,862	$ 746,433	$ 35,390	$ 1,367,209	$ 648,394	$ 1,420,705	$ 384,184	$ 907,127	$ 9,727 (Agrees to Exhibit A)	$ 1,547,257 (Agrees to Exhibit A)	$ 1,289,830	$ 4,441,474	48.21%
129	Total Charges per PS&R or Exhibit Detail	$ 221,862	$ 746,433	$ 35,390	$ 1,367,209	$ 648,394	$ 1,420,705	$ 384,184	$ 907,127	$ 9,727	$ 1,547,257			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 192,130	$ 412,843	$ 31,633	$ 621,023	$ 498,551	$ 776,441	$ 305,221	$ 486,993	$ 7,689	$ 943,196	$ 1,027,535	$ 2,297,300	51.87%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 178,995	$ 255,162	$ -	$ -	$ 60,304	$ 52,612	$ -	$ -			$ 239,299	$ 307,774	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 21,765	$ 379,415	$ -	$ -	$ -	$ -			$ 21,765	$ 379,415	
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ -	$ 137,844	$ 247,428			$ 137,844	$ 247,428	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ 781	$ -	$ 20,705	$ -	$ 1,065	$ -	$ 3,553			$ -	$ 26,104	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 178,995	$ 255,943	$ 21,765	$ 400,120									
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ (2,457)	$ -	$ -							$ -	$ (2,457)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 358,666	$ 299,313	$ -	$ -			$ 358,666	$ 299,313	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -			$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 20,821	$ 18,413	$ -	$ -			$ 20,821	$ 18,413	
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 493	$ 105,237			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 13,135	$ 159,357	$ 9,868	$ 220,903	$ 58,760	$ 405,038	$ 167,377	$ 236,012	$ 7,196	$ 837,959	$ 249,140	$ 1,021,310	
146	**Calculated Payments as a Percentage of Cost**	93%	61%	69%	64%	88%	48%	45%	52%	6%	11%	76%	56%	

147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**	575
148	**Percent of cross-over days to total Medicare days from the cost report**	39%

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

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2019-12/31/2019) JEFFERSON HOSPITAL

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 FFS Primary Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,134.95										-	
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			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges											$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.996534									$ -	$ -
23	50 Operating Room		0.424693									$ -	$ -
24	53 Anesthesiology		0.346987									$ -	$ -
25	54 Radiology-Diagnostic		0.241734									$ -	$ -
26	60 Laboratory		0.267207									$ -	$ -
27	65 Respiratory Therapy		0.678301									$ -	$ -
28	66 Physical Therapy		0.599631									$ -	$ -
29	71 Medical Supplies Charges to Patients		0.206907									$ -	$ -
30	73 Drugs Charged to Patients		0.433712									$ -	$ -
31	76 Sleep Lab		0.342046									$ -	$ -
32	90 Clinic		10.521459									$ -	$ -
33	91 Emergency Room		0.974047									$ -	$ -
34			-									$ -	$ -
35			-									$ -	$ -
36			-									$ -	$ -
37			-									$ -	$ -
38			-									$ -	$ -
39			-									$ -	$ -
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2019-12/31/2019) JEFFERSON HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2019-12/31/2019) JEFFERSON HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)									$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									$ -	$ -
134	Private Insurance (including primary and third party liability)									$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	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 all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

Cost Report Year (01/01/2019-12/31/2019) JEFFERSON HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	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	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$ -	$ -	$ -		0										
2	Kidney Acquisition	$ -	$ -	$ -		0										
3	Liver Acquisition	$ -	$ -	$ -		0										
4	Heart Acquisition	$ -	$ -	$ -		0										
5	Pancreas Acquisition	$ -	$ -	$ -		0										
6	Intestinal Acquisition	$ -	$ -	$ -		0										
7	Islet Acquisition	$ -	$ -	$ -		0										
8		$ -	$ -	$ -		0										
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

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

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

Cost Report Year (01/01/2019-12/31/2019) JEFFERSON HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (01/01/2019-12/31/2019) JEFFERSON HOSPITAL

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**	5,731,304
19	Uninsured Hospital	**Charges Sec. G**	1,556,984
20	Total Hospital	**Charges Sec. G**	15,117,336
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		37.91%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		10.30%
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.*

DSH Cost & Payment Summary

-

Hospital Name	JEFFERSON HOSPITAL			
Hospital Medicaid Number	000001031A			
Cost Report Period	From	1/1/2019	To	12/31/2019

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	K
	Regular IP/OP Medicaid FFS Rate Payments [2]	IP/OP Medicaid MCO Payments [2]	Total Medicaid IP/OP Payments (A+B) [1, 2]	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Net Cost (D-C) [2]	Total IP/OP Indigent Care/Self-Pay Revenues	Total Applicable Section 1011 Payments	Total IP/OP Uninsured Cost of Care	Total Uninsured Uncompensated Care Cost (H-G-F)	Total Cost Report Period UCC* (E+I) Note 2	Total Cumulative Trend (See Table Below)	Trended Total Estimated Net Cost (J*K) [2]	Trended Estimated Medicaid Net Cost (E*K) [2]	Trended Estimated Uninsured Uncompensated Care Cost (UCC) (I*K)	Out of State (OOS) DSH Payment
{A}	$ 1,632,500	$ 421,885	$ 2,054,385	$ 3,324,835	$ 1,270,450	$ 105,730	$ -	$ 950,885	$ 845,155	$ 2,115,605	0.00%	$ -	$ -	$ -	$ -

* Note 1: Total Medicaid payments do not include other Medicaid payments paid during the state DSH year (i.e., supplemental payments, GME, UPL, etc.) which must be included in the final uncompensated care cost calculation in determining the DSH UCC.

Note 2:

Row {A} includes Medicare and private insurance (TPL) payments in the payment and net cost columns. Cost, payments, and UCC included in this row reconcile to columns N-P of the adjusted section of the "DSH Examination UCC Cost & Payment Summary" page.