

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

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	01/01/2017	12/31/2017
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:

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.)
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?

DSH Examination Year (07/01/16 - 06/30/17)
Yes

No

No

Yes

1/29/1971

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 nonemergency obstetric procedures.)

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

Mark Taylor, MD
 Theodore Yarboro, MD

DSH Payment Year (07/01/18 - 06/30/19)
Yes

No

No

C. 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.)

\$ 71,117

Certification:

Answer

Yes

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.

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	10/31/2018
Hospital CEO or CFO Signature	Title	Date
John Graham	478-625-7000 x200	_____
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	John Graham
Title	Chief Financial Officer
Telephone Number	478-625-7000 x200
E-Mail Address	jgraham@jeffersonhosp.com
Mailing Street Address	1067 Peachtree Street
Mailing City, State, Zip	Louisville, 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 - 07/01/2016 - 06/30/2017
X	2. Electronic copy of the DSH Survey Part II - Cost Report Data - Cost Report Year 01/01/2017 - 12/31/2017
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 payor 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 payor 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 <u>out-of-state</u> Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	9. Copies of all <u>out-of-state</u> Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	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 - Examples may include remittances, detailed general ledgers, or add-on rates.
X	13. Financial statements or other documentation to support total charity care charges and subsidies reported on Section F of DSH Survey Part II
X	14. 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 payor/contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, 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:**

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

Example of Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Code (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N) *	Routine Days of Care (O)	Total Patient Payments for Services Provided (P) **	Total Private Insurance Payments for Services Provided (Q) **	Claim Status (Exhausted or Non-Covered Service ***, if applicable) (R)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	\$ 4,000.00	7		\$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	\$ 4,500.00	3		\$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	\$ 5,200.25			\$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	\$ 2,700.00			\$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	\$ 15,000.75			\$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	\$ 1,000.25			\$ -	
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	\$ 150.00		\$ 500.00	\$ -	Exhausted
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	\$ 750.00		\$ 500.00	\$ -	Exhausted
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010	Outpatient	450	\$ 1,100.00			\$ -	Non-Covered Service

Notes for Completing Exhibit A:

* All charges for non-hospital services should be excluded.

** Payments reported in Columns P & Q are not reported in the survey. These amounts are used for examination purposes only. Amount should include all payments received to date on the account.

*** Report services not covered under the patient's insurance package as a "Non-Covered Service". Note - the service must be covered under the state Medicaid plan.

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

Example of Exhibit B - Self Pay Collections

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Code (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O)***	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q)†	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S)†	Insurance Status When Services Were Provided (Insured or Uninsured) (T)†	Claim Status (Exhausted or Non-Covered Service****, If applicable) (U)	Calculated Hospital Uninsured Collections If (T)="Uninsured" or (U)="Exhausted" or (U)="Non-Covered Service", (Q)/((Q)+(R)+(S))/(N)†
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	1/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	2/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	3/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	4/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	9/30/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	10/31/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	11/30/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/15/2010	\$ 90	No	Inpatient	\$ 15,000	\$ 1,000	\$ -	Uninsured		\$ 84
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/31/2010	\$ 90	No	Inpatient	\$ 15,000	\$ 1,000	\$ -	Uninsured		\$ 84
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2010	\$ 130	No	Inpatient	\$ 14,000	\$ 400	\$ 50	Insured	Non-Covered Service	\$ 126

Notes for Completing Exhibit B:
 * Charges and insurance status will be the same when listing multiple payments for the same patient and dates of service.
 ** Other Non-Hospital Charges should include RHC, FOHC, Pharmacy, etc...
 *** If Section 1011 (Undocumented Alien) payments are applied at a patient level, include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.
 **** Report services not covered under the patient's insurance package as a "Non-Covered Service". Note - the service must be covered under the state Medicaid plan.
 ***** The total Calculated Hospital Uninsured Collections (column V) should tie to the total Inpatient and Outpatient payments reported in Section H, Line 143 of the DSH Survey.

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

D. General Cost Report Year Information 1/1/2017 - 12/31/2017

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

1/1/2017 through 12/31/2017		
X		

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

1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database:

6/29/2018

4. Hospital Name:

JEFFERSON HOSPITAL

5. Medicaid Provider Number:

000001031A

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

0

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

0

8. Medicare Provider Number:

110100

8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):

Non-State Govt.

8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):

Small Rural

Data	Correct?	If Incorrect, Proper Information
JEFFERSON HOSPITAL	Yes	
000001031A	Yes	
0	Yes	
0	Yes	
110100	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

State Name	Provider No.

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2017 - 12/31/2017)

- 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)

\$ -

- 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)
- 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)
- 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)
- 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

	Inpatient	Outpatient	Total
	\$ 3,848	\$ 110,016	\$113,864
	\$ 39,821	\$ 370,327	\$410,148
	\$43,669	\$480,343	\$524,012
	8.81%	22.90%	21.73%

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?

No

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 (01/01/2017 - 12/31/2017)

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. 1, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) 1,045 (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	57,076
8. Outpatient Hospital Charity Care Charges	336,795
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 393,871

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$417,650.00			\$ 244,182	\$ -	\$ -	\$ 173,468
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$82,950.00			\$ 48,497	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$0.00			\$ -	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$2,149,411.00	\$9,939,809.00		\$ 1,256,669	\$ 5,811,382	\$ -	\$ 5,021,169
20. Outpatient Services		\$3,374,537.00			\$ 1,972,948	\$ -	\$ 1,401,589
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	\$1,729,395.00	\$4,504,936.00	\$ -	\$ 1,011,103	\$ 2,633,844	\$ 718,292
27. Total	\$ 2,567,061	\$ 15,043,741	\$ 4,587,886	\$ 1,500,851	\$ 8,795,434	\$ 2,682,341	\$ 7,314,517
28. Total Hospital and Non Hospital		Total from Above	\$ 22,198,688		Total from Above	\$ 12,978,626	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	22,198,688	Total Contractual Adj. (G-3 Line 2)	12,978,626
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				12,978,626

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) 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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 1,318,641	\$ -	\$ -	\$ 0.00	\$ 1,318,641	1,169	\$ 500,600.00	\$ 1,128.01
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	\$ 1,318,641	\$ -	\$ -	\$ -	\$ 1,318,641	1,169	\$ 500,600	\$ 1,128.01
19		Weighted Average								\$ 1,128.01

Observation Data (Non-Distinct)

20	09200	Observation (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
124	-	-	\$ 139,873	\$ 9,244.00	\$ 38,798.00	\$ 48,042	2.911473

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	5000	OPERATING ROOM	\$ 266,567.00	\$ -	\$ 0.00	\$ 266,567	\$ 41,894.00	\$ 897,133.00	\$ 939,027	0.283876
22	5300	ANESTHESIOLOGY	\$ 103,236.00	\$ -	\$ 0.00	\$ 103,236	\$ 8,362.00	\$ 266,505.00	\$ 274,867	0.375585
23	5400	RADIOLOGY-DIAGNOSTIC	\$ 674,730.00	\$ -	\$ 0.00	\$ 674,730	\$ 297,623.00	\$ 3,003,186.00	\$ 3,300,809	0.204414
24	6000	LABORATORY	\$ 1,191,980.00	\$ -	\$ 0.00	\$ 1,191,980	\$ 460,945.00	\$ 3,166,675.00	\$ 3,627,620	0.328585
25	6500	RESPIRATORY THERAPY	\$ 365,212.00	\$ -	\$ 0.00	\$ 365,212	\$ 301,301.00	\$ 433,078.00	\$ 734,379	0.497307
26	6600	PHYSICAL THERAPY	\$ 573,222.00	\$ -	\$ 0.00	\$ 573,222	\$ 284,097.00	\$ 1,222,459.00	\$ 1,506,556	0.380485
27	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 69,868.00	\$ -	\$ 0.00	\$ 69,868	\$ 195,583.00	\$ 158,949.00	\$ 354,532	0.197071
28	7300	DRUGS CHARGED TO PATIENTS	\$ 509,034.00	\$ -	\$ 0.00	\$ 509,034	\$ 559,606.00	\$ 612,874.00	\$ 1,172,480	0.434152
29	7600	SLEEP LAB	\$ 63,932.00	\$ -	\$ 0.00	\$ 63,932	\$ 0.00	\$ 178,950.00	\$ 178,950	0.357262
30	9000	CLINIC	\$ 1,493.00	\$ -	\$ 0.00	\$ 1,493	\$ 0.00	\$ 91,430.00	\$ 91,430	0.016329

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) 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	9100 EMERGENCY	\$1,914,238.00	\$ -	\$110,072.00	\$ 2,024,310	\$331,996.00	\$2,903,069.00	\$ 3,235,065	0.625740
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	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) 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		\$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	Total Ancillary	\$ 5,733,512	\$ -	\$ 110,072	\$ 5,843,584	\$ 2,490,651	\$ 12,973,106	\$ 15,463,757	
127	Weighted Average								0.386934
128	Sub Totals	\$ 7,052,153	\$ -	\$ 110,072	\$ 7,162,225	\$ 2,991,251	\$ 12,973,106	\$ 15,964,357	
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)				\$109,004.00				
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	Grand Total				\$ 7,053,221				
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 (01/01/2017-12/31/2017) 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		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			
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days				
1	03000 ADULTS & PEDIATRICS	\$ 1,128.01		46		7		225		124		9		402		39.33%
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	\$ -															
18			Total Days	46		7		225		124		9		402		35.16%
19	Total Days per PS&R or Exhibit Detail			46		7		225		124		9				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
21	Routine Charges			\$ 18,400		\$ 2,800		\$ 98,400		\$ 49,600		\$ 3,600		\$ 169,200		34.52%
21.01	Calculated Routine Charge Per Diem			\$ 400.00		\$ 400.00		\$ 437.33		\$ 400.00		\$ 400.00		\$ 420.90		
22	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	
22	09200 Observation (Non-Distinct)	2,911,473		50	972	-	1,032	824	8,280	456	5,964	1,068	3,016	1,330	16,248	45.09%
23	5000 OPERATING ROOM	0.283876		-	48,853	-	130,818	3,319	75,361	-	46,391	752	19,785	3,319	301,413	34.94%
24	5300 ANESTHESIOLOGY	0.375585		286	2,948	-	14,556	198	10,864	-	14,687	798	3,828	484	43,055	17.42%
25	5400 RADIOLOGY-DIAGNOSTIC	0.204414		6,459	151,560	2,724	249,878	62,056	329,627	28,779	205,753	3,969	273,629	100,018	936,818	39.82%
26	6000 LABORATORY	0.328585		762	217,769	10,217	209,315	125,798	252,776	78,946	217,553	13,305	320,822	215,723	897,413	39.90%
27	6500 RESPIRATORY THERAPY	0.497307		18,387	24,168	3,756	20,755	72,219	37,818	41,536	27,190	1,908	50,470	135,898	109,931	40.61%
28	6600 PHYSICAL THERAPY	0.380485		747	6,395	-	52,223	9,105	94,242	7,597	57,798	-	14,747	17,449	210,658	16.12%
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.197071		8,760	11,865	1,897	15,467	40,814	24,558	21,354	9,623	1,013	18,543	72,825	61,513	43.41%
30	7300 DRUGS CHARGED TO PATIENTS	0.434152		54,557	28,297	3,172	38,066	125,379	82,269	55,943	55,423	10,654	74,335	239,051	204,055	45.04%
31	7600 SLEEP LAB	0.357262		-	-	-	4,772	-	24,009	-	14,316	-	-	-	43,097	24.08%
32	9000 CLINIC	0.016329		-	15,076	-	-	-	-	-	-	-	-	-	15,076	16.49%
33	9100 EMERGENCY	0.625740		17,446	230,289	3,285	522,229	87,363	342,665	46,050	171,779	5,173	539,048	154,144	1,266,962	60.75%
34																
35																
36																
37																
38																
39																
40																
41																
42																
43																
44																
45																
46																
47																
48																
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																

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

Cost Report Year (01/01/2017-12/31/2017) 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		%
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													
112													
113													
114													
115													
116													
117													
118													
119													
120													
121													
122													
123													
124													
125													
126													
Totals / Payments	\$ 107,454	\$ 738,192	\$ 25,051	\$ 1,259,111	\$ 527,075	\$ 1,282,469	\$ 280,661	\$ 826,467	\$ 38,640	\$ 1,318,223			
128 Total Charges (includes organ acquisition from Section J)	\$ 125,854	\$ 738,192	\$ 27,851	\$ 1,259,111	\$ 625,475	\$ 1,282,469	\$ 330,261	\$ 826,467	\$ 42,240	\$ 1,318,223	\$ 1,109,441	\$ 4,106,239	41.19%
129 Total Charges per PS&R or Exhibit Detail	\$ 125,854	\$ 738,192	\$ 27,851	\$ 1,259,111	\$ 625,475	\$ 1,282,469	\$ 330,261	\$ 826,467	\$ 42,240	\$ 1,318,223			
130 Unreconciled Charges (Explain Variance)													
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 99,469	\$ 293,765	\$ 17,484	\$ 543,715	\$ 467,761	\$ 518,238	\$ 253,882	\$ 323,665	\$ 27,969	\$ 581,127	\$ 838,596	\$ 1,679,383	44.34%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 116,491	\$ 191,529	\$ -	\$ -	\$ 79,543	\$ 52,502	\$ -	\$ -	\$ -	\$ -	\$ 196,034	\$ 244,031	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 9,706	\$ 385,395	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 9,706	\$ 385,395	
134 Private Insurance (including primary and third party liability)	\$ -	\$ -	\$ -	\$ 166	\$ -	\$ -	\$ 148,630	\$ 207,710	\$ -	\$ -	\$ 148,630	\$ 207,876	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 55	\$ -	\$ -	\$ -	\$ 55	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 116,491	\$ 191,529	\$ 9,706	\$ 385,561	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
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)	\$ -	\$ -	\$ -	\$ -	\$ 374,333	\$ 265,320	\$ -	\$ -	\$ -	\$ -	\$ 374,333	\$ 265,320	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
141 Medicare Cross-Over Bad Debt Payments	\$ -	\$ -	\$ -	\$ -	\$ 1,768	\$ 1,048	\$ -	\$ -	\$ -	\$ -	\$ 1,768	\$ 1,048	
142 Other Medicare Cross-Over Payments (See Note D)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,848	\$ 110,016	\$ -	\$ -	
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)	\$ (17,022)	\$ 102,236	\$ 7,778	\$ 158,154	\$ 12,117	\$ 199,368	\$ 105,252	\$ 115,900	\$ 24,121	\$ 471,111	\$ 108,125	\$ 575,658	
146 Calculated Payments as a Percentage of Cost	117%	65%	56%	71%	97%	62%	59%	64%	14%	19%	87%	66%	
147 Total Medicare Days from WS S-3 of the Cost Report Excluding Swing-Bed (CIR, WS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					743								
148 Percent of cross-over days to total Medicare days from the cost report					30%								

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 (01/01/2017-12/31/2017) 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		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	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
		From Section G	From Section G										
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,128.01											
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)												
21	Routine Charges												
21.01	Calculated Routine Charge Per Diem												

Line #	Ancillary Cost Centers (from W/S C) (list below):	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	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	
				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)		2.911473										
23	5000 OPERATING ROOM		0.283876										
24	5300 ANESTHESIOLOGY		0.375585										
25	5400 RADIOLOGY-DIAGNOSTIC		0.204414										
26	6000 LABORATORY		0.328585										
27	6500 RESPIRATORY THERAPY		0.497307										
28	6600 PHYSICAL THERAPY		0.380485										
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.197071										
30	7300 DRUGS CHARGED TO PATIENTS		0.434152										
31	7600 SLEEP LAB		0.357262										
32	9000 CLINIC		0.016329										
33	9100 EMERGENCY		0.625740										
34			-										
35			-										
36			-										
37			-										
38			-										
39			-										
40			-										
41			-										
42			-										
43			-										
44			-										
45			-										
46			-										
47			-										
48			-										
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			-										

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2017-12/31/2017) JEFFERSON HOSPITAL

			Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
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												
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)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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 (01/01/2017-12/31/2017)

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-Over (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)
	<i>Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61</i>	<i>Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost</i>	<i>Sum of Cost Report Organ Acquisition Cost and the Add-On Cost</i>	<i>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.</i>	<i>Cost Report Worksheet D-4, Pt. III, Line 62</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Hospital's Own Internal Analysis</i>	<i>From Hospital's Own Internal Analysis</i>
1	Lung Acquisition	\$0.00	\$ -	\$ -	0										
2	Kidney Acquisition	\$0.00	\$ -	\$ -	0										
3	Liver Acquisition	\$0.00	\$ -	\$ -	0										
4	Heart Acquisition	\$0.00	\$ -	\$ -	0										
5	Pancreas Acquisition	\$0.00	\$ -	\$ -	0										
6	Intestinal Acquisition	\$0.00	\$ -	\$ -	0										
7	Islet Acquisition	\$0.00	\$ -	\$ -	0										
8		\$0.00	\$ -	\$ -	0										
9	Totals	\$ -	\$ -	\$ -	0	\$ -		\$ -		\$ -		\$ -		\$ -	
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 (01/01/2017-12/31/2017)

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-Over (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)
	<i>Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61</i>	<i>Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost</i>	<i>Sum of Cost Report Organ Acquisition Cost and the Add-On Cost</i>	<i>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.</i>	<i>Cost Report Worksheet D-4, Pt. III, Line 62</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>
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	\$ -	\$ -	\$ -	0	\$ -		\$ -		\$ -		\$ -	
20	Total Cost												

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B - Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (01/01/2017-12/31/2017) 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)*	\$ 103,542	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	40961865.00 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ 103,542	
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	\$ 103,542
---	------------

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