

## A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2024	06/30/2025

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

JENKINS MEMORIAL MEDICAL CENTER

### Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1

Cost Report Begin Date(s)	Cost Report End Date(s)
01/01/2023	12/31/2023

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

6. Medicaid Provider Number:

Data
000001042A
0
0
111311

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

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

9. Medicare Provider Number:

## B. DSH 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?

DSH Examination  
Year (07/01/24 -  
06/30/25)

Yes

No

No

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

Yes

3b. What date did the hospital open?

5/1/1974

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

**1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025**

\$ 95,267

(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 07/01/2024 - 06/30/2025**

\$ -

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

NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

**3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2024 - 06/30/2025**

\$ 95,267

**Certification:**

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

Answer

Yes

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:

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

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

\_\_\_\_\_  
Hospital CEO or CFO Signature

\_\_\_\_\_  
Chief Executive Officer  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Andrea Graham  
Hospital CEO or CFO Printed Name

\_\_\_\_\_  
(478) 982-4221  
Hospital CEO or CFO Telephone Number

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agraham@jcmcga.com  
Hospital CEO or CFO E-Mail

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

**Hospital Contact:**

Name	Andrea Graham
Title	CEO
Telephone Number	(478) 982-4221
E-Mail Address	agraham@jcmcga.com
Mailing Street Address	931 E. Winthrope Avenue
Mailing City, State, Zip	Millen, GA 30442

**Outside Preparer:**

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