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DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT SURVEY UPDATE 2016

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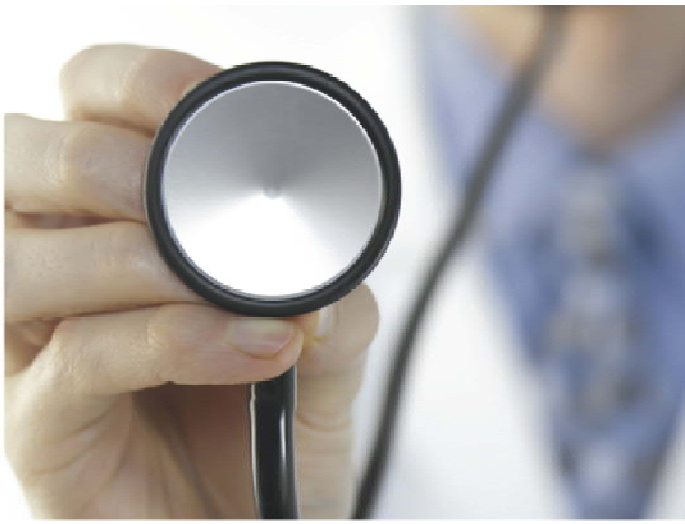
DEDICATED TO GOVERNMENT HEALTH PROGRAMS



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OVERVIEW

- DSH Examination Policy
- DSH Year 2016 Examination Timeline
- Paid Claims Data Review
- Review of DSH Payment Year 2016 Survey & Exhibits
- Submission Checklist
- Recap of Prior Year Examinations (2012)
- Myers and Stauffer DSH FAQ

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RELEVANT DSH POLICY

- DSH Implemented under Section 1923 of the Social Security Act (42 U.S. Code, Section 1396r-4)
- Audit/Reporting implemented in FR Vol. 73, No. 245, Friday, Dec. 19, 2008, Final Rule
- Medicaid Reporting Requirements
  42 CFR 447.299 (c)
- Independent Certified Audit of State DSH Payment Adjustments
  42 CFR 455.300 Purpose
  42 CFR 455.301 Definitions
  42 CFR 455.304 Conditions for FFP
- February, 2010 CMS FAQ titled, "*Additional Information on the DSH Reporting and Audit Requirements*"

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RELEVANT DSH POLICY

- FR Vol. 77, No. 11, Wednesday, January 18, 2012, Proposed Rule
- Allotment Reductions and Additional Reporting Requirements implemented in FR Vol. 78, No. 181, September 18, 2013, Final Rule
- CMS Informational Bulletin Dated December 27, 2013 delaying implementation of DSH Allotment reductions 2 years
- April 7, 2014 CMS FAQ titled, "*Additional Information of the DSH Reporting and Audit Requirements-Part 2*"
- DSH Payments-Uninsured Definition implemented in FR Vol. 79, No. 232, Wednesday, December 3, 2014 Final Rule

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RELEVANT DSH POLICY

- Protecting Access to Medicare Act of 2014 (P.L. 113-93), enacted April 1, 2014 delayed DSH reduction to FY 2017
- The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10), enacted on April 16, 2015 delayed DSH reduction until FY 2018
  - Current schedule for DSH reductions:
    - $2.0 billion in FY 2018;
    - $3.0 billion in FY 2019;
    - $4.0 billion in FY 2020;
    - $5.0 billion in FY 2021;
    - $6.0 billion in FY 2022;
    - $7.0 billion in FY 2023;
    - $8.0 billion in FYs 2024 and 2025.

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DSH YEAR 2016 PAYMENT TIMELINE

- Surveys emailed to hospital contacts August 18, 2015
- Crossover data will be mailed
- Surveys returned by October 1, 2015
- October-Mid December survey review
- Detailed review of hospitals with significant uncompensated care cost variances, if deemed necessary December-January
- End of December initial payment

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STATE PAID CLAIMS DATA (HS&R)

- Medicaid fee-for-service paid claims data
  - Will be posted on the DCH website
  - Reported based on cost report year (using admit date)
  - Include odd summary types
  - Even summary types should be included also. However, the charge data should be verified. Full charges aren't always included. Relate to zero pay Medicaid claims with TPLs payments that exceed what Medicaid would have paid.
  - At revenue code level
  - Detailed data is available upon request from the State

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STATE PAID CLAIMS DATA

- Medicare/Medicaid cross-over paid claims data
  - Summary and patient detail will be mailed to hospitals
  - Only includes traditional Medicare/traditional Medicaid crossovers
  - A reconciliation between the hospital's data and the state detail **MUST** be performed if the hospital wants to use internal data
  - If using internal data, an Exhibit C must be completed and submitted with the survey for claims not in the state detail or variances between state and internal data
  - Segregate payments between payer source if possible

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STATE PAID CLAIMS DATA

- Medicare/Medicaid cross-over paid claims data
  - Approach agreed upon in 2015 by State, GHA and hospital committee
  - Forces verification of accuracy of paid claims data
  - Eliminates automatic adjustment to the Medicare payment-to-cost ratio based on the cost report
  - Non-claims based payments will still be added if the hospital doesn't include
  - May require detailed testing of hospital's internal data

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STATE PAID CLAIMS DATA

- Medicare/Medicaid cross-over paid claims data
  - Reported based on cost report year (using admit date).
  - At revenue code level.
  - Hospital is responsible for ensuring all Medicare payments are included in the final survey even if the payments are not reflected on the state's paid claim totals.
    - Medicare bad debt pmts
    - Direct graduate medical education payments
    - Hold harmless payments
    - Settlement related to MCR DSH, etc

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STATE PAID CLAIMS DATA

- Medicaid managed care paid claims data
  - Hospitals may utilize their internal data, Exhibit C should be completed and submitted with the survey
  - Should be reported based on cost report year (using admit date).
  - HS&R reports from managed care plans can be used, but there have been issues regarding the reliability of the reports in prior years
  - Peachcare should not be included in managed care. It is paid through Title 21 rather than Title 19.

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PAID CLAIMS DATA

- Out-of-State Medicaid paid claims data should be obtained from the state making the payment
  - If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in Exhibit C format.
  - Must EXCLUDE non-Title 19 services.
  - Should be reported based on cost report year (using admit date).
  - In future years, request out-of-state paid claims listing at the time of your cost report filing

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PAID CLAIMS DATA

- "Other" Medicaid Eligibles
  - **Definition:** Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing included in the state's data.
  - The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).
  - Must exclude CHIP and non-Title 19 services
  - Segregate payments between payer source if possible
  - Should be reported based on cost report year (using admit date).

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PAID CLAIMS DATA

- Uninsured Services
  - Uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.
  - Exhibit A charges/days should be reported based on cost report year (using admit date).
  - Exhibit B patient payments will be reported based on cash basis (received during the cost report year).
  - Only include Medicaid covered inpatient and outpatient hospital services should be included.

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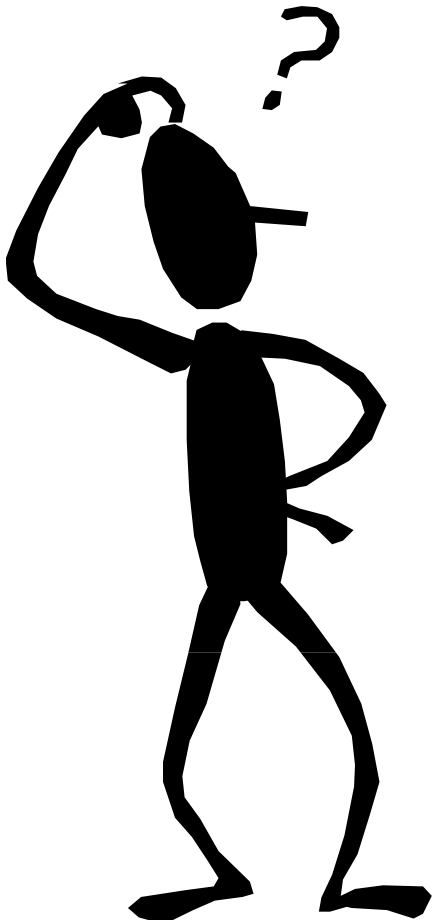

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DSH PAYMENT SURVEYS

General Instruction – Survey Files

- The survey is split into 2 separate Excel files:
  - DSH Survey Part I – DSH Year Data
    - DSH year-specific information
    - Complete one copy for the DSH year
  - DSH Survey Part II – Cost Report Year Data
    - Cost reporting period-specific information
    - Complete a separate copy for each cost reporting period
    - Hospitals with year end changes may have to complete 2 separate Part II surveys

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DSH PAYMENT SURVEYS

General Instruction – Survey Files

- Both parts of the DSH survey have Instructions tabs that have been updated for 2016 DSH year changes. Please refer to those tabs if you are unsure of what to enter in a section or contact Myers and Stauffer for additional guidance.

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DSH PAYMENT SURVEYS

General Instruction – HCRIS Data

- Myers and Stauffer will pre-load certain sections of Part II of the survey using the Healthcare Cost Report Information System (HCRIS) data from CMS. However, the hospital is responsible for reviewing the data to ensure it is correct and reflects the best available cost report information.
  - Hospitals with subproviders must collapse the subprovider costs and days into the A&P cost center
  - In accordance with the state's methodology

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DSH PAYMENT SURVEYS

General Instruction – HCRIS Data

- Hospitals that do not have a Medicare cost report on file with CMS will not see any data pre-loaded and will need to complete all lines as instructed.

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DSH SURVEY PART I – DSH YEAR DATA

Section A

- DSH Year should already be filled in
- Hospital name should be selected (if not, select from the drop-down box)
- Verify the cost reporting period dates
    - If these are incorrect, please call Myers and Stauffer and request a new copy. The HS&R reports are run based on the cost reporting period dates populated for each hospital. If the periods are incorrect, HS&R reports will need to be rerun also.

Section B

- Answer all OB questions using drop-down boxes based on SFY 2016

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DSH SURVEY PART I – DSH YEAR DATA

Section C

- Enter the hospital's total Other Medicaid Payments for the DSH Year.
- Report any Medicaid Non-Claim Specific payments, including UPL and Medicaid neonatal services, medical education, CMO GME, and contracted services payments. The state will provide MSLC with a schedule of payments so the hospital data can be verified. Please submit support for the payments.

Certification

- Answer the "Retain DSH" question but please note that IGTs are not a basis for answering the question "No".
- Enter contact information.
- Have CEO or CFO sign this section after the survey is complete

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2016

DSH Version 5.12 1/7/2015

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2015	06/30/2016

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

Select Hospital Name

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	10/01/2013	09/30/2014
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

Only cost report years to be submitted with be shown here.
Need to prepare a separate Part II DSH Survey for each cost report year listed here

	Data
6. Medicaid Provider Number:	111111
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	11-0000

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 Year 07/01/2015 - 06/30/2016:

	Answer
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?	

Answer all OB questions

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2015 - 06/30/2016**
(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

Include all supplemental payments for the DSH year (UPL, CMO GME, etc)

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2016

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.**	

Must answer the retain DSH question

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. 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.

Complete Certification and Contact Information

Hospital CEO or CFO Signature	Title	Date
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	
Title	
Telephone Number	
E-Mail Address	
Mailing Street Address	
Mailing City, State, Zip	

Outside Preparer:	
Name	
Title:	
Firm Name:	
Telephone Number	
E-Mail Address	

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DSH YEAR SURVEY PART II SECTION D – GENERAL INFORMATION

Submit one copy of the Part II survey for each cost report period not previously submitted.

- Question #2 – An "X" should be shown in the column of the cost report year survey you are preparing.
  - If the survey has multiple periods listed, a separate survey must be completed for each period.
  - If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.
- Question #3 – This question may be already answered based on pre-loaded HCRIS data. Please update this to specify the Medicaid version of the cost report used to complete Section G of the survey.

DSH Version 6.00 1/3/2013

D. General Cost Report Year Information 1/1/2010 - 12/31/2010

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:	Hospital ABC		
	1/1/2010 through 12/31/2010		
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):	3 - Settled with Audit		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	Hospital ABC	Yes	
5. Medicaid Provider Number:	111111	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:	001111	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	Kansas	0123
10. State Name & Number	Illinois	1244
11. State Name & Number	Iowa	1511
12. State Name & Number	Arkansas	1566
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

Should have an "X" for the cost report year you are reporting on. Should have a separate Excel file for each year listed here.

Please indicate the status of the cost report being used to complete the survey (e.g., as-filed, audited, reopened)

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DSH YEAR SURVEY PART II SECTION E, MISC. PAYMENT INFO.

- 1011 Payments – According to Novitas, Georgia exhausted its Section 1011 funds as of November 26,2010. If the hospital had any activity related to Section 1011 payments it should be reported in this section and segregated between payments included or excluded from Exhibit B and between hospital and non-hospital services.
- If the hospital received DSH payments from another state (any state other than Georgia) these payments must be reported on this section of the survey. Out-of-state DSH payments should be reported based on the cost reporting period if it differs from the DSH year.
- Total cash basis patient payments should agree to the detailed Exhibit B submitted with the survey. Only the uninsured payments are utilized to calculate the uncompensated care costs.

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2010 - 12/31/2010)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ 10,000	
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ 5,000	
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ 2,500	
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$17,500	
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ 1,000	
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)**	$1,000	
8. **Out-of-State DSH Payments (See Note 2)**	$ 50,000	

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 250,000	$ 1,000,000	$1,250,000
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 3,000,000	$ 9,000,000	$12,000,000
11. Total Cash Basis Patient Payments Reported on Exhibit B(Agrees to Column (H) on Exhibit B)	$3,250,000	$10,000,000	$13,250,000
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	7.69%	10.00%	9.43%

1011 Payment (undocumented patients) Reconciliation

Out-of-state DSH payments

Should agree to the total cash-basis payments on the submitted Exhibit B

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.

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DSH YEAR SURVEY PART II SECTION F MIUR/LIUR

MUIR and LIUR data is required for each hospital to determine "deemed" hospital status:

- Section F-1: Total hospital days from cost report. Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- Section F-2: If cash subsidies are specified for I/P or O/P services, segregate accordingly, otherwise record entire amount as unspecified. Should include any state-only or local funds received for patient care services. (i.e. county tax)
- Section F-2: Report charity care charges based on hospital financials or the definition used for state DSH payment (support must be submitted).

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DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

Section F-3: Report hospital revenues and contractual adjustments.

- Myers and Stauffer will pre-load HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recent version of the cost report, please correct as need and update question #3 in Section D.
- Totals should agree with the cost report worksheets G-2 and G-3. If not, provide an explanation with the survey.
- Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If the hospital maintains contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.

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DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

Section F-3: **New Lines** – Reconciling Items Necessary for Proper Calculation of LIUR

- Bad debt and charity care write-off not included on G-3, line 2 should be entered on lines 28 and 29 so they can be properly included in calculate net patient service revenue utilized in the LIUR.
- Medicaid DSH payments and state and local patient care cash subsidies included on G-3, line 2 should be entered on line 30 and 31 so they can be properly excluded in calculating net patient service revenue also.
- Medicaid Provider Tax included on G-3, line 2 should be entered on line 32 so it can be properly excluded in calculating net patient service revenue.

F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2011 - 12/31/2011)

Days per cost report.

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.xx less lines 5 & 6)	51,628 (See Note in Section F-3, below)

State or Local Govt. Subsidies.

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	100,000
5.	Total Hospital Subsidies	$ 100,000

Charity Care Charges (only used in LIUR - NOT UCC).

6.	Inpatient Charity Care Charges	450,000
7.	Outpatient Charity Care Charges	390,000
8.	Total Charity Care Charges	$ 840,000

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)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
9.	Hospital	$ 67,439,528			$ 46,480,429	$ -	$ -	$ 20,959,099
10.	Subprovider I (Psych or Rehab)	$ 1,892,975			$ 1,304,669	$ -	$ -	$ 588,306
11.	Subprovider II (Psych or Rehab)	$ -			$ -	$ -	$ -	$ -
12.	Swing Bed - SNF			$ -			$ -	
13.	Swing Bed - NF			$ -			$ -	
14.	Skilled Nursing Facility			$ -			$ -	
15.	Nursing Facility			$ -			$ -	
16.	Other Long-Term Care			$ -			$ -	
17.	Ancillary Services	$ 279,649,863	$ 179,425,587		$ 192,739,271	$ 123,663,057	$ -	$ 142,673,122
18.	Outpatient Services		$ 1,149,822			$ 792,476	$ -	$ 357,346
19.	Home Health Agency			$ 2,780,004			$ 1,916,024	
20.	Ambulance			$ -			$ -	
21.	Outpatient Rehab Providers			$ -	$ -	$ -	$ -	$ -
22.	ASC	$ -	$ -		$ -	$ -	$ -	$ -
23.	Hospice			$ 2,157,554			$ 1,487,022	
24.	Other	$ -	$ 1,944,955	$ -	$ -	$ 1,340,495	$	$ 604,460
25.	Total	$ 348,982,366	$ 182,520,364	$ 4,937,558	$ 240,524,369	$ 125,796,028	$ 3,403,046	$ 165,182,333
26.	Total Hospital and Non Hospital		Total from Above	$ 536,440,288		Total from Above	$ 369,723,443	

Overwrite contractual formulas if unreasonable or hospital has actual numbers by service center.

27.	Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	536,440,288		Total Contractual Adj. (G-3 Line 2)	376,033,443
28.	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)					+	500,000
29.	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)					+	1,000,000
30.	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)					+	90,000
31.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)					+	100,000
32.	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)					-	8,000,000
33.	Adjusted Contractual Adjustments						369,723,443
34.	Unreconciled Difference		Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -

Reconciling lines utilized to ensure that only true contractuals are included in the calculation of the LIUR.

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DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

- Calculation of Routine Cost Per Diems
  - Days
  - Costs
- Calculation of Ancillary Cost-to-Charge Ratios
  - Charges
  - Cost
- Total Hospital Cost from line 132 used in calculating the uncompensated care cost as a percentage of total costs.

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2011-09/30/2012) | Any Hospital

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost		O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge 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*			*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 46,000,000	$ -	$ -	$ -	$ 46,000,000	65,000			$ 707.69
2	03100 INTENSIVE CARE UNIT	$ 13,850,000	$ -	$ 75,000		$ 13,925,000	12,000			$ 1,160.42
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	$ 3,500,000	$ -	$ -		$ 3,500,000	5,400			$ 648.15
17		$ -	$ -	$ -		$ -	-			$ -
18	Total Routine	$ 63,350,000	$ -	$ 75,000	$ -	$ 63,425,000	82,400			
19	Weighted Average									$ 769.72

		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
	Observation Data (Non-Distinct)								
20	092xx Observation (Non-Distinct)	500	-	-	$ 353,845	500,000	-	$ 500,000	**0.707690**

All Cost Report Data. Calculation of Routine Cost Per Diems

Calculation of Observation CCR--uses per diems calculated in first section to carve out and calculate observation cost.

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2013-09/30/2014)

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	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge 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*		*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	$8,863,706.00	$ -	$0.00		$ 8,863,706	$22,073,746.00	$30,029,273.00	$ 52,103,019	0.170119
22	5100 RECOVERY ROOM	$1,094,338.00	$ -	$0.00		$ 1,094,338	$3,142,192.00	$2,816,936.00	$ 5,959,128	0.183641
23	5200 DELIVERY ROOM & LABOR ROOM	$4,537,984.00	$ -	$0.00		$ 4,537,984	$14,477,463.00	$737,952.00	$ 15,215,415	0.298249
24	5300 ANESTHESIOLOGY	$565,406.00	$ -	$0.00		$ 565,406	$1,538,996.00	$1,656,309.00	$ 3,195,305	0.176949
25	5400 RADIOLOGY-DIAGNOSTIC	$14,091,620.00	$ -	$0.00		$ 14,091,620	$15,228,386.00	$63,858,105.00	$ 79,086,491	0.178180
26	5700 CT SCAN	$2,323,259.00	$ -	$0.00		$ 2,323,259	$10,908,992.00	$35,835,869.00	$ 46,744,861	0.049701
27	5800 MRI	$1,806,318.00	$ -	$0.00		$ 1,806,318	$7,254,188.00	$18,532,595.00	$ 25,786,783	0.070048
28	5900 CARDIAC CATHETERIZATION	$2,687,773.00	$ -	$0.00		$ 2,687,773	$15,943,695.00	$14,265,273.00	$ 30,208,968	0.088973
29	6000 LABORATORY	$9,758,152.00	$ -	$0.00		$ 9,758,152	$55,421,406.00	$76,382,486.00	$ 131,803,892	0.074035
30	6500 RESPIRATORY THERAPY	$2,720,078.00	$ -	$0.00		$ 2,720,078	$19,998,807.00	$7,154,934.00	$ 27,153,741	0.100173
31	6600 PHYSICAL THERAPY	$4,072,114.00	$ -	$0.00		$ 4,072,114	$3,474,404.00	$3,756,041.00	$ 7,230,445	0.563190
32	6900 ELECTROCARDIOLOGY	$2,070,267.00	$ -	$0.00		$ 2,070,267	$8,434,895.00	$17,816,783.00	$ 26,251,678	0.078862
33	7100 MEDICAL SUPPLIES CHARGED TO PAT	$8,142,623.00	$ -	$0.00		$ 8,142,623	$17,467,550.00	$15,527,641.00	$ 32,995,191	0.246782
34	7200 IMPL. DEV. CHARGED TO PATIENTS	$12,363,363.00	$ -	$0.00		$ 12,363,363	$16,435,210.00	$9,316,642.00	$ 25,751,852	0.480096
35	7300 DRUGS CHARGED TO PATIENTS	$16,711,053.00	$ -	$0.00		$ 16,711,053	$31,590,268.00	$51,746,579.00	$ 83,336,847	0.200524
36	7400 RENAL DIALYSIS	$458,608.00	$ -	$0.00		$ 458,608	$2,176,165.00	$555,795.00	$ 2,731,960	0.167868
37	7501 PSYCHIATRIC ANCILLARY	$1,253,549.00	$ -	$0.00		$ 1,253,549	$1,847,658.00	$1,109,556.00	$ 2,957,214	0.423895
38	9000 CLINIC	$2,340,411.00	$ -	$0.00		$ 2,340,411	$40,425.00	$4,318,081.00	$ 4,358,506	0.536976
39	9100 EMERGENCY	$11,725,096.00	$ -	$0.00		$ 11,725,096	$13,848,170.00	$36,162,285.00	$ 50,010,455	0.234453
126	**Total Ancillary**	$ 107,585,718	$ -	$ -		$ 107,585,718	$ 261,328,882	$ 397,784,275	$ 659,113,157	
127	**Weighted Average**									0.168145
128	**Sub Totals**	$ 146,556,942	$ -	$ -		$ 146,556,942				
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)*					$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*									
132	**Grand Totals**					$ 146,556,942				
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.

All cost report data. Caclulation of ancillary cost-to-charge ratios.

Total hospital costs used to calculate percentage of UCC to total hospital costs

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / longfall for:
  - In-State FFS Medicaid Primary *(Traditional Medicaid) from state's paid claim summaries*
  - In-State Medicaid Managed Care Primary *(Medicaid MCO) supported by an Exhibit C*
  - In-State Medicare FFS Cross-Overs *(Traditional Medicare with Traditional Medicaid Secondary) from state's paid claim summaries or an Exhibit C.*
  - In-State Other Medicaid Eligibles *(May include Medicare MCO cross-overs and other Medicaid not included elsewhere) supported by an Exhibit C*

State of Any State
Disproportionate Share Hospital (DSH) Audit Survey Part II
12/31/2010

Version 6.00

All Medicaid Categories

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

Cost Report Year (01/01/2010-12/31/2010) | Hospital ABC

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-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	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 (from Section G):			Days		Days		Days		Days	
1	02500 ADULTS & PEDIATRICS	$ 1,020.00		29,500		11,000		22,000		5	
2	02600 INTENSIVE CARE UNIT	$ 2,250.00		1,600		40		1,500			
3	02700 CORONARY CARE UNIT	$ 1,500.00		500		15		600			
4	02800 BURN INTENSIVE CARE UNIT	$ -									
5	02900 SURGICAL INTENSIVE CARE UNIT	$ 1,750.00		1,100		140		600			
6	03000 OTHER SPECIAL CARE UNIT	$ -									
7	03100 SUBPROVIDER I	$ 1,272.73		3,000		250		2,800			
8	03101 SUBPROVIDER II	$ -									
9	03300 NURSERY	$ 340.00		1,255		4,000					
10		$ -									
11		$ -									
12		$ -									
13		$ -									
14		$ -									
15		$ -									
16		$ -									
17		$ -									
18			Total Days	36,955		15,445		27,500		5	
19	Total Days per PS&R or Other Paid Claims Summary										
20	Unreconciled Days (Explain Variance)			36,955		15,445		27,600		5	
				Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 35,500,000		$ 10,405,000		$ 26,800,000		$ 3,500	
21.01	Calculated Routine Charge Per Diem			$ 960.63		$ 673.60		$ 974.55		$ 700.00	

Enter in Medicaid days and total routine charges. Per diem cost amounts carry over from Section G cost report data.

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

Cost Report Year (01/01/2010-12/31/2010) | Hospital ABC

	Ancillary Cost Centers (from W/S C) (from Section G):			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)	
				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	062xx	Observation (Non-Distinct)	1.417829	30,000	130,000	-	50,000	-	90,000	-	-
23	03700	OPERATING ROOM	0.393873	10,830,000	3,680,000	1,450,000	1,320,000	8,010,000	3,200,000	-	2,000
24	03800	RECOVERY ROOM	0.416667	1,650,000	2,170,000	290,000	730,000	1,340,000	1,890,000	-	600
25	03900	DELIVERY ROOM & LABOR ROOM	1.027273	940,000	260,000	3,630,000	1,040,000	110,000	20,000	-	-
26	04000	ANESTHESIOLOGY	0.273333	2,650,000	1,360,000	480,000	570,000	1,860,000	1,070,000	-	500
27	04100	RADIOLOGY-DIAGNOSTIC	0.172881	11,830,000	13,170,000	1,260,000	3,110,000	8,860,000	10,380,000	-	10,000
28	04200	RADIOLOGY-THERAPEUTIC	0.256410	750,000	10,540,000	60,000	1,380,000	520,000	4,790,000	-	-
29	04300	RADIOISOTOPE	0.260625	650,000	850,000	50,000	160,000	690,000	730,000	-	-
30	04400	LABORATORY	0.132043	31,820,000	15,820,000	6,140,000	6,340,000	25,430,000	10,180,000	1,500	5,000
31	04700	BLOOD STORING, PROCESSING & TRAN	0.266667	11,340,000	3,030,000	2,410,000	590,000	7,800,000	2,070,000	3,000	190
32	04900	RESPIRATORY THERAPY	0.269841	6,360,000	220,000	480,000	70,000	6,530,000	180,000	-	-
33	05000	PHYSICAL THERAPY	0.321782	1,070,000	20,000	120,000	-	990,000	10,000	-	-
34	05100	OCCUPATIONAL THERAPY	0.314685	850,000	20,000	100,000	-	820,000	20,000	-	-
35	05200	SPEECH PATHOLOGY	0.476190	240,000	20,000	30,000	-	170,000	20,000	-	-
36	05300	ELECTROCARDIOLOGY	0.090901	4,790,000	3,240,000	350,000	540,000	4,740,000	2,650,000	-	2,000
37	05400	ELECTROENCEPHALOGRAPHY	0.200000	530,000	90,000	70,000	20,000	530,000	60,000	-	-
38	05500	MEDICAL SUPPLIES CHARGED TO PATI	0.395918	23,630,000	5,400,000	3,680,000	1,120,000	20,900,000	5,120,000	500	800
39	05530	IMPL. DEV. CHARGED TO PATIENT	0.521739								
40	05600	DRUGS CHARGED TO PATIENTS	0.333333	30,140,000	5,780,000	5,160,000	1,030,000	22,330,000	5,010,000	800	400
41	05700	RENAL DIALYSIS	0.232828	1,440,000	20,000	20,000	-	3,890,000	100,000	1,000	-
42	05900	CAT SCAN	0.052632	9,460,000	10,040,000	1,070,000	2,140,000	7,020,000	5,870,000	-	-
43	05901	ULTRASOUND	0.169444	950,000	2,000,000	190,000	2,050,000	680,000	670,000	-	900
44	05902	CARDIAC CATHETERIZATION LABORATO	0.216667	2,260,000	1,110,000	200,000	70,000	2,850,000	1,130,000	-	-
45	05903	ENDOSCOPY	0.271429	1,060,000	2,110,000	70,000	200,000	930,000	1,500,000	-	-
46	05907	PSYCHIATRIC/PSYCHOLOGICAL SERVIC	0.283186	-	360,000	-	10,000	10,000	1,340,000	-	-
47	06000	CLINIC	1.058995	50,000	4,480,000	60,000	2,890,000	70,000	2,430,000	-	-
48	06100	EMERGENCY	0.310268	8,870,000	10,940,000	1,210,000	6,530,000	7,050,000	4,630,000	-	-

Enter in all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Payments Include:
  - Medicaid/Medicaid MCO claim payments
  - Medicaid cost report settlements
  - Medicare claim payments (cross-overs)
  - Medicare bad debt payments (cross-overs)
  - Medicare cost report settlement payments (cross-overs)
  - Other third party payments (TPL)

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

Cost Report Year (01/01/2010-12/31/2010) | Hospital ABC

		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)	
	Totals / Payments								
103	**Total Charges** ***(Includes organ acquisition from Section J)***	$ 199,580,000	$ 96,950,000	$ 38,985,000	$ 31,770,000	$ 160,730,000	$ 65,170,000	$ 11,100	$ 22,390
104	Total Charges per PS&R or Other Paid Claims Summary	$ 199,580,000	$ 96,950,000	$ 38,985,000	$ 31,770,000	$ 160,730,000	$ 65,170,000	$ 11,100	$ 22,390
105	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-
106	**Total Calculated Cost (Includes organ acquisition from Section J)**	$ 93,914,981	$ 25,679,281	$ 23,546,916	$ 10,315,678	$ 66,162,462	$ 17,125,232	$ 6,982	$ 4,414
107	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 48,300,000	$ 20,000,000	$ 15,500,000	$ 9,000,000	$ 2,100,000	$ 3,000,000	$ -	$ -
108	Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare on crossovers)	$ 16,000	$ 100,000	$ 600,000	$ 300,000	$ 15,000	$ 10,000	$ -	$ 156
109	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 48,316,000	$ 20,100,000	$ 16,100,000	$ 9,300,000				
110	Medicaid Cost Settlement Payments (See Note B)								
111	Other Medicaid Payments Reported on Cost Report Year (See Note C)								
112	Medicare Paid Amount (excludes coinsurance/deductibles)					$ 60,000,000	$ 10,500,000	$ 5,000	$ 1,900
113	Medicare Cross-Over Bad Debt Payments					$ 2,000,000	$ 7,000		
114	Other Medicare Cross-Over Payments (See Note D)					$ 8,200,000	$ 1,200,000	$ 300	$ 400
115	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)								
116	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)								
117	**Calculated Payment Shortfall / (Longfall)**	$ 37,598,981	$ 5,679,281	$ 7,446,916	$ 1,015,678	$ (6,152,538)	$ 2,408,232	$ 1,682	$ 1,956
118	**Calculated Payments as a Percentage of Cost**	55%	78%	68%	90%	109%	86%	76%	56%

Enter in all Medicaid, TPL, and Medicare crossover payments.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II SECTION H, UNINSURED

- Report uninsured services, patient days (by routine cost center) and ancillary charges by cost center from Exhibit A submitted with the survey.
- Survey form Exhibit A outlines the data elements that need to be provided to Myers and Stauffer for uninsured patient accounts.
- For uninsured payments, enter the uninsured hospital patient cash-basis payment totals from Exhibit B. **Exclude** include the non-hospital or insured patient payments in Section H even though they are reported in Exhibit B.

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

Cost Report Year (01/01/2010-12/31/2010) | Hospital ABC

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Uninsured: Inpatient (See Exhibit A)	Uninsured: Outpatient (See Exhibit A)
		From Section G	*From Section G*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Routine Cost Centers (from Section G):			**Days**	
1	02500 ADULTS & PEDIATRICS	$ 1,020.00		1,000	
2	02600 INTENSIVE CARE UNIT	$ 2,250.00		80	
3	02700 CORONARY CARE UNIT	$ 1,500.00		60	
4	02800 BURN INTENSIVE CARE UNIT	$ -			
5	02900 SURGICAL INTENSIVE CARE UNIT	$ 1,750.00		120	
6	03000 OTHER SPECIAL CARE UNIT	$ -			
7	03100 SUBPROVIDER I	$ 1,272.73		400	
8	03101 SUBPROVIDER II	$			
9	03300 NURSERY	$ 340.00		60	
10		$ -			
11		$ -			
12		$ -			
13		$ -			
14		$ -			
15		$ -			
16		$ -			
17		$ -			
18			**Total Days**	1,720	
19	Total Days per PS&R or Other Paid Claims Summary				
20	Unreconciled Days (Explain Variance)				
				Routine Charges	
21	Routine Charges			$ 1,650,000	
21.01	Calculated Routine Charge Per Diem			$ 959.30	
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**
22	062xx Observation (Non-Distinct)		1.417829	-	80,000
23	03700 OPERATING ROOM		0.393873	3,640,000	2,000,000
24	03800 RECOVERY ROOM		0.416667	1,160,000	1,250,000
25	03900 DELIVERY ROOM & LABOR ROOM		1.077273	100,000	30,000
26	04000 ANESTHESIOLOGY		0.273333	1,840,000	960,000
27	04100 RADIOLOGY-DIAGNOSTIC		0.172881	2,000,000	4,000,000
28	04200 RADIOLOGY-THERAPEUTIC		0.256410	140,000	1,990,000
29	04300 RADIOISOTOPE		0.260625	220,000	900,000
30	04400 LABORATORY		0.132043	5,000,000	6,000,000
31	04700 BLOOD STORING, PROCESSING & TRAN		0.266667	2,000,000	970,000
32	04900 RESPIRATORY THERAPY		0.269841	1,030,000	250,000
33	05000 PHYSICAL THERAPY		0.321782	300,000	10,000
34	05100 OCCUPATIONAL THERAPY		0.314685	210,000	10,000
35	05200 SPEECH PATHOLOGY		0.476190	40,000	-
36	05300 ELECTROCARDIOLOGY		0.098901	580,000	550,000
37	05400 ELECTROENCEPHALOGRAPHY		0.280000	110,000	40,000
38	05500 MEDICAL SUPPLIES CHARGED TO PATI		0.395918	3,000,000	2,000,000
39	05530 IMPL. DEV. CHARGED TO PATIENT		0.521739		-
40	05600 DRUGS CHARGED TO PATIENTS		0.333333	1,800,000	1,300,000
41	05700 RENAL DIALYSIS		0.232829	90,000	2,900,000
42	05900 CAT SCAN		0.052632	3,000,000	720,000
43	05901 ULTRASOUND		0.189444	290,000	280,000
44	05902 CARDIAC CATHETERIZATION LABORATO		0.216667	1,150,000	710,000
45	05903 ENDOSCOPY		0.271429	400,000	10,000
46	05907 PSYCHIATRIC/PSYCHOLOGICAL SERVIC		0.283186	-	-
47	06000 CLINIC		1.056995	10,000	1,870,000
48	06100 EMERGENCY		0.310266	2,100,000	7,000,000
	Totals / Payments				
103	**Total Charges** ***(includes organ acquisition from Section J)***			$ 31,660,000 (Agrees to Exhibit A)	$ 35,240,000 (Agrees to Exhibit A)
104	Total Charges per PS&R or Other Paid Claims Summary				
105	Unreconciled Charges (Explain Variance)				
106	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 9,713,438	$ 10,477,934
107	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				
108	Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare on crossovers)				
109	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)				
110	Medicaid Cost Settlement Payments (See Note B)				
111	Other Medicaid Payments Reported on Cost Report Year (See Note C)				
112	Medicare Paid Amount (excludes coinsurance/deductibles)				
113	Medicare Cross-Over Bad Debt Payments			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)
114	Other Medicare Cross-Over Payments (See Note D)				
115	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)			$ 250,000	$ 1,000,000
116	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Secti			$ 5,000	$ 2,500
117	**Calculated Payment Shortfall / (Longfall)**			$ 9,458,438	$ 9,475,434
118	**Calculated Payments as a Percentage of Cost**			3%	10%

Uninsured days - should agree to Exhibit A

Uninsured Charges must agree to Exhibit A

Uninsured cash-basis payments must agree to the UNINSURED on Exhibit B

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DSH SURVEY PART II – SECTION H, IN-STATE MEDICAID AND UNINSURED

- Additional Edits
  - In the far right column, an edit message will appear and the line will be highlighted if total charges or days by cost center on Section H and I exceed those reported from the cost report in Section G of the survey. Please clear these edits prior to filing the survey.
    - The errors occur when the cost report groupings differ from the grouping methodology used in the completion of the DSH survey.
  - Calculated payments as a percentage of cost by payor (at bottom)
    - Review percentage for reasonableness

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DSH SURVEY PART II
SECTION I, OUT OF STATE MEDICAID

- Report Out-of-State Medicaid days, ancillary charges and payments.
- Report in the same format as Section H. Days, charges and payments received must agree to the other state's PS&R (or similar) claim payment summary. If no summary is available, submit Exhibit C (hospital data) as support.
- If your hospital provided Medicaid services to several other states, please consolidate the OOS data.

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DSH SURVEY PART II – SECTIONS J & K, ORGAN ACQUISITION

- Total organ acquisition cost and total useable organs will be pre-loaded from HCRIS data. If it is incorrect or doesn't agree to a more recent version of the cost report, please correct as needed and update question #3 in Section D.
- These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured.
- Summary claims data (PS&R) or similar documents and provider records (organ counts) must be provided to support the charges and useable organ counts reported on the survey. The data for uninsured organ acquisitions should be reported separately from the Exhibit A.

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DSH SURVEY PART II - SECTIONS J & K, ORGAN ACQUISITION

- All organ acquisition charges should be reported in Sections J & K of the survey and should be EXCLUDED from Section H & I of the survey. (days should also be excluded from H & I)
- Medicaid and uninsured charges/days included in the cost report on Worksheet D-4 as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey as those costs are included in the cost per organ amount on Section J & K.

Add-On Cost Factor for I&R, FRA tax

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

Cost Report Year (01/01/2011-12/31/2011) | Hospital ABC

In-State organ acquisitions

		Total Organ Acquisition Cost	Additional Provider Tax Add-In and Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ 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-6, Pt. III, Col. 1, Ln 53	*Add-On Cost Factor on Section G, Line 104 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-6, Pt. III, Col. 1, Ln 58 (substitute Medicare with Medicaid/ uninsured). See Note C below.*	*Cost Report Worksheet D-6, Pt. III, Line 54*	*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	$0.00		$ -		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				$ -												
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 (01/01/2011-12/31/2011) | Hospital ABC

Out-of-State organ acquisitions

		Total Organ Acquisition Cost	Additional Provider Tax Add-In and Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ 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-6, Pt. III, Col. 1, Ln 53	*Add-On Cost Factor on Section G, Line 104 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-6, Pt. III, Col. 1, Ln 58 (substitute Medicare with Medicaid/ uninsured). See Note C below.*	*Cost Report Worksheet D-6, Pt. III, Line 54*	*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

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- Provides for add-on of the allowable provider tax, which is excluded from the Medicaid version of the 2552-10 used to complete the DSH survey.
- Assists in reconciling total provider tax expense reported in the Medicaid cost report and the amount actually incurred by a hospital (paid to the state).
    - The treatment of the tax and the allowable amount may differ between the Medicare cost report and what is allowable in the calculation of uncompensated care costs for DSH purposes.

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- Complete the section using Medicare cost report data and hospital's own general ledger.
- Include the Worksheet A line number the tax is included on or provide a reason for the variance between the tax per the general ledger and the amount included in the cost report.
- The tax expense should be reflected based on the cost reporting period rather than the DSH year.
- The uninsured and Medicaid portion of the permissible provider tax not included in allowable cost on the Medicare cost report will be added into uncompensated care costs based on charges

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 audit 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 audit surveys.

Cost Report Year (10/01/2011-09/30/2012) Any Hospital

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 1,500,000		
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 1,350,000	4.00	(Where is the cost included on w/s A?)
3	Difference (Explain Here --------->)	Additional reimb netted with tax	$ 150,000		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	(Reclassified to / (from))
5	*Reclassification Code*	0	$ -	-	(Reclassified to / (from))
6	*Reclassification Code*	0	$ -	-	(Reclassified to / (from))
7	*Reclassification Code*	0	$ -	-	(Reclassified to / (from))
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	0	$ -	-	(Adjusted to / (from))
9	*Reason for adjustment*	0	$ -	-	(Adjusted to / (from))
10	*Reason for adjustment*	0	$ -	-	(Adjusted to / (from))
11	*Reason for adjustment*	0	$ -	-	(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*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 1,350,000		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ 150,000	
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital **Charges**	188,841,996	
19	Uninsured Hospital **Charges**	67,160,448	
20	Total Hospital **Charges**	764,577,563	
21	Percentage of Provider Tax Assessment Adjustment to Include in DSH Medicaid UCC	24.70%	
22	Percentage of Provider Tax Assessment Adjustment to Include in DSH Uninsured UCC	8.78%	
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC	$ 37,048	
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC	**$ 13,176**	
25	Provider Tax Assessment Adjustment to DSH UCC	**$ 50,224**	

Enter G/L and cost report total tax amounts and cost center tax is classified in

Tax reclassifications, if any, on W/S A-6

Enter tax adjustments from W/S A-8 that are allowable for DSH purposes (ie increased reimbursement offset)

Tax excluded from W/S A

Addtl expense added to UCC related to MCD and uninsured for tax excluded from allowable expenses on the cost report

** Assessment must exclude any non-hospital assessment including 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 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.*

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EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

- Survey form Exhibit A has been designed to assist hospitals in collecting and reporting all uninsured charges and routine days needed to cost out the uninsured services.
  - Total hospital charges / routine days from Exhibit A must agree to the total entered in Section H of the survey.
  - Must be for dates of service in the cost report fiscal year.
  - Line item data must be at patient date of service level with multiple lines showing revenue code level charges

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EXHIBIT A - UNINSURED

- Exhibit A:
  - Include *Primary Payor Plan and Secondary Payor Plan* fields
    - A complete list (key) of payor plans is required to be submitted separately with the survey.
    - Gender, Date of Birth, and SSN not requested this year

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EXHIBIT A - UNINSURED

- Claim Status (Column R)– need to indicate if Exhausted / Non-Covered Insurance claims are being included
  - If exhausted / non-covered insurance services are included on Exhibit A, then the corresponding payments must also be included on Exhibit B for patient payments.
- Submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (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 Third Party 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			$ 100.00	Non-Covered Service

EXHIBIT A - UNINSURED CHARGES / DAYS

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EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Survey form Exhibit B has been designed to assist hospitals in collecting and reporting all patient payments received on a cash basis.
  - Exhibit B should include all patient payments regardless of the patient's insurance status.
  - Total patient payments from this exhibit are entered in Section E of the survey.
  - Insurance status should be noted on each patient payment so the sub-total of uninsured hospital patient payments can be entered in Section H of the survey.

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EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Patient payments received for uninsured services need to be reported on a cash basis.
  - For example, a cash payment received during the 2014 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2014 cost report year.

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EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Exhibit B
  - Include *Primary Payor Plan*, *Secondary Payor Plan*, and *Payment Transaction Code*
    - A separate “key” for all payment transaction codes should be submitted with the survey
- Submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Number (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 "Non-Covered Service", (Q)/((Q)+(R)+(S))*(N), 0)
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

Exhibit B - Cash Basis Patient Payments

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Medicaid data reported on the survey must be supported by a third-party paid claims summary such as a PS&R, Managed Care Plan provided report, or state-run paid claims report.
  - If not available, the hospital must submit the detail behind the reported survey data in the Exhibit C format. Otherwise, the data may not be allowed in the final UCC.
- Medicaid fee-for-service (FFS) claims summaries provided by the state must be used to complete the DSH survey FFS section.

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that may require an Exhibit C are as follows:
  - Self-reported Medicaid MCO data (Section H)
  - Additional or adjusted crossover claims noted during reconciliation of state and internal hospital data (Section H)
  - Self-reported “Other” Medicaid eligibles (Section H)
  - All self-reported Out-of-State Medicaid categories (Section I)

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - Include *Primary Payor Plan*, *Secondary Payor Plan* fields
    - A complete list (key) of payor plans is required to be submitted separately with the survey.

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - No need to include *Birth Date*, *Social Security Number, and Gender* fields
- Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Medicaid Recipient # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O)	Routine Days of Care (P)	Total Medicare Payments for Services Provided (Q)	Total Medicaid Payments for Services Provided (R)	Total Third Party Liability Payments for Services Provided (S)	Self-Pay Payments (T)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	120	$ 1,200	3	$ -	$ 1,500	$ 50	$ -	$ 1,550
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	206	$ 1,500	1	$ -	$ 1,500	$ 50	$ -	$ 1,550
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	250	$ 100	-	$ -	$ 1,500	$ 50	$ -	$ 1,550
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	300	$ 375	-	$ -	$ 1,500	$ 50	$ -	$ 1,550
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	450	$ 1,500	-	$ -	$ 1,500	$ 50	$ -	$ 1,550
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	250	$ 100	-	$ -	$ 900	$ -	$ 75	$ 975
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	300	$ 375	-	$ -	$ 900	$ -	$ 75	$ 975
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	450	$ 1,500	-	$ -	$ 900	$ -	$ 75	$ 975
Medicaid MCO	BCBS Blue Advantage	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	300	$ 375	-	$ -	$ 1,000	$ 100	$ -	$ 1,100
Medicaid MCO	BCBS Blue Advantage	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	450	$ 1,500	-	$ -	$ 1,000	$ 100	$ -	$ 1,100

EXHIBIT C - MANAGED CARE

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SUBMISSION CHECKLIST

- Checklist is in a separate tab in Part I of the survey.
- Should be completed after Part I and Part II surveys are prepared.
- Includes list of all supporting documentation that needs to be submitted with the survey for audit.
- Includes Myers and Stauffer address and phone numbers.

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SUBMISSION CHECKLIST

1. Electronic copy of the DSH Survey Part I – DSH Year Data
2. Electronic copy of the DSH Survey Part II – Cost Report Year Data
3. 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)*
4. 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.

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SUBMISSION CHECKLIST

5. 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)*
6. 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.

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SUBMISSION CHECKLIST

7. Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare cross-over, 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)*

8. 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.

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SUBMISSION CHECKLIST

9. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs)

10. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs)

11. Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs)

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SUBMISSION CHECKLIST

12. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B

13. Documentation supporting out-of-state DSH payments received. Examples may include remittances, detailed general ledgers, or add-on rates

14. Financial statements to support total charity care charges and state / local govt. cash subsidies reported

15. Revenue code cross-walk used to prepare cost report

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SUBMISSION CHECKLIST

16. A detailed working trial balance used to prepare each cost report (including revenues)

17. 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)

18. Electronic copy of all cost reports used to prepare each DSH Survey Part II

19. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligibles)

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WEB-BASED ELECTRONIC SUBMISSION OF 2016 DSH SURVEY

- MSLC has developed a web-based process to allow hospitals to submit DSH surveys as well as supporting documentation through a secure website
- MSLC will collect email addresses and IP addresses from each hospital to set up a hospital-specific account
- Hospitals will appoint facility representatives to access upload and download permissions

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WEB-BASED ELECTRONIC SUBMISSION OF 2016 DSH SURVEY

- Hospital contacts should expect an email within the next few weeks requesting account information and instructions on how to access the website
- Hospital email addresses from 2015 payment surveys will be used as the point of contact
- Please inform MSLC of any changes in contacts from the 2015 survey submission

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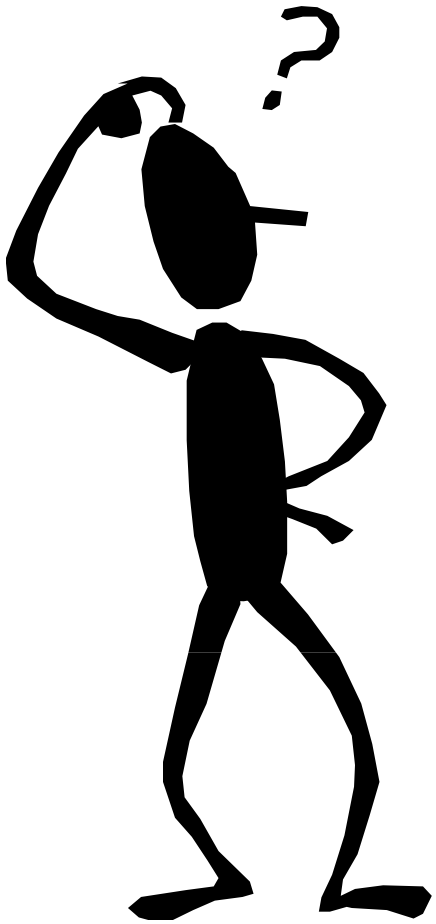

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PRIOR YEAR DSH EXAMINATION

Common Issues Noted During Examination

- Hospitals had duplicate patient claims in the uninsured, cross-over, and state's Medicaid FFS data. Review query logic to ensure no overlap
- Patient payor classes that were not updated. (ex. a patient was listed as self-pay and it was determined that they later were Medicaid eligible and paid by Medicaid yet the patient was still claimed as uninsured).
- Incorrectly reporting elective (cosmetic surgeries) services as uninsured.

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PRIOR YEAR DSH EXAMINATION

Common Issues Noted During Examination

- Charges and days reported on survey exceeded total charges and days reported on the cost report (by cost center).

  Crosswalk utilized to prepare the cost report must be used for preparation of DSH survey

- Inclusion of patients in the uninsured charges listing (Exhibit A) that are concurrently listed as insured in the payments listing (Exhibit B).

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PRIOR YEAR DSH EXAMINATION

Common Issues Noted During Examination

- Patient-level documentation on uninsured Exhibit A and uninsured patient payments from Exhibit B didn't agree to totals on the survey.
- Hospitals reported "Exhausted" / "Insurance Non-Covered" on Exhibit A (Uninsured) but did not report the payments on Exhibit B

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PRIOR YEAR DSH EXAMINATION

Common Issues Noted During Examination

- "Exhausted" / "Insurance Non-Covered" reported in uninsured incorrectly included the following:
  - Services partially exhausted
  - Denied due to timely filing
  - Denied for medical necessity
  - Denials for pre-certification

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PRIOR YEAR DSH EXAMINATION

Common Issues Noted During Examination

- Exhibit B – Patient payments didn't always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.
- Some hospitals didn't include their charity care patients in the uninsured even though they had no third party coverage.

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PRIOR YEAR DSH EXAMINATION

Common Issues Noted During Examination

- Medicare cross-over payments didn't include all Medicare payments (outlier, cost report settlements, lump-sum/pass-through, payments received after year end, etc.).
- Only uninsured payments are to be on cash basis – all other payor payments must include all payments made for the dates of service as of the audit date.

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PRIOR YEAR DSH EXAMINATION

Common Issues Noted During Examination

- Liability insurance claims were incorrectly included in uninsured even when the insurance (e.g., auto policy) made a payment on the claim
- Hospitals didn't report their charity care in the LIUR section of the survey or didn't include a break-down of inpatient and outpatient charity.

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PRIOR YEAR DSH EXAMINATION

Common Issues Noted During Examination

- State and local subsidies weren't included on Section F of the survey
  - County, district or city taxes
  - State only funding

- Inclusion of miscellaneous accounts receivable in uninsured due to "self pay" financial class

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PRIOR YEAR DSH EXAMINATION

Common Issues Noted During Examination

- Non-hospital services included in Exhibit A (swingbed, professional fees).
- Accounts included in crossover payor classification without Medicare primary insurance causing payment to cost ratios from the Medicare cost report to crossover to differ.

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FAQ

1. **What is the definition of uninsured for Medicaid DSH purposes?**

   Uninsured patients are individuals with no source of third party health care coverage (insurance). If the patient had health insurance, even if the third party insurer did not pay, those services are insured and cannot be reported as uninsured on the survey. Prisoners must be excluded.

   - CMS released a final rule in the December 3, 2014 Federal Register to clarify the definition of uninsured and prisoners.
   - Under thebrule, the DSH examination will now look at whether a patient is uninsured using a “service-specific” approach as opposed to the creditable coverage approach previously employed.
   - The rule allows for hospitals to report “exhausted” and “insurance non-covered” services as uninsured.

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FAQ

1. **What is the definition of uninsured for Medicaid DSH purposes? (Continued from previous slide)**

Excluded prisoners were defined in the rule as:

- Individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as a result of criminal charges. These individuals are considered to have a source of third party coverage.
  - Prisoner Exception
    - If a person has been released from secure custody and is referred to the hospital by law enforcement or correction authorities, they can be included.
    - The individual must be admitted as a patient rather than an inmate to the hospital.
    - The individual cannot be in restraints or seclusion.

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FAQ

2. **What is meant by "Exhausted" and "Non-Covered" in the uninsured Exhibits A and B?**

   Under the December 3, 2014 final rule, hospitals can report services if insurance is "exhausted" or if the service provided was "not covered" by insurance. The service must still be a hospital service that would normally be covered by Medicaid.

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FAQ

3. **What categories of services can be included in uninsured on the DSH survey?**

Services that are defined under the Medicaid state plan as a Medicaid inpatient or outpatient hospital service may be included in uninsured *(Auditing & Reporting pg. 77907 & Reporting pg. 77913)*

- There has been some confusion with this issue. CMS attempts to clarify this in #24 of their FAQ titled "*Additional Information on the DSH Reporting and Audit Requirements*". It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.
    - EXAMPLE : A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is "Yes" since speech therapy is a Medicaid hospital service even though they wouldn't cover beneficiaries over 18.

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FAQ

4. **Can a service be included as uninsured, if insurance didn't pay due to improper billing, late billing, or lack of medical necessity?**

   No. Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care (would include denials due to medical necessity). *(Reporting pages 77911 & 77913)*

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FAQ

5. **Can unpaid co-pays or deductibles be considered uninsured?**

   No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the proposed rule. *(Reporting pg. 77911)*

6. **Can a hospital report their charity charges as uninsured?**

   Typically a hospital's charity care will meet the definition of uninsured but since charity care policies vary there may be exceptions. If charity includes unpaid co-pays or deductibles, those cannot be included. Each hospital will have to review their charity care policy and compare it to the DSH rules for uninsured.

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FAQ

7. **Can bad debts be considered uninsured?**

Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the proposed rule as an exhausted or insurance non-covered service.

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FAQ

8. Can a hospital report services covered under automobile polices as uninsured?

Not if the automobile policy pays for the service. We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). *(Reporting pages 77911 & 77916)*

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FAQ

9. How are patient payments to be reported on Exhibit B?

Cash-basis! Exhibit B should include patient payments collected during the cost report period (cash-basis). Under the DSH rules, uninsured cost must be offset by uninsured cash-basis payments.

10. Does Exhibit B include only uninsured patient payments or ALL patient payments?

ALL patient payments. Exhibit B includes all cash-basis patient payments so that testing can be done to ensure no payments were left off of the uninsured. The total patient payments on Exhibit B should reconcile to your total self-pay payments collected during the cost report year.

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FAQ

11. Should we include state and local government payments for indigent in uninsured on Exhibit B?

Uninsured payments do not include payments made by State-only or local only government programs for services provided to indigent patients (no Federal share or match). *(Reporting pg. 77914)*

12. Can physician services be included in the DSH survey?

Physician costs that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital-specific DSH limit. *(Reporting pg. 77924)*

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FAQ

13. Do dual eligibles (Medicare/Medicaid) have to be included in the Medicaid UCC?

Yes. CMS believes the costs attributable to dual eligible patients should be included in the calculation of the uncompensated care costs, but in calculating the uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made. In calculating the Medicare payment, the hospital should include all Medicare adjustments (DSH, IME, GME, etc.) *(Reporting pg. 77912)*

14. Does Medicaid MCO and Out-of-State Medicaid have to be included?

Yes. Under the statutory hospital-specific DSH limit, it is necessary to calculate the cost of furnishing services to the Medicaid populations, including those served by Managed Care Organizations (MCO), and offset those costs with payments received by the hospital for those services. *(Reporting pages 77920 & 77926)*

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OTHER INFORMATION

Please use the DSH Part I Survey Submission Checklist when preparing to submit your surveys and supporting documentation.

Send survey and other data to:

Please notice the new address

Myers and Stauffer LC
Attn: GA DSH Survey
700 W. 47th Street, Ste 1100
Kansas City, MO 64112
(800) 374-6858
gadsh@mslc.com

Note: Exhibits A-C include protected health information and must be sent accordingly (no e-mail).