DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT SURVEY UPDATE 2016

Jim Erickson, CPA
Judy Hatfield, CPA
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
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”
■ 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
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.
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
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
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
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
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
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.
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.
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).
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.
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
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.
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
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.
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
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.
### A. General DSH Year Information

<table>
<thead>
<tr>
<th></th>
<th>Begin</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DSH Year</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
</tr>
</tbody>
</table>

Select Hospital Name

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

<table>
<thead>
<tr>
<th>Cost Report Year</th>
<th>Begin Date(s)</th>
<th>End Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>10/01/2013</td>
<td>09/30/2014</td>
</tr>
</tbody>
</table>

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.

6. Medicaid Provider Number:
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
9. Medicare Provider Number:

### 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:**

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.)
Certification:

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

Explanation for "No" answers:

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

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other  
records of the hospital. 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 ___________________________ 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:

<table>
<thead>
<tr>
<th>Hospital Contact:</th>
<th>Outside Preparer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td>Title</td>
<td>Title</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>Firm Name</td>
</tr>
<tr>
<td>E-Mail Address</td>
<td>Telephone Number</td>
</tr>
<tr>
<td>Mailing Street Address</td>
<td>E-Mail Address</td>
</tr>
<tr>
<td>Mailing City, State, Zip</td>
<td></td>
</tr>
</tbody>
</table>

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
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.
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 or more 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:
   - Facility: Hospital ABC
   - Date: 1/1/2010 through 12/31/2010
   - Status: Selected as Audit

2. Select Cost Report Year Covered by this Survey (enter "X")
   - Date: 1/1/2010 through 12/31/2010
   - Status: Selected
   - Comment: Yes

3. Status of Cost Report Used for this Survey (Should be audited if available)
   - Status: Correct
   - Comment: Yes

4. Hospital Name:
   - Hospital ABC

5. Medicaid Provider Number:
   - Provider Number: 123456

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
   - Status: Correct
   - Comment: Yes

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
   - Status: Correct
   - Comment: Yes

8. Medicare Provider Number:
   - Provider Number: 789012

9. Out-of-State Medicaid Provider Number: List all states where you had a Medicaid provider agreement during the cost report year.
   - State: California
   - Provider No.: 321

10. State Name & Number
    - State: Texas
    - Provider No.: 456

11. State Name & Number
    - State: Florida
    - Provider No.: 789

12. State Name & Number
    - State: Pennsylvania
    - Provider No.: 123

13. State Name & Number
    - State: New York
    - Provider No.: 456

14. State Name & Number
    - State: Massachusetts
    - Provider No.: 789

15. State Name & Number
    - State: New Jersey
    - Provider No.: 123

(Add additional states on a separate attachment)

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

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Section 1011 Payment Related to Hospital Services (See Note 1)</td>
<td>$1,000.00</td>
<td>$2,000.00</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B &amp; B-1 (See Note 1)</td>
<td>$1,000.00</td>
<td>$2,000.00</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>3. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B &amp; B-1 (see Note 1)</td>
<td>$1,000.00</td>
<td>$2,000.00</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>4. Total Section 1011 Payments Related to Hospital Services (See Note 1)</td>
<td>$17,500.00</td>
<td>$3,500.00</td>
<td>$21,000.00</td>
</tr>
<tr>
<td>5. Section 1011 Payment Related to Non-Hospital Services Excluded in Exhibits B &amp; B-1 (See Note 1)</td>
<td>$1,000.00</td>
<td>$2,000.00</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>6. Section 1011 Payment Related to Non-Hospital Services (Excluded in Exhibits B &amp; B-1) (See Note 1)</td>
<td>$1,000.00</td>
<td>$2,000.00</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)</td>
<td>$1,000.00</td>
<td>$2,000.00</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>8. Out-of-State DSH Payments (See Note 2)</td>
<td>$2,500.00</td>
<td>$5,000.00</td>
<td>$7,500.00</td>
</tr>
</tbody>
</table>

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 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 any funds 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.

1011 Payment (undocumented patients) Reconciliation
Out-of-state DSH payments
Should agree to the total cash-basis payments on the submitted Exhibit B
DSH YEAR SURVEY PART II
SECTION F MIUR/LIUR

MIUR 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).
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.
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)

F.1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1. Total Hospital Days Per Cost Report Excluding Swing Beds (CFR, 42CFR3, Pt. 1, Col. 8, Sum of Lins. 14, 16, 17, 18 xx less lines 5 & 6)
   - 51,825

F.2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges used in Low-Income Utilization Rate (LIUR) Calculation

<table>
<thead>
<tr>
<th>Subsidy Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Subsidies</td>
<td>$100,000</td>
</tr>
<tr>
<td>Outpatient Hospital Subsidies</td>
<td>$100,000</td>
</tr>
<tr>
<td>Charity Care Charges</td>
<td>$400,000</td>
</tr>
</tbody>
</table>

F.3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S 0-2 and 0-3 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 HCCH 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.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Inpatient Hospital</th>
<th>Outpatient Hospital</th>
<th>Non-Hospital</th>
<th>Contractual Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>$348,962,266</td>
<td>$182,520,364</td>
<td>$4,937,558</td>
<td></td>
</tr>
<tr>
<td>Subprovider I (Psych or Rehab)</td>
<td>$1,692,075</td>
<td>$735,140</td>
<td>$1,944,955</td>
<td></td>
</tr>
<tr>
<td>Subprovider II (Psych or Rehab)</td>
<td>$1,000,000</td>
<td>$305,000</td>
<td>$1,305,000</td>
<td></td>
</tr>
<tr>
<td>Swing Bed - NF</td>
<td>$150,000</td>
<td>$75,000</td>
<td>$225,000</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>$279,649,663</td>
<td>$173,425,587</td>
<td>$2,790,004</td>
<td></td>
</tr>
<tr>
<td>Other Long-Term Care</td>
<td>$194,923.375</td>
<td>$1,128,000</td>
<td>$-</td>
<td></td>
</tr>
<tr>
<td>Ancillary Services</td>
<td>$240,524,369</td>
<td>$125,796,028</td>
<td>$3,430,049</td>
<td></td>
</tr>
<tr>
<td>Contractual Services</td>
<td>$240,524,369</td>
<td>$125,796,028</td>
<td>$3,430,049</td>
<td></td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>$240,524,369</td>
<td>$125,796,028</td>
<td>$3,430,049</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>$240,524,369</td>
<td>$125,796,028</td>
<td>$3,430,049</td>
<td></td>
</tr>
<tr>
<td>Outpatient Rehab Providers</td>
<td>$240,524,369</td>
<td>$125,796,028</td>
<td>$3,430,049</td>
<td></td>
</tr>
<tr>
<td>ASC</td>
<td>$240,524,369</td>
<td>$125,796,028</td>
<td>$3,430,049</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>$240,524,369</td>
<td>$125,796,028</td>
<td>$3,430,049</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>$240,524,369</td>
<td>$125,796,028</td>
<td>$3,430,049</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$348,962,266</td>
<td>$182,520,364</td>
<td>$4,937,558</td>
<td></td>
</tr>
<tr>
<td>Hospital and Non Hospital</td>
<td>$348,962,266</td>
<td>$182,520,364</td>
<td>$4,937,558</td>
<td></td>
</tr>
</tbody>
</table>

F.4. Total Per Cost Report

| Total Patient Revenues (G.3 Line 1) | $348,962,266 |
| Total Contractual Adjustments (G.3 Line 2) | $378,033,449 |

<table>
<thead>
<tr>
<th>Reconciling lines utilized to ensure that only true contractuals are included in the calculation of the LIUR.</th>
<th>Unreconciled Difference (Should be $0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Increase worksheet G.3 Line 2 for Bad Debts NOT INCLUDED on worksheet G.3 Line 1 (impact is a decrease in net patient revenue)</td>
<td>+ $500,000</td>
</tr>
<tr>
<td>21. Increase worksheet G.3 Line 2 for Bad Debts NOT INCLUDED on worksheet G.3 Line 1 (impact is a decrease in net patient revenue)</td>
<td>+ $1,000,000</td>
</tr>
<tr>
<td>22. 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)</td>
<td>+ $90,000</td>
</tr>
<tr>
<td>23. 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)</td>
<td>+ $100,000</td>
</tr>
<tr>
<td>24. 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)</td>
<td>+ $8,000,000</td>
</tr>
</tbody>
</table>

Dedicated to Government Health Programs
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 Cost** (100-1201-100300177) Any Hospital

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Total Chargeable Cost</th>
<th>Intern &amp; Resident Costs Removed on Cost Report*</th>
<th>ROE and Therapy AddBack (If Applicable)</th>
<th>Net Cost</th>
<th>OOP Charges</th>
<th>Total Charges</th>
<th>Medicaid Per Diem / Cost-to-Charge Ratio</th>
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<tr>
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<td></td>
<td></td>
<td>All Cost Report Data. Calculation of Routine Cost Per Diems</td>
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<td>-</td>
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<td>-</td>
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<td>Observation (Non-District)</td>
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<td>Observation (Non-District)</td>
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<td>10</td>
<td>Observation (Non-District)</td>
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<td>Total Routine</td>
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<td>Weighted Average</td>
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<td>-</td>
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<td>$1,108.42</td>
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#### 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)

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Total Allowable Cost</th>
<th>Intern &amp; Resident Costs Removed on Cost Report *</th>
<th>RCE and Therapy Add-Back (if Applicable)</th>
<th>Total Cost</th>
<th>CIP</th>
<th>O/P Charges</th>
<th>Total Charges</th>
<th>Medicaid Per Diem</th>
<th>Cost-to-Charge Ratio</th>
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<td>21</td>
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<td>5400 RADIOLOGY-DIAGNOSTIC</td>
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<td>$ -</td>
<td>$1,806,310</td>
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<td>$10,252,595.00</td>
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<td>$2,687,773</td>
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<td>$3,756,041.00</td>
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<td>$8,434,895.00</td>
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<td>7100 MEDICAL SUPPLIES CHARGED TO PAT</td>
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<td>$ -</td>
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<td>7300 DRUGS CHARGED TO PATIENTS</td>
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<td>$16,711,053</td>
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<td>$11,746,767.00</td>
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<td>36</td>
<td>7400 RENAL DIALYSIS</td>
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<td>$2,176,156.00</td>
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<td>38</td>
<td>7600 CLINIC</td>
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<td>7700 EMERGENCY</td>
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<td>$15,812,936.00</td>
<td>$30,613,455</td>
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</tbody>
</table>

| Line 126 | Total Ancillary | $107,585,718 | $ - | $ - | $107,585,718 | $261,328,882 | $39,784,275 | $659,113,157 | $168,145 |

#### Weighted Average

| Sub Totals | $146,656,942 | $ - | $ - | $146,656,942 |

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)

| NF, SNF, and Swing Bed Cost for Medicaid (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 |

| NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.) | $0.00 |

| Grand Totals | $146,656,942 |

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 D, Pt. I of the cost report you are using.

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

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
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
H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Medicaid Per Diem Cost for Routine Cost Centers</th>
<th>Medicaid Cost to Charge Ratio for Ancillary Cost Centers</th>
<th>In-State Medicaid PSAR Primary</th>
<th>In-State Medicaid Managed Care Primary</th>
<th>In-State Medicaid PSAR Primary (with Medicaid Secondary)</th>
<th>In-State Other Medicaid Inpatient (Not Included Elsewhere)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>From Section C</td>
<td>From Section D</td>
<td>Inpatient</td>
<td>Outpatient</td>
<td>Inpatient</td>
<td>Outpatient</td>
</tr>
<tr>
<td>02900</td>
<td>ADULTS SLEEP CENTER</td>
<td>1,620.00</td>
<td>1,860.00</td>
<td>22,400</td>
<td>3,500</td>
<td>1,220.00</td>
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<tr>
<td>03300</td>
<td>SURGICAL CARE UNIT</td>
<td>1,300.00</td>
<td>1,600.00</td>
<td>580</td>
<td>90</td>
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<td>800</td>
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<td>03301</td>
<td>MEDICAL INTENSIVE CARE UNIT</td>
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<td>80</td>
<td>900.00</td>
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<tr>
<td>03302</td>
<td>OTHER SPECIAL CARE UNIT</td>
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<td>800.00</td>
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<tr>
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<td>1,860.00</td>
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<td></td>
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<td>32,845</td>
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<td>15,445</td>
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<tr>
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<td>Total Days</td>
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<td>27,000</td>
<td>6</td>
<td>27,000</td>
<td>6</td>
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</table>

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:

<table>
<thead>
<tr>
<th>Cost Report Year (01/01/1991 - 12/31/1992)</th>
<th>Hospital ABC</th>
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</table>

<table>
<thead>
<tr>
<th>Ancillary Cost Centers (From WtG C) (From Section G)</th>
<th>In-State Medicaid FFS Primary</th>
<th>In-State Medicaid Managed Care Primary</th>
<th>In-State Medicare FFSE Cross-Servings (with Medicaid Secondary)</th>
<th>In-State Other Medicaid Eligibles Not Included (Excluded)</th>
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</thead>
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<tr>
<td>32 3205 Inpatient Lab Cores (A)</td>
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<td>32 3210 Operating Room</td>
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<td>32 3215 OR Management</td>
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<td>$1,200,000</td>
<td>$1,200,000</td>
<td>$1,200,000</td>
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<tr>
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<td>$1,200,000</td>
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<td>32 3225 Inpatient Lab Cores (C)</td>
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<tr>
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<td>$3,093,000</td>
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<td>$3,280,000</td>
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Enter in all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.
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)
### In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

<table>
<thead>
<tr>
<th>Category</th>
<th>In-State Medicaid EFS Primary</th>
<th>In-State Medicaid Managed Care Primary</th>
<th>In-State Medicare TE abolished (with Medicaid Exclusions)</th>
<th>In-State Other Medicaid Eligibles (Not abolished Exclusions)</th>
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<tbody>
<tr>
<td>Total Charges, (includes organ acquisition from Section 2)</td>
<td>$156,650,000</td>
<td>$46,940,000</td>
<td>$31,710,000</td>
<td>$21,720,000</td>
</tr>
<tr>
<td>Total Charges per PSSL or Other Paid Claims Summary</td>
<td>$156,650,000</td>
<td>$46,940,000</td>
<td>$31,710,000</td>
<td>$21,720,000</td>
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<tr>
<td>Unrecovered Charges (Allowance Variance)</td>
<td>$156,650,000</td>
<td>$46,940,000</td>
<td>$31,710,000</td>
<td>$21,720,000</td>
</tr>
<tr>
<td>Total Calculated Cost (Includes organ acquisition from Section 2)</td>
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<td>$23,878,000</td>
<td>$16,316,000</td>
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<tr>
<td>Total Medicaid Paid Amount (includes POS, Co-Pay and Spend-Down)</td>
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<td>$46,940,000</td>
<td>$31,710,000</td>
<td>$21,720,000</td>
</tr>
<tr>
<td>Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare on crossovers)</td>
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<td>$46,940,000</td>
<td>$31,710,000</td>
<td>$21,720,000</td>
</tr>
</tbody>
</table>

#### Notes:
- Medicaid Cost Settlement Payments (See Note B)
- Other Medicaid Payments Reported on Cost Report Year (See Note C)
- Medicare Paid Amount (includes uninsured/underinsureds)
- Medicare Cross-Over Bad Debt Payments
- Other Medicaid Cross-Over Payments (See Note D)
- Payment from Hospital Uninsured During Cost Report Year (Cash Basis)
- Section 1011 Payment Related to Inpatient Hospital Services MTF included in Exhibits B & B-1 (from Section E)

#### Calculated Payment Sheet:

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<thead>
<tr>
<th>Calculation</th>
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<th>103</th>
<th>104</th>
<th>105</th>
<th>106</th>
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<td>6,519,000</td>
<td>7,440,000</td>
<td>3,970,000</td>
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<td>Percentage</td>
<td>55%</td>
<td>91%</td>
<td>68%</td>
<td>67%</td>
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<td>103</td>
<td>104</td>
<td>105</td>
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<td>2,469,000</td>
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<td>1,600</td>
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</tbody>
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---

Enter in all Medicaid, TPL, and Medicare crossover payments.
**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.
<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Routine Charges</th>
<th>Ancillary Charges</th>
<th>Ancillary Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>No.</th>
<th>In-State Organ Acquisitions</th>
<th>Out-of-State Organ Acquisitions</th>
<th>Add-On Cost Factor for I&amp;R, FRA tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Long Acquisition</td>
<td>$100,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>2</td>
<td>Kidney Acquisition</td>
<td>$125,000</td>
<td>$62,500</td>
</tr>
<tr>
<td>3</td>
<td>Liver Acquisition</td>
<td>$150,000</td>
<td>$75,000</td>
</tr>
<tr>
<td>4</td>
<td>Heart Acquisition</td>
<td>$200,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>5</td>
<td>Lung Acquisition</td>
<td>$250,000</td>
<td>$125,000</td>
</tr>
<tr>
<td>6</td>
<td>Other Organ Acquisition</td>
<td>$300,000</td>
<td>$150,000</td>
</tr>
</tbody>
</table>

#### Note:
- The amounts listed above are for in-state Medicaid and uninsured patients only. If applicable, use your hospital's scale and add the appropriate cost factors.
- Out-of-state organ acquisitions should not be included in this table.
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.
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 reflect allowable costs 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 example, if your hospital removed part of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not be reflected on the DSH adjustment form, 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, LLC along with your hospital's DSH audit surveys.

<table>
<thead>
<tr>
<th>Worksheet 8: Provider Tax Assessment Reconciliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospital Gross Provider Tax Assessment (from general ledger)*</td>
</tr>
<tr>
<td>2. Hospital Gross Provider Tax Assessment included in expense on the Cost Report (WS8A, Col. 23)</td>
</tr>
<tr>
<td>3. Difference (Explain Here ————)</td>
</tr>
<tr>
<td>Additional / reduced with tax</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Tax Assessment Reclassifications (from ws A-6 of the Medicare cost report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
</tr>
<tr>
<td>6.</td>
</tr>
<tr>
<td>7.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DSH UCC ALLOWABLE: Provider Tax Assessment Adjustments (from ws A-6 of the Medicare cost report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for adjustment</td>
</tr>
<tr>
<td>Linearized to (from)</td>
</tr>
<tr>
<td>Linearized to (from)</td>
</tr>
<tr>
<td>Linearized to (from)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DSH UCC NON-ALLOWABLE: Provider Tax Assessment Adjustments (from ws A-6 of the Medicare cost report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for adjustment</td>
</tr>
<tr>
<td>Linearized to (from)</td>
</tr>
<tr>
<td>Linearized to (from)</td>
</tr>
<tr>
<td>Linearized to (from)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Net Provider Tax Assessment Expense Included In the Cost Report:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 1,390,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DSH UCC Provider Tax Assessment Adjustment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for adjustment</td>
</tr>
<tr>
<td>Linearized to (from)</td>
</tr>
<tr>
<td>Linearized to (from)</td>
</tr>
</tbody>
</table>

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

Tax reclassifications, if any, on WS A-6.

Enter tax adjustments from WS A-8 that are allowable for DSH purposes (re increased reimbursement offset).

Tax excluded from WS A.

Add'l 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 expenses and including matching facility.

** The Gross Allowable Assessment Not included in the Cost Report (line 17, above) will be apportioned to Medicaid and Uninsured based on Charge unless the hospital provides a revised cost report to include the amount in the service charge notice and per donor survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
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.
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
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).
<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Payer Plan</th>
<th>Hospital's Provider #</th>
<th>Patient Identifier#</th>
<th>Patient's Name</th>
<th>Patient's Date of Birth</th>
<th>Patient's Sex</th>
<th>Patient's Social Security Number</th>
<th>Hospital's Name</th>
<th>Discharge Date</th>
<th>Hospital's Revenue Code</th>
<th>Total Charges for Services Provided</th>
<th>Total Patient Payments for Services Provided</th>
<th>Total Third Party Payments for Services Provided</th>
<th>Revenue Code</th>
<th>Hospital's Name</th>
<th>Patient's Social Security Number</th>
<th>Patient's Name</th>
<th>Patient's Date of Birth</th>
<th>Patient's Sex</th>
<th>Patient's Social Security Number</th>
<th>Hospital's Name</th>
<th>Discharge Date</th>
<th>Hospital's Revenue Code</th>
<th>Total Charges for Services Provided</th>
<th>Total Patient Payments for Services Provided</th>
<th>Total Third Party Payments for Services Provided</th>
</tr>
</thead>
</table>
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.
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.
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).
<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Primary Payor</th>
<th>Secondary Payor</th>
<th>Insurance Paid Before</th>
<th>Insurance Paid After</th>
<th>Total Payment Before</th>
<th>Total Payment After</th>
<th>Claim Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Pay/Patient</td>
<td>Medical</td>
<td>Medical</td>
<td>505</td>
<td>12345</td>
<td>32352223</td>
<td>3/2/2022</td>
<td>999.99</td>
</tr>
<tr>
<td>Self-Pay/Patient</td>
<td>Medical</td>
<td>Medical</td>
<td>505</td>
<td>12346</td>
<td>32352223</td>
<td>3/2/2022</td>
<td>999.99</td>
</tr>
</tbody>
</table>

Exhibit B - Cash Basis Patient Payments
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.
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)
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.
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).
<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Primary/Secondary Claims</th>
<th>Hospital/Provider Name</th>
<th>Hospital/Provider Number</th>
<th>Patient ID #</th>
<th>Patient’s Name</th>
<th>Patient’s Address</th>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Service Description</th>
<th>Service Code</th>
<th>Revenue Code</th>
<th>Total Charges for Service</th>
<th>Total Medicare Payments</th>
<th>Total Other Payments</th>
<th>Total Third-Party Payments</th>
<th>Payor</th>
<th>State of Al</th>
<th>Payments Made/Credit/Credit</th>
<th>State of Al</th>
<th>Payments Made/Credit/Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>Medicaid</td>
<td>HealthCare USA</td>
<td>BCBS Blue Advantage</td>
<td>12345</td>
<td>John Doe</td>
<td>123 Main St, Anytown, USA</td>
<td>01/01/2023</td>
<td>01/31/2023</td>
<td>Inpatient</td>
<td>014000</td>
<td>040000</td>
<td>$10,000</td>
<td>$5,000</td>
<td>$2,000</td>
<td>$3,000</td>
<td>Self-Pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>Medicaid</td>
<td>HealthCare USA</td>
<td>BCBS Blue Advantage</td>
<td>67890</td>
<td>Jane Smith</td>
<td>456 Oak St, Anytown, USA</td>
<td>02/01/2023</td>
<td>02/28/2023</td>
<td>Inpatient</td>
<td>015000</td>
<td>040000</td>
<td>$15,000</td>
<td>$7,500</td>
<td>$3,000</td>
<td>$4,500</td>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>Medicaid</td>
<td>HealthCare USA</td>
<td>BCBS Blue Advantage</td>
<td>12345</td>
<td>John Doe</td>
<td>123 Main St, Anytown, USA</td>
<td>03/01/2023</td>
<td>03/31/2023</td>
<td>Inpatient</td>
<td>016000</td>
<td>040000</td>
<td>$16,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>Medicaid</td>
<td>HealthCare USA</td>
<td>BCBS Blue Advantage</td>
<td>67890</td>
<td>Jane Smith</td>
<td>456 Oak St, Anytown, USA</td>
<td>04/01/2023</td>
<td>04/30/2023</td>
<td>Inpatient</td>
<td>017000</td>
<td>040000</td>
<td>$17,000</td>
<td>$8,500</td>
<td>$5,000</td>
<td>$3,500</td>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EXHIBIT C - MANAGED CARE**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
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.
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.
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.
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.
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)
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
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)
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.
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.
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.
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).
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.
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
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.
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.
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.
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
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.
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 the rule, 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.
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.
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.
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.
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)*
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.
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.
8. Can a hospital report services covered under automobile policies 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)
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.
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)*
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)
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).