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DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE DSH YEAR 2013

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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OVERVIEW

- DSH Examination Policy
- DSH Year 2013 Examination Timeline
- DSH Year 2013 Examination Impact
- Paid Claims Data Review
- Review of DSH Year 2013 Survey and Exhibits
- 2013 Clarifications / Changes
- 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 (CONT.)

- Allotment Reductions and Additional Reporting Requirements implemented in FR Vol. 78, No. 181, September 18, 2013, Final Rule
- CMCS Informational Bulletin Dated December 27, 2013 delaying implementation of Medicaid DSH Allotment reductions 2 years.
- April 1, 2014 – P.L. 113-93 (Protecting Access to Medicare Act) delays implementation of Medicaid DSH Allotment reductions 1 additional year.
- Additional Information of the DSH Reporting and Audit Requirements – Part 2, clarification published April 7, 2014.
- Audit/Reporting implemented in FR Vol. 79, No. 232, Wednesday, Dec. 03, 2014, Final Rule

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RELEVANT DSH POLICY (CONT.)

- “Medicare Access and CHIP Reauthorization Act” - Public Law, April 16, 2015, Sec. 412 Delay of Reduction to Medicaid DSH Allotments

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DSH YEAR 2013 EXAMINATION TIMELINE

- Providers should have already received the DSH Surveys
- Surveys returned by May 20, 2016
- Draft report to the state by October 31, 2016
- Final report to CMS by December 31, 2016

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DSH YEAR 2013 EXAMINATION IMPACT

- **Per 42 CFR 455.304,** findings of state reports and audits for Medicaid state plan years 2005-2010 will not be given weight except to the extent that the findings draw into question the reasonableness of the state's uncompensated care cost estimates used for calculating prospective DSH payments for Medicaid state plan year 2011 and thereafter.
- The current DSH year 2013 examination report is the third year that may result in DSH payment recoupments.

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PAID CLAIMS DATA UPDATE FOR 2013

- Medicaid fee-for-service paid claims data
  - Will be sent to hospitals.
  - Same format as last year.
  - Reported based on cost report year (using discharge date).
  - Will exclude non-Title 19 services (such as SCHIP).

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PAID CLAIMS DATA UPDATE FOR 2013

- Medicare/Medicaid cross-over paid claims data
  - Will be sent to hospitals.
  - Same format as last year.
  - Reported based on cost report year (using discharge date).
  - 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.
  - Will exclude non-Title 19 services (such as SCHIP).

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PAID CLAIMS DATA UPDATE FOR 2013

- 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 SCHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge 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 UPDATE FOR 2013

- "Other" Medicaid Eligibles
  - Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing may not be 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 SCHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

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PAID CLAIMS DATA UPDATE FOR 2013

- "Other" Medicaid Eligibles (cont.)
  - 2008 DSH Rule and January, 2010 CMS FAQ #33 requires that ***all*** Medicaid eligibles are reported on the DSH survey and included in the UCC calculation.
  - Exhibit C should be submitted for this population. If no "other" Medicaid eligibles are submitted, we will contact you to request that they be submitted. If we still do not receive the requested Exhibit C or a signed statement verifying there are none to report, we may have to list the hospital as non-compliant in the 2013 DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicaid MCO, Medicare, Medicare HMO, private insurance, and self-pay payments in Exhibit C.
  - Discussion on current federal court injunction later in the presentation.

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PAID CLAIMS DATA UPDATE FOR 2013

- Uninsured Services
  - As in years past, uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.
  - Should be reported based on cost report year (using discharge date).
  - Exhibit B patient payments will be reported based on cash basis (received during the cost report year).

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DSH EXAMINATION 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.
    - Always complete one copy.
  - DSH Survey Part II – Cost Report Year Data.
    - Cost report year-specific information.
    - Complete a separate copy for each cost report year needed to cover the DSH year.
    - Hospitals with year end changes or that are new to DSH may have to complete 2 or 3 year ends.

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- Don't complete a DSH Part II survey for a cost report year already submitted in a previous DSH exam year.
    - Example: Hospital A provided a survey for their year ending 12/31/12 with the DSH examination of SFY 2012 in the prior year. In the DSH year 2013 exam, Hospital A would only need to submit a survey for their year ending 12/31/13.
- Both surveys have an Instructions tab that has been updated. Please refer to those tabs if you are unsure of what to enter in a section. If it still isn't clear, please contact Myers and Stauffer.

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DSH EXAMINATION 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 (audited if available).

- 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 may already be selected (if not, select from the drop-down box).
- Verify the cost report year end dates (should only include those that weren't previously submitted).
    - If these are incorrect, please call Myers and Stauffer and request a new copy.

Section B

- Answer all OB questions using drop-down boxes.

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DSH SURVEY PART I – DSH YEAR DATA

Section C

- Report any Medicaid supplemental payments, including UPL and Non-Claim Specific payments, for the state fiscal year. Do NOT include DSH payments.

Certification

- Answer the “Retain DSH” question but please note that IGTs and CPEs are not a basis for answering the question “No”.
- Enter contact information.
- Have CEO or CFO sign this section after completion of Part II of the survey.

State of Any State
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2013

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2012	06/30/2013

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

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	01/01/2013	12/31/2013
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

	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:	00-1111

Only cost report years to be submitted will show here.

Need to prepare a separate Part II DSY Survey Excel file for each cost report year listed here.

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:

	DSH Examination Year (07/01/12 - 06/30/13)
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.

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State of Any State
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2013

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2012 - 06/30/2013**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

Input all supplemental payments for the DSH year (UPL, etc...) Should agree to the state's report.

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:

Complete certification and contact information.

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

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

Hospital CEO or CFO Signature | 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:		Outside Preparer:	
Name		Name	
Title		Title:	
Telephone Number		Firm Name:	
E-Mail Address		Telephone Number	
Mailing Street Address		E-Mail Address	
Mailing City, State, Zip			

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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 year not previously submitted.

- **Question #2 – An "X" should be shown in the column of the cost report year survey you are preparing.**
  - If you have multiple years listed, you will need to prepare multiple surveys).
  - 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. If your hospital is going to update the cost report data to a more recent version of the cost report, select the status of the cost report you are using with this drop-down box.**

DSH Version 7.20 12/3/2015

D. General Cost Report Year Information 1/1/2013 - 12/31/2013

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		
	1/1/2013 through 12/31/2013		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):			
3a. Date CMS processed the HCRIS file into the HCRIS database:	12:00:00 AM		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	Hospital ABC		
5. Medicaid Provider Number:	111111		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	00-1111		

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
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 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 - You must report your Section 1011 payments included in payments on Exhibit B (posted at the patient level), and payments received but not included in Exhibit B (not posted at the patient level), and separate the 1011 payments between hospital services and non-hospital services (non-hospital services include physician services).
- If your facility received DSH payments from another state (other than your home state) these payments must be reported on this section of the survey (calculate amount for the cost report period).
- Enter in total cash basis patient payment totals from Exhibit B as instructed. These are check totals to compare to the supporting Exhibit B.

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2013 - 12/31/2013)

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 (N) 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: Uninsured payments reported on Section H do not reconcile to uninsured payments reported on Section E. Please verify this is correct.

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

- The state must report your actual MIUR and LIUR for the DSH year - data is needed to calculate the MIUR/LIUR.
- 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, record them as such, otherwise record entire amount as unspecified. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.
- Section F-2: Report charity care charges based on your own hospital financials or the definition used for your 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 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.
- 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 you have 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: Reconciling Items Necessary for Proper Calculation of LIUR

- Bad debt and charity care write-offs not included on G-3, line 2 should be entered on lines 30 and 31 so they can be properly excluded in calculating 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 32 and 33 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 34 so it can be properly excluded in calculating net patient service revenue.

State of Any State
Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 7.20

Days per cost report.

State or local govt. subsidies.

Charity care charges (only used in LIUR - NOT UCC).

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)

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.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 100,000
7.	Inpatient Charity Care Charges	450,000
8.	Outpatient Charity Care Charges	390,000
9.	Non-Hospital Charity Care Charges	
10.	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
11.	Hospital	$67,439,528.00			$ 46,480,429	$ -	$ -	$ 20,959,099
12.	Subprovider I (Psych or Rehab)	$1,892,975.00			$ 1,304,669	$ -	$ -	$ 588,306
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$279,649,863.00	$179,425,587.00		$ 192,739,271	$ 123,663,057	$ -	$ 142,673,122
20.	Outpatient Services		$1,149,822.00			$ 792,476	$ -	$ 357,346
21.	Home Health Agency			$2,780,004.00			$ 1,916,024	
22.	Ambulance			$0.00			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$2,157,554.00			$ 1,487,022	
26.	Other	$0.00	$1,944,955.00	$0.00	$ -	$ 1,340,495	$	$ 604,460
27.	Total	$ 348,982,366	$ 182,520,364	$ 4,937,558	$ 240,524,369	$ 125,796,028	$ 3,403,046	$ 165,182,333
28.	Total Hospital and Non Hospital		Total from Above	$ 536,440,288		Total from Above	$ 369,723,443	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	536,440,288	Total Contractual Adj. (G-3 Line 2)	376,033,443
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	500,000
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	1,000,000
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	90,000
33.	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
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	8,000,000
35.	Adjusted Contractual Adjustments				369,723,443
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

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

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
  - Cost
- Calculation of Ancillary Cost-to-Charge Ratios
  - Charges
  - Cost
- NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other Payors

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2013-12/31/2013) Hospital ABC

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P	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	$ 200,000,000	$ 55,000,000	$ -	$0.00	$ 255,000,000	250,000			$ 1,020.00
2	03100 INTENSIVE CARE UNIT	$ 14,000,000	$ 8,500,000	$ -		$ 22,500,000	10,000			$ 2,250.00
3	03200 CORONARY CARE UNIT	$ 7,500,000	$ -	$ -		$ 7,500,000	5,000			$ 1,500.00
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-			$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 12,500,000	$ 1,500,000	$ -		$ 14,000,000	8,000			$ 1,750.00
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-			$ -
7	04000 SUBPROVIDER I	$ 12,000,000	$ 2,000,000	$ -		$ 14,000,000	11,000			$ 1,272.73
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-			$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-			$ -
10	04300 NURSERY	$ 2,000,000	$ 40,000	$ -		$ 2,040,000	6,000			$ 340.00
11		$ -	$ -	$ -		$ -	-			$ -
12		$ -	$ -	$ -		$ -	-			$ -
13		$ -	$ -	$ -		$ -	-			$ -
14		$ -	$ -	$ -		$ -	-			$ -
15		$ -	$ -	$ -		$ -	-			$ -
16		$ -	$ -	$ -		$ -	-			$ -
17		$ -	$ -	$ -		$ -	-			$ -
18	Total Routine	$ 248,000,000	$ 67,040,000	$ -	$ -	$ 315,040,000	290,000			
19	Weighted Average									$ 1,086.34

All cost report data. Calculation of routine cost per diems.

		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)	1,100	150	-	$ 1,312,910	$106,000.00	$820,000.00	$ 926,000	1.417829

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2013-12/31/2013) | Hospital ABC

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	3700 OPERATING ROOM	70,000,000	20,000,000	-		90,000,000	154,500,000	74,000,000	228,500,000	0.393873
22	3800 RECOVERY ROOM	25,000,000	-	-		25,000,000	23,000,000	37,000,000	60,000,000	0.416667
23	3900 DELIVER ROOM & LABOR ROOM	10,000,000	1,300,000	-		11,300,000	9,000,000	2,000,000	11,000,000	1.027273
24	4000 ANESTHESIOLOGY	13,000,000	7,500,000	-		20,500,000	40,000,000	35,000,000	75,000,000	0.273333
25	4100 RADIOLOGY - DIAGNOSTIC	50,000,000	1,000,000	-		51,000,000	100,000,000	195,000,000	295,000,000	0.172881
26	4200 RADIOLOGY - THERAPEAUTIC	30,000,000	-	-		30,000,000	7,000,000	110,000,000	117,000,000	0.256410
27	4300 RADIOSOTOPE	4,000,000	170,000	-		4,170,000	5,000,000	11,000,000	16,000,000	0.260625
28	4400 LABORATORY	55,000,000	6,400,000	-		61,400,000	290,000,000	175,000,000	465,000,000	0.132043
29	4700 BLOOD STORING PROCESSING & TRAN	40,000,000	-	-		40,000,000	115,000,000	35,000,000	150,000,000	0.266667
30	4900 RESPIRATORY THERAPY	17,000,000	-	-		17,000,000	60,000,000	3,000,000	63,000,000	0.269841
31	5000 PHYSICAL THERAPY	6,500,000	-	-		6,500,000	20,000,000	200,000	20,200,000	0.321782
32	5100 OCCUPATIONAL THERAPY	2,250,000	-	-		2,250,000	7,000,000	150,000	7,150,000	0.314685
33	5200 SPEECH PATHOLOGY	1,000,000	-	-		1,000,000	2,000,000	100,000	2,100,000	0.476190
34	5300 ELECTROCARDIOLOGY	9,000,000	-	-		9,000,000	46,000,000	45,000,000	91,000,000	0.098901
35	5400 ELECTROENCEPHALOGRAPHY	1,500,000	250,000	-		1,750,000	5,500,000	750,000	6,250,000	0.280000
36	5500 MEDICAL SUPPLIES CHARGED TO PATIENT	97,000,000	-	-		97,000,000	185,000,000	60,000,000	245,000,000	0.395918
37	5530 IMPL. DEV. CHARGED TO PATIENT	120,000,000	-	-		120,000,000	180,000,000	50,000,000	230,000,000	0.521739
38	5600 DRUGS CHARGED TO PATIENTS	120,000,000	-	-		120,000,000	270,000,000	90,000,000	360,000,000	0.333333
39	5700 RENAL DIALYSIS	4,000,000	-	-		4,000,000	17,000,000	180,000	17,180,000	0.232829
40	5900 CAT SCAN	10,000,000	-	-		10,000,000	75,000,000	115,000,000	190,000,000	0.052632
41	5901 ULTRASOUND	4,500,000	75,000	-		4,575,000	7,000,000	20,000,000	27,000,000	0.169444
42	5902 CARDIAC CATHETERIZATION LABORATORY	12,500,000	500,000	-		13,000,000	35,000,000	25,000,000	60,000,000	0.216667
43	5903 ENDOSCOPY	9,500,000	-	-		9,500,000	10,000,000	25,000,000	35,000,000	0.271429
44	5907 PSYCHIATRIC/PSYCHOLOGICAL SERVICE	800,000	-	-		800,000	25,000	2,800,000	2,825,000	0.283186
45	6000 CLINIC	20,000,000	10,600,000	-		30,600,000	950,000	28,000,000	28,950,000	1.056995
46	6100 EMERGENCY	30,500,000	10,300,000	-		40,800,000	55,500,000	76,000,000	131,500,000	0.310266
126	**Total Ancillary**	$ 763,050,000	$ 58,095,000	$ -		$ 821,145,000	$ 1,719,581,000	$ 1,216,000,000	$ 2,935,581,000	
127	**Weighted Average**									0.280169
128	**Sub Totals**	$ 1,011,050,000	$ 125,135,000	$ -		$ 1,136,185,000				
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**					$ 1,136,185,000				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					12.38%				

* 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. Calculation of ancillary cost-to-charge ratios.

Enter NF, SNF, and Swing bed costs for Medicaid and Medicare per cost report. Enter data for other payors per hospital internal records.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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 / long-fall for:
  - In-State FFS Medicaid Primary *(Traditional Medicaid).*
  - In-State Medicaid Managed Care Primary *(Medicaid MCO).*
  - In-State Medicare FFS Cross-Overs *(Traditional Medicare with Traditional Medicaid Secondary).*
  - In-State Other Medicaid Eligibles *(May include Medicare MCO cross-overs and other Medicaid not included elsewhere).*

All Medicaid categories.

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

Cost Report Year (01/01/2013-12/31/2013) 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	03000 ADULTS & PEDIATRICS	$ 1,020.00		29,500		11,000		22,000			
2	03100 INTENSIVE CARE UNIT	$ 2,250.00		1,800		40		1,500			
3	03200 CORONARY CARE UNIT	$ 1,500.00		500		15		600			
4	03300 BURN INTENSIVE CARE UNIT	$ -									
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 1,750.00		1,100		140		600			
6	03500 OTHER SPECIAL CARE UNIT	$ -									
7	04000 SUBPROVIDER I	$ 1,272.73		3,000		250		2,800			
8	04100 SUBPROVIDER II	$ -									
9	04200 OTHER SUBPROVIDER	$ -									
10	04300 NURSERY	$ 340.00		1,255		4,000					
18			Total Days	37,155		15,445		27,500		-	
19	Total Days per PS&R or Other Paid Claims Summary										
20	Unreconciled Days (Explain Variance)			37,155		15,445		27,500		-	
				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			$ 955.46		$ 673.68		$ 974.55		$ -	

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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

Cost Report Year (01/01/2013-12/31/2013) 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	092xx	Observation (Non-Distinct)	1.417829	30,000	130,000	-	50,000	-	90,000	-	-
23	3700	OPERATING ROOM	0.393873	10,930,000	3,690,000	1,450,000	1,320,000	8,010,000	3,200,000	-	2,000
24	3800	RECOVERY ROOM	0.416667	1,650,000	2,170,000	290,000	730,000	1,340,000	1,890,000	-	600
25	3900	DELIVER ROOM & LABOR ROOM	1.027273	940,000	260,000	3,630,000	1,040,000	110,000	20,000	-	-
26	4000	ANESTHESIOLOGY	0.273333	2,650,000	1,360,000	480,000	570,000	1,860,000	1,070,000	-	500
27	4100	RADIOLOGY - DIAGNOSTIC	0.172881	11,930,000	13,170,000	1,260,000	3,110,000	8,860,000	10,390,000	-	10,000
28	4200	RADIOLOGY - THERAPEAUTIC	0.256410	750,000	10,540,000	60,000	1,390,000	520,000	4,790,000	-	-
29	4300	RADIOSOTOPE	0.260625	650,000	850,000	50,000	160,000	690,000	730,000	-	-
30	4400	LABORATORY	0.132043	31,920,000	15,920,000	6,140,000	6,340,000	25,430,000	10,180,000	1,500	5,000
31	4700	BLOOD STORING PROCESSING & TRAN	0.266667	11,340,000	3,030,000	2,410,000	590,000	4,800,000	2,070,000	3,000	190
32	4900	RESPIRATORY THERAPY	0.269841	6,360,000	220,000	480,000	70,000	6,530,000	180,000	-	-
33	5000	PHYSICAL THERAPY	0.321782	1,070,000	20,000	120,000	-	990,000	10,000	-	-
34	5100	OCCUPATIONAL THERAPY	0.314685	650,000	20,000	100,000	-	620,000	20,000	-	-
35	5200	SPEECH PATHOLOGY	0.476190	240,000	20,000	30,000	-	170,000	20,000	-	-
36	5300	ELECTROCARDIOLOGY	0.098901	4,780,000	3,240,000	350,000	540,000	4,740,000	2,650,000	-	2,000
37	5400	ELECTROENCEPHALOGRAPHY	0.280000	530,000	90,000	70,000	20,000	530,000	60,000	-	-
38	5500	MEDICAL SUPPLIES CHARGED TO PATIENT	0.395918	23,630,000	5,400,000	3,680,000	1,120,000	20,900,000	5,120,000	500	800
39	5530	IMPL. DEV. CHARGED TO PATIENT	0.521739	-	-	-	-	-	-	-	-
40	5600	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	5700	RENAL DIALYSIS	0.232829	1,440,000	20,000	20,000	-	3,890,000	100,000	1,800	-
42	5900	CAT SCAN	0.052632	9,460,000	10,040,000	1,070,000	2,140,000	7,020,000	5,670,000	-	-
43	5901	ULTRASOUND	0.169444	950,000	2,000,000	190,000	2,050,000	680,000	670,000	-	900
44	5902	CARDIAC CATHETERIZATION LABORATORY	0.216667	2,260,000	1,110,000	200,000	70,000	2,850,000	1,130,000	-	-
45	5903	ENDOSCOPY	0.271429	1,060,000	2,110,000	70,000	200,000	930,000	1,500,000	-	-
46	5907	PSYCHIATRIC/PSYCHOLOGICAL SERVICE	0.283186	-	360,000	-	10,000	10,000	1,340,000	-	-
47	6000	CLINIC	1.056995	50,000	4,460,000	60,000	2,690,000	70,000	2,430,000	-	-
48	6100	EMERGENCY	0.310266	8,670,000	10,940,000	1,210,000	6,530,000	7,050,000	4,630,000	-	-
				$ 164,080,000	$ 96,950,000	$ 28,580,000	$ 31,770,000	$ 130,930,000	$ 65,170,000	$ 7,600	$ 22,390

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Medicaid Payments Include:
  - Claim payments.
    - NEW PAYMENT LINES – Payments should be broken out between payor sources
    - Payment lines added for Medicaid Managed Care payments, Medicare HMO payments, Private Insurance, and Self-Pay
  - Medicaid cost report settlements.
  - Medicare bad debt payments (cross-overs).
  - Medicare cost report settlement payments (cross-overs).

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

Cost Report Year (01/01/2013-12/31/2013) Hospital ABC

	Totals / Payments	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)	
128	**Total Charges** *(Includes organ acquisition from Section J)*	$ 199,580,000	$ 96,950,000	$ 38,985,000	$ 31,770,000	$ 157,730,000	$ 65,170,000	$ 11,100	$ 22,390
129	Total Charges per PS&R or Other Paid Claims Summary	$ 199,580,000	$ 96,950,000	$ 38,985,000	$ 31,770,000	$ 157,730,000	$ 65,170,000	$ 11,100	$ 22,390
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-
131	**Total Calculated Cost (Includes organ acquisition from Section J)**	$ 84,364,961	$ 25,679,281	$ 23,546,916	$ 10,315,678	$ 65,362,461	$ 17,125,232	$ 1,882	$ 4,414
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 46,300,000	$ 20,000,000	$ -	$ -	$ 1,000,000	$ 2,000,000	$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 10,000,000	$ 1,000,000	$ 15,500,000	$ 9,000,000	$ 500,000	$ 1,150,000	$ -	$ -
134	Private Insurance (Including primary and third party liability)	$ 10,000	$ 900,000	$ 580,000	$ 250,000	$ 10,000	$ 7,000	$ -	$ 156
135	Self-Pay (Including Co-Pay and Spend-Down)	$ 6,000	$ 10,000	$ 20,000	$ 50,000	$ 5,000	$ 3,000	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 56,316,000	$ 21,910,000	$ 16,100,000	$ 9,300,000				
137	Medicaid Cost Settlement Payments (See Note B)								
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)								
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 50,000,000	$ 10,000,000	$ 1,000	$ 1,900
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ 10,000,000	$ 500,000	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments					$ 2,000,000	$ 7,000	$ 300	$ 400
142	Other Medicare Cross-Over Payments (See Note D)					$ 8,200,000	$ 1,200,000	$ -	$ -
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)								
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)								
145	**Calculated Payment Shortfall / (Longfall)**	$ 28,048,961	$ 3,769,281	$ 7,446,916	$ 1,015,678	$ (6,352,539)	$ 2,258,232	$ 582	$ 1,958
146	**Calculated Payments as a Percentage of Cost**	67%	85%	68%	90%	110%	87%	69%	56%

Enter in all Medicaid, Medicare, Private Insurance, Self-Pay, Cost Settlement, and Medicare Crossover payments. **NEW LINES to split out Medicaid Managed Care, Medicare Managed Care, and Private Insurance Payments.**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.
- Survey form Exhibit A shows the data elements that need to be collected and provided to Myers and Stauffer.
- For uninsured payments, enter the uninsured hospital patient payment totals from your Survey form Exhibit B. Do NOT pick up 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 (01/01/2013-12/31/2013) | 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	03000 ADULTS & PEDIATRICS	$ 1,020.00		1,000	
2	03100 INTENSIVE CARE UNIT	$ 2,250.00		80	
3	03200 CORONARY CARE UNIT	$ 1,500.00		60	
4	03300 BURN INTENSIVE CARE UNIT	$ -			
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 1,750.00		120	
6	03500 OTHER SPECIAL CARE UNIT	$ -			
7	04000 SUBPROVIDER I	$ 1,272.73		400	
8	04100 SUBPROVIDER II	$ -			
9	04200 OTHER SUBPROVIDER	$ -			
10	04300 NURSERY	$ 340.00		60	
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			$ 1,850,000	
21.01	Calculated Routine Charge Per Diem			$ 1,075.58	
	Ancillary Cost Centers (from W/S C) (from Section G)			**Ancillary Charges**	**Ancillary Charges**
22	092xx Observation (Non-Distinct)		1.417829	-	60,000
23	3700 OPERATING ROOM		0.393873	3,640,000	2,000,000
24	3800 RECOVERY ROOM		0.416667	1,160,000	1,250,000
25	3900 DELIVER ROOM & LABOR ROOM		1.027273	100,000	30,000
26	4000 ANESTHESIOLOGY		0.273333	1,640,000	960,000
27	4100 RADIOLOGY - DIAGNOSTIC		0.172881	2,000,000	4,000,000
28	4200 RADIOLOGY - THERAPEAUTIC		0.256410	140,000	1,990,000
29	4300 RADIOISOTOPE		0.260625	220,000	300,000
30	4400 LABORATORY		0.132043	5,000,000	6,000,000
31	4700 BLOOD STORING PROCESSING & TRAN		0.266667	2,000,000	970,000
32	4900 RESPIRATORY THERAPY		0.269841	1,030,000	250,000
33	5000 PHYSICAL THERAPY		0.321782	300,000	10,000
34	5100 OCCUPATIONAL THERAPY		0.314685	210,000	10,000
35	5200 SPEECH PATHOLOGY		0.476190	40,000	-
36	5300 ELECTROCARDIOLOGY		0.098901	580,000	650,000
37	5400 ELECTROENCEPHALOGRAPHY		0.260000	110,000	40,000
38	5500 MEDICAL SUPPLIES CHARGED TO PATIENT		0.395918	3,000,000	2,000,000
39	5530 IMPL. DEV. CHARGED TO PATIENT		0.521739	-	-
40	5600 DRUGS CHARGED TO PATIENTS		0.333333	1,800,000	1,300,000
41	5700 RENAL DIALYSIS		0.232629	90,000	2,900,000
42	5900 CAT SCAN		0.052632	3,000,000	720,000
43	5901 ULTRASOUND		0.169444	290,000	290,000
44	5902 CARDIAC CATHETERIZATION LABORATORY		0.216667	1,150,000	710,000
45	5903 ENDOSCOPY		0.271429	400,000	10,000
46	5907 PSYCHIATRIC/PSYCHOLOGICAL SERVICE		0.283186	-	-
47	6000 CLINIC		1.056995	10,000	1,870,000
48	6100 EMERGENCY		0.310266	2,100,000	7,000,000
				$ 30,010,000	$ 35,240,000
	Totals / Payments				
128	**Total Charges (Includes organ acquisition from Section J)**			$ 31,860,000 (Agrees to Exhibit A)	$ 35,240,000 (Agrees to Exhibit A)
129	Total Charges per PS&R or Other Paid Claims Summary				
130	Unreconciled Charges (Explain Variance)				
131	**Total Calculated Cost (Includes organ acquisition from Section J)**			$ 9,713,438	$ 10,477,994
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down)				
134	Private Insurance (including primary and third party liability)				
135	Self-Pay (including Co-Pay and Spend-Down)				
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)				
137	Medicaid Cost Settlement Payments (See Note B)				
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)				
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)				
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)				
141	Medicare Cross-Over Bad Debt Payments			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)
142	Other Medicare Cross-Over Payments (See Note D)				
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)			$ 250,000	$ 1,000,000
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Sectio			$ 5,000	$ 2,500
145	**Calculated Payment Shortfall / (Longfall)**			$ 9,458,438	$ 9,475,434
146	**Calculated Payments as a Percentage of Cost**			3%	10%

Uninsured days - must 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, UNINSURED

- If BOTH of the following conditions are met, a hospital is NOT required to submit any uninsured data on the survey nor Exhibits A and B:

1. The hospital Medicaid shortfall is greater than the hospital's total Medicaid DSH payments for the year.
    - The shortfall is equal to all Medicaid (FFS, MCO, cross-over, In-State, Out-of-State) cost less all applicable payments in the survey and non-claim payments such a UPL, GME, outlier, and supplemental payments.

2. The hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals.

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DSH SURVEY PART II SECTION H, UNINSURED

NOTE: It is important to remember that if you are not required to submit uninsured data that it may still be to the advantage of the hospital to submit it.

1. Your hospital's total UCC may be used to redistribute overpayments from other hospitals (to your hospital).
2. Your hospital's total UCC may be used to establish future DSH payments.
3. CMS DSH allotment reductions may be partially based on states targeting DSH payments to hospitals with high uninsured and Medicaid populations.

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

- Additional Edits
  - In the far right column, you will see an edit message if your total charges or days by cost center exceed those reported from the cost report in Section G of the survey. Please clear these edits prior to filing the 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 services to several other states, please consolidate your data and provide support for your survey responses.

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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 recently audited 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 D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey.

Add-On Cost Factor for I&R, Provider Tax.

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

Cost Report Year (01/01/2013-12/31/2013) Hospital ABC

In-State organ acquisitions.

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$0.00	$ -	$ -		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 (01/01/2013-12/31/2013) Hospital ABC

Out-of-State organ acquisitions.

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

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

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- **Federal Register / Vol. 75, No. 157 dated Monday, August 16, 2010 (CMS-1498-F)**
  - Discussion on costs of provider taxes as allowable costs for CAHs. (page 50362)
  - CMS is concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, ‘‘incur’’ the entire amount of these assessed taxes. (page 50363)

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

"This clarification will not have an effect of disallowing any particular tax but rather make clear that our **Medicare contractors** will continue to **make a determination** of whether a provider tax is allowable, on a **case-by-case basis**, using our current and longstanding reasonable cost principles. In addition, the **Medicare contractors** will continue to determine if an adjustment to the amount of allowable provider taxes is warranted to account for payments a provider receives that are associated with the assessed tax." (emphasis added)

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- Due to Medicare cost report tax adjustments, an adjustment to cost may be necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals.
- Medicaid and uninsured share of the provider tax assessment is an allowable cost for Medicaid DSH even if Medicare offsets some of the tax.

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- The Medicaid DSH audit rule clearly indicates that the portion of permissible provider taxes applicable to Medicaid and uninsured is an allowable cost for the Medicaid DSH UCC. (FR Vol. 73, No. 245, Friday, Dec. 19, 2008, page 77923)
- By "permissible", they are referring to a "valid" tax in accordance with 42 CFR §433.68(b).

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- *Ober Kaler 2005 and 2006 Illinois Tax Groups v. Blue Cross Blue Shield Association/National Government Services, ¶82,616, (Mar. 30, 2010)* supports allowing the provider taxes to be treated differently for Medicare than for Medicaid.

- *Abraham Lincoln Memorial Hospital v. Sebelius*, No. 11-2809 (7th Cir. October 16, 2012) also states that because the two programs are independent of one another, CMS's decisions with respect to a State's Medicaid program are not controlling on how CMS interprets the application of Medicare provisions.

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- Section L is used to report allowable Medicaid Provider Tax.
- Added to assist in reconciling total provider tax expense reported in the cost report and the amount actually incurred by a hospital (paid to the state).
- Complete the section using cost report data and hospital's own general ledger.

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- All permissible provider tax not included in allowable cost on the cost report will be added back and allocated to the Medicaid and uninsured UCC on a reasonable basis (e.g., charges).

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- At a minimum the following should still be excluded from the final tax expense:
  - Additional payments paid into the association "pool" should NOT be included in the tax expense.
  - Association fees.
  - Non-hospital taxes (e.g., nursing home and pharmacy taxes).

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 examination surveys.

Enter in G/L and cost report total tax amount.

Cost Report Year (01/01/2013-12/31/2013) Hospital ABC

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 10,000,000		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense		*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 10,000,000	6.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here -------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	Recovery offset for Medicare rules	$ (5,000,000)	6.00	*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*	Payment to association "pool"	$ (50,000)	6.00	
13	*Reason for adjustment*	Payment for association fees	$ (35,000)	6.00	
14	*Reason for adjustment*	Nursing home provider taxes	$ (500,000)	6.00	
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 4,415,000		

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

Enter in tax adjustments on W/S A-8 that are allowable for Medicaid DSH.

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 5,000,000
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	Charges	593,218,490
19	Uninsured Hospital	Charges	66,900,000
20	Total Hospital	Charges	2,959,000,000
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		20.05%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		2.26%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 1,002,397
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 113,045
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 1,115,442**

Enter in tax adjustments on W/S A-8 that are not allowable even for Medicaid DSH.

Tax allocation to UCC is estimated here but is subject to examination.

** 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 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 discharges 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*, *Secondary Payor Plan*, *Provider #, PCN, Birth Date, SSN*, and *Gender, Name, Admit, Discharge, Service Indicator, Revenue Code, Total Charges, Days, Patient Payments, Private Insurance Payments, and Claim Status* fields.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.

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EXHIBIT A - UNINSURED

- Claim Status (Column R) is the same as the prior year – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the December 3, 2014 final DSH rule.
  - If exhausted / non-covered insurance services are included on Exhibit A, then they 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 Private Insurance Payments for Services Provided (Q)	Claim Status (Exhausted or Non-Covered Service, if applicable) (R)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7			
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3			
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	460	$ 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 their 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 you can sub-total the uninsured hospital patient payments and enter them 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 2013 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2013 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*, *Payment Transaction Code, Provider #, PCN, Birth Date, SSN*, and *Gender, Admit, Discharge, Date of Collection, Amount of Collection, 1011 Indicator, Service Indicator, Hospital Charges, Physician Charges, Non-Hospital Charges, Insurance Status, Claim Status and Calculated Collection* fields.
    - 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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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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.

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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).
  - Self-reported Medicaid/Medicare cross-over data (Section H).
  - Self-Reported Medicaid Eligible but Not Billed 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, Hospital MCD #, PCN, Patient's MCD Recipient #, DOB, Social, Gender, Name, Admit, Discharge, Service Indicator, Rev Code, Total Charges, Days, Medicare Traditional Payments,* ***Medicare Managed Care Payments****, Medicaid FFS Payments,* ***Medicaid Managed Care Payments****, Private Insurance Payments, Self-Pay Payments, and Sum All Payments* fields.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.
  - 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 Traditional Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services Provided (T)	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)+(
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	000000	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	000000	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	200	$ 1,500	1	$ -	$ -	$ -	$ 1,500	$ 50	$ -	$ 1,550
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	000000	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	000000	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	000000	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	000000	978654321	7/12/1965	999-99-999	Female	Johnson, Sandy	9/30/2010	9/30/2010	Outpatient	250	$ 100	-	$ -	$ -	$ -	$ 900	$ -	$ 75	$ 975
Medicaid MCO	Family Health Partners		12345	000000	978654321	7/12/1965	999-99-999	Female	Johnson, Sandy	9/30/2010	9/30/2010	Outpatient	300	$ 375	-	$ -	$ -	$ -	$ 900	$ -	$ 75	$ 975
Medicaid MCO	Family Health Partners		12345	000000	978654321	7/12/1965	999-99-999	Female	Johnson, Sandy	9/30/2010	9/30/2010	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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DSH SURVEY PART I – DSH YEAR DATA

Checklist

- 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 examination.
- Includes Myers and Stauffer address and phone numbers.
- Include Item # in file name (e.g. 4_Exh A Logic)

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DSH SURVEY PART I – DSH YEAR DATA

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. N/A
4. N/A
5. (a) Electronic Copy of Exhibit A – Uninsured Charges/Days.
    - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)*.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

5. (b) Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

6. (a) Electronic Copy of Exhibit B – Self-Pay Payments.

   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

6. (b) Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.

7. (a) 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).*

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

7. (b) Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

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

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

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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

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

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

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

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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

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

15. (b) 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).

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

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

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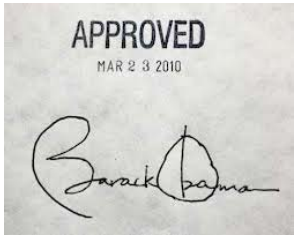
2013 CLARIFICATIONS

- *DSH Allotments*
  - Allotment reduction has been delayed even further until federal fiscal year 2018, through the Medicare Access and CHIP Reauthorization Act of 2015. The total reduction amount was increased to $2,000,000,000 for 2018.



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2013 CLARIFICATIONS / CHANGES

- *Labor and delivery days and costs associated with L&D equivalent days must be properly matched in the Medicaid version of the cost report for accurate calculation of costs.*
  - In some states, hospitals are adding labor and delivery days from line 32 of S-3 to total adults and peds days on line 1 of S-3 in the Medicaid version of their cost reports. However, the costs associated with these days are not reclassified from labor and delivery to adults and peds.
  - This understates the A&P per diem for the calculation of the DSH UCC.
  - If L&D day costs are included in adults and peds in the cost report, it is proper to add the L&D days to A&P days in calculating the per diem.

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2013 CLARIFICATIONS / CHANGES

- *Labor and delivery days and costs (Continued)*
  - The methodology used to capture labor and delivery cost and days is also dependent on whether labor and delivery days are counted in the hospital census and whether they are billed as an inpatient day.
    - *According to Medicare guidelines, a labor and delivery day is defined as a day during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission. In the case where the maternity patient is in a single multipurpose labor, delivery and postpartum room, hospital must determine the proportion of each inpatient stay that is associated with ancillary services versus routine adult and pediatric services and report the days associated with the labor and delivery portion of the stay on line 32 of S-3.*
  - If the L&D days are billed as inpatient days, the days should also be included in total days.

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2013 CLARIFICATIONS / CHANGES

- *Managed Care contracts with all-inclusive rates.*
  - If MCO payments are all-inclusive, providers should remove the professional fee portion of the payment from the DSH surveys, if identifiable.
  - If hospital cannot identify the pro-fee portion of the payment, a reasonable % to total allocation of payments to professional fees will be accepted.

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2013 CLARIFICATIONS / CHANGES

- *OB Requirements*
  - Section 1923(d) of the SSA includes exceptions to OB service requirements. One exception is that hospitals that did not offer emergency OB services to the general population as of December 22, 1987 are not required to meet the two-OB rule for DSH payment eligibility.
  - CMS issued a clarification titled *Additional Information on the DSH Reporting and Auditing Requirements* on April 7, 2014.
    - "The law does not contemplate a grandfathering clause or otherwise make exception to the obstetrician requirement for hospitals that came into existence after December 22, 1987; therefore, such hospitals would not be considered exempt from the obstetrician requirement at section 1923(d) of the act."

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2013 CLARIFICATIONS / CHANGES

- *December 3, 2014 Final Rule*
  - Definitions of uninsured as laid out in the January 2012 proposed rule have been finalized.
  - Myers and Stauffer has been utilizing the definitions of uninsured as stated in the January 2012 proposed rule since the 2009 DSH examinations.
  - Now that the proposed rule has been finalized, Myers and Stauffer will continue to utilize those definitions as they have been since the 2009 DSH examinations.
  - For details and examples of the definition of uninsured based on the December 3, 2014 Final Rule, see the “Uninsured Definitions” tab of DSH Survey Part II.

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2013 CLARIFICATIONS

- The 2008 DSH rule and January, 2010 CMS FAQ #33 both require that a hospital's DSH uncompensated care cost include all Other Medicaid Eligibles.

- The 2008 DSH rule specifically states that the UCC calculation must include "regular Medicaid payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and 1011 payments." *FR Vol. 73, No. 245, Friday, Dec. 19, 2008, Final Rule, 77904*

- January, 2010 CMS FAQ #33 was issued on January 10, 2010, and clarified that the Other Medicaid Eligible population includes patients with private insurance who are dually eligible for Medicaid, and that any payments from private insurance must be included in the UCC calculation. *(See question and answers at the end of this presentation.)*

- Seattle Children's and Texas Children's Hospitals have sued to stop recoupments of their DSH overpayments that have resulted from the inclusion of these private insurance claims in their DSH UCC. On December 29, 2014, a federal court ordered an injunction against Washington and Texas state Medicaid agencies and CMS preventing the state and/or CMS from recouping the overpayments as included in the DSH examination report.

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2013 CLARIFICATIONS

- This does **not** change how Myers and Stauffer or any other independent CPA firm must calculate a hospital's uncompensated care cost for the 2013 DSH examinations at this time.

- Until new CMS audit guidance is issued, we must continue to calculate each hospital's UCC including all Other Medicaid Eligibles (including those with private insurance).

- However, we do recommend that you submit your Other Medicaid Eligibles exactly as requested in Exhibit C. Specifically, ensure that you **separately identify** each claims' Medicaid FFS, Medicaid Managed Care, Medicare Traditional, Medicare Managed Care, Private Insurance and Self-Pay payments into their individual columns as laid out in the Exhibit A-C template that was provided on your disc.

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PRIOR YEAR DSH EXAMINATION (2012)

Significant Data Issues in Final Report

- DSH Surveys Part I and Part II were not completed.
- Hospitals included patients that had third party coverage in their uninsured data (Exhibit A).
- No support for allocation/mapping of days and charges to cost centers in DSH Survey Part I Section H.

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PRIOR YEAR DSH EXAMINATION (2012)

Common Issues Noted During Examination

- Hospitals had duplicate patient claims in the uninsured, cross-over, and state's Medicaid FFS data.
- 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, and non-Medicaid untimely filings as uninsured patient claims.

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PRIOR YEAR DSH EXAMINATION (2012)

Common Issues Noted During Examination

- Charges and days reported on survey exceeded total charges and days reported on the cost report (by cost center).
- Inclusion of patients in the uninsured charges listing (Exhibit A) that are concurrently listed as insured in the payments listing (Exhibit B).
- Patients listed as both insured and uninsured in Exhibit B for the same dates of service.

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PRIOR YEAR DSH EXAMINATION (2012)

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.
- Under the December 3, 2014 final DSH rule, 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 (2012)

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 (2012)

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 (2012)

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 examination date.

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PRIOR YEAR DSH EXAMINATION (2012)

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 (2012)

Common Issues Noted During Examination

- Medicaid portion of Medicare GME payments for cross-over claims was not included in the DSH Survey Part II.

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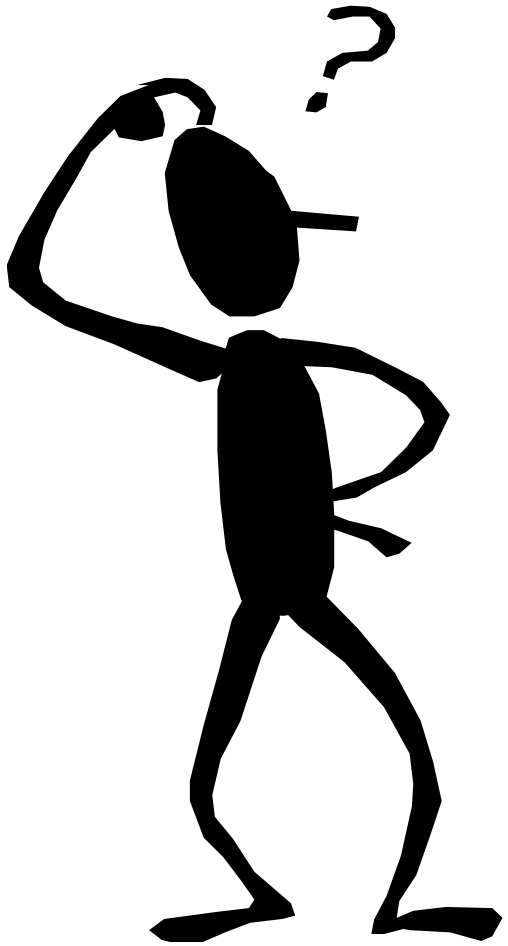

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OTHER INFORMATION

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

Upload completed surveys and other data to the FTP site.

Questions concerning the FTP site can be directed to:
Tammy Zimmerman: TZimmerman@mslc.com

Questions concerning DSH Surveys and Exh. A-C can be directed to:
Erik Grimes: EGrimes@mslc.com
Johstin Williams: JWilliams@mslc.com

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

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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) for the specific inpatient or outpatient hospital service provided. Prisoners must be excluded.

   - On December 3, 2014, CMS finalized the proposed rule published on January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.
   - Under this final DSH rule, the DSH examination looks at whether a patient is uninsured using a “service-specific” approach.
   - Based on the 2014 final DSH rule, the survey allows for hospitals to report “fully 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 2014 final DSH 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 DSH rule, hospitals can report services if insurance is “fully 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 2014 final DSH 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 2014 final DSH rule as an exhausted or insurance non-covered service (but those must be separately identified).

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FAQ

8. How do IMDs (Institutes for Mental Disease) report patients between 22-64 that are not Medicaid-eligible due to their admission to the IMD?

- Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as uncompensated care for the uninsured. If these individuals are reported on the Medicaid eligibility rolls, they should be reported as uncompensated care for the Medicaid population. *(Reporting pg. 77929 and CMS Feb. 2010 FAQ #28 – Additional Information on the DSH Reporting and Audit Requirements)*

- Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare, they cannot be included in the DSH UCC.

  - Under the 2014 final DSH rule, these patients may be included in the DSH UCC if Medicare is exhausted.

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FAQ

9. 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

10. 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.

11. 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

12. 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)*

13. 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

14. 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)*

15. 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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FAQ

16. Do Other Medicaid Eligibles (Private Insurance/Medicaid) have to be included in the Medicaid UCC?

Days, costs, and revenues associated with patients that are dually eligible for Medicaid and private insurance should be included in the calculation of the Medicaid inpatient utilization rate (MIUR) for the purposes of determining a hospital eligible to receive DSH payments. Section 1923(g)(1) does not contain an exclusion for individuals eligible for Medicaid and also enrolled in private health insurance. Therefore, days, costs and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. *(January, 2010 CMS FAQ 33 titled, "Additional Information on the DSH Reporting and Audit Requirements")*

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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:

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

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