DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE DSH YEAR 2014

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
OVERVIEW

- DSH Policy
- DSH Year 2014 Procedures Timeline
- DSH Year 2014 Procedures Impact
- Paid Claims Data Review
- Review of DSH Year 2014 Survey and Exhibits
- 2014 Clarifications / Changes
- Recap of Prior Year (2013)
- Myers and Stauffer DSH FAQ
RELEVANT DSH POLICY

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

- “Medicare Access and CHIP Reauthorization Act” - Public Law, April 16, 2015, Sec. 412 Delay of Reduction to Medicaid DSH Allotments
DSH YEAR 2014 PROCEDURES

TIMELINE

• Survey files and data request emailed to hospitals on February 7, 2017

• Tentatively the State MMIS FFS data and supplemental/enhanced payments will be provided to hospitals the week of March 6th

• Completed surveys and patient level detail due by March 31, 2017

• Draft report to the state by September 30, 2017

• Final report to CMS by December 31, 2017
**DSH YEAR 2014 PROCEDURES 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 2014 report is the fourth year that may result in DSH payment recoupments.
PAID CLAIMS DATA UPDATE FOR 2014

- Medicaid fee-for-service paid claims data
  - Will be sent to hospitals within the next few days via the FTP site.
  - Same summary format as last year.
  - At revenue code level.
  - Detailed data is available upon request.
  - Will exclude non-Title 19 services (such as CHIP).
PAID CLAIMS DATA UPDATE FOR 2014

• Medicare/Medicaid cross-over paid claims data
  • This data was not provided last year.
  • Reported based on cost report year (using discharge date).
  • At revenue code level.
  • The hospital should submit the claims detail in the Exhibit C format.
• Medicare/Medicaid cross-over paid claims data (cont.)
  
  • Hospital is responsible for ensuring all Medicare payments are included in the final survey even if the payments are not reflected in the paid claim totals. Non-claims based Medicare payments can include:

  - Medicare Cost Report settlement
  - Direct GME payments
  - Medicare DSH adjustments
  - Organ Acquisition payments
  - Pass-through cost payments
  - Bad Debt reimbursement
  - IME payments
  - Inpatient capital payments
  - Intern and resident payments
  - Transitional corridor payments

• Note: The expectation is that Critical Access Hospitals are reimbursed at cost after sequestration.
PAID CLAIMS DATA UPDATE FOR 2014

- Medicaid managed care paid claims data is not available
  - This data was not provided last year.
  - If the hospital cannot obtain a paid claims listing from the MCO, the hospital should send in a detailed listing in Exhibit C format.
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).
PAID CLAIMS DATA UPDATE FOR 2014

- 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 CHIP 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.
PAID CLAIMS DATA UPDATE FOR 2014

- “Other” Medicaid Eligibles (including Private Insurance/Medicaid)
  - 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 CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).
PAID CLAIMS DATA UPDATE FOR 2014

• “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 2014 DSH report.

• Ensure that you separately report Medicaid, Medicaid MCO, Medicare, Medicare HMO, private insurance, and self-pay payments in Exhibit C.
PAID CLAIMS DATA UPDATE FOR 2014

- 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).
FILES EACH HOSPITAL RECEIVED

- Notice of the 2014 DSH Procedures:
  - DSH Survey Part I – DSH year data
  - DSH Survey Part II – cost report year data
  - Exhibit A-C Hospital Provided Claims Data Template
  - DSH Survey - Revenue Code Crosswalk Template
- Data received from the State and provided to the hospitals:
  - Traditional FFS MMIS data
  - Supplemental/Enhanced Payments
DSH 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.
DSH SURVEYS

General Instruction – Survey Files

• Don’t complete a DSH Part II survey for a cost report year already submitted in a previous DSH year.

  • Example: Hospital A provided a survey for their year ending 12/31/13 with the DSH procedures for SFY 2013 in the prior year. In the 2014 DSH year, Hospital A would only need to submit a survey for their year ending 12/31/14.

• 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.
DSH 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.
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.
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.
1. DSH Year:
   - Begin: 10/01/2013
   - End: 09/30/2014

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

3. Identification of cost reports needed to cover the DSH Year:
   - Cost Report Year 1
   - Begin Date(s): 01/01/2014
   - End Date(s): 12/31/2014

4. Cost Report Year 2 (if applicable)
5. Cost Report Year 3 (if applicable)

6. Medicaid Provider Number:
   - Data: 1111111

7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
   - Data: 0

8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
   - Data: 0

9. Medicare Provider Number:
   - Data: 00-1111

B. DSH OB Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:

1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)

2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?

3. Was the hospital exempt from the requirement listed under #1 above because it did not offer nonemergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

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

3b. What date did the hospital open?
C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for DSH Year 10/01/2013 - 09/30/2014
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

Certification:

1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.

   Explanation for "No" answers:

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

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

   Hospital CEO or CFO Signature
   Title
   Date

   Hospital CEO or CFO Printed Name

Contact Information for individuals authorized to respond to inquiries related to this survey:
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 will already be 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.
D. General Cost Report Year Information 1/1/2014 - 12/31/2014

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

2. Select Cost Report Year Covered by this Survey (enter "X"):
   - 1/1/2014 through 12/31/2014

3. Status of Cost Report Used for this Survey (should be noted if available):

3a. Date CMS processed the HCRIS file into the HCRIS database:
   - 12:00:00 AM

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:

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).
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: (01/01/2014 - 12/31/2014)**

1. **Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1** (See Note 1)
2. **Section 1011 Payment Related to Inpatient Hospital Services NOT included in Exhibits B & B-1** (See Note 1)
3. **Section 1011 Payment Related to Outpatient Hospital Services NOT included in Exhibits B & B-1** (See Note 1)
4. **Total Section 1011 Payments Related to Hospital Services** (See Note 1)
5. **Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1** (See Note 1)
6. **Section 1011 Payment Related to Non-Hospital Services NOT included in Exhibits B & B-1** (See Note 1)
7. **Total Section 1011 Payments Related to Non-Hospital Services** (See Note 1)

8. **Out-of-State DSH Payments** (See Note 2)
   - **Inpatient**
   - **Outpatient**
   - **Total**

9. **Total Cash Basis Patient Payments from Uninsured** (On Exhibit B)
10. **Total Cash Basis Patient Payments from All Other Patients** (On Exhibit B)
11. **Total Cash Basis Patient Payments Reported on Exhibit B** (Agrees to Column(N) on Exhibit B)
12. **Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:**

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

    **Should include all non-claim-specific payments such as lump sum payments (full Medicaid pricing, supplemental, quality payments, bonus payments, capitation payments received by the hospital NCOI, or other incentive payments):**

14. **Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services**
15. **Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services**
16. **Total Medicaid managed care non-claims payments (see question 13 above) received**

**Note 1:** Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled “Section 1011 Payments Related to Non-Hospital Services.” Otherwise report 100 percent of the funds you received in the section related to hospital services.

**Note 2:** Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

### 1101 Payment (undocumented patients) Reconciliation.

### Out-of-State DSH payments

### Should agree to the total cash-basis payments on the submitted Exhibit B.
DSH YEAR SURVEY PART II
SECTION F MIUR/LIUR

- 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).
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.
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.
**F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2014 – 12/31/2014)**

1. **Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)**
   - Total Hospital Days Per Cost Report Excluding Swing-Bed (CRF, W2G-0, Pt I, Col 8; Sum of Lns. 14, 16, 17, 18, 20-30, 31 less lines 5 & 6)
   - Note: In Section F-3, below
   - Days per cost report: [Value]

2. **Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-income Utilization Ratio (LIUR) Calculation):**
   - State or local govt. subsidies
   - Charity care charges (only used in LIUR, Not UCC)

3. **Calculation of Net Hospital Revenue from Patient Services (Used for LIUR with O-2 and O-3 of Cost report):**
   - Total Patient Revenues (Charges)
     - Inpatient Hospital
     - Outpatient Hospital
     - Non-Hospital
   - Contractual Adjustments (formulas below can be overwritten if amounts are known)
     - Inpatient Hospital
     - Outpatient Hospital
     - Non-Hospital
   - Net Hospital Revenue

**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 HCOR5 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 Per Cost Report**
  - Total Patient Revenues (O-3, Line 1)
  - Total Contractual Adj. (O-3, Line 2)

**Reconciling lines utilized to ensure that only true contractuals are include in the calculation of the LIUR**

**Overwrite Contractual formulas if unreasonable or hospital has actual numbers by service center**
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

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<th>Line #</th>
<th>Cost Center Description</th>
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<th>B/P</th>
<th>O/P Charges</th>
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<td>18</td>
<td>19000 STAFF NURSE</td>
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<td>256</td>
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<td>$1,107.10</td>
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<td>Total Routine</td>
<td>$60,846.456</td>
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<td>$75,750.568</td>
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<td>$98,657</td>
<td>$1,063.02</td>
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<td>Weighted Average</td>
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<td>60</td>
<td>256</td>
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</table>

### Observation Data (Non-Distinct)

<table>
<thead>
<tr>
<th>Observation</th>
<th>Observation (Non-Distinct)</th>
<th>Calculation of observation CCR - uses per diems calculated in first section to carve out and calculate observation cost.</th>
</tr>
</thead>
<tbody>
<tr>
<td>032/40 Observation</td>
<td>3.829</td>
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</table>

Note: All cost report data. Calculation of routine cost per diems.
### G. Cost Report - Cost / Days / Charges

#### Cost Report Year (01/01/2014-12/31/2014)

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Total Allowable Cost</th>
<th>Intern &amp; Resident Costs Remained on Cost Report</th>
<th>Total Cost</th>
<th>NP</th>
<th>OP Charges</th>
<th>Total Charges</th>
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<tbody>
<tr>
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<td>Cost Report Worksheet B, Part I, Col. 25</td>
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<tr>
<td>21</td>
<td>OPERATING ROOM</td>
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<td>$2,518,026</td>
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<td>22</td>
<td>RECOVERY ROOM</td>
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<td>23</td>
<td>DELIVERY ROOM &amp; LABOR ROOM</td>
<td>$4,261,310.00</td>
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<td>$4,708,486</td>
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<td>24</td>
<td>ANESTHESIOLOGY</td>
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<td>25</td>
<td>RADIOLOGY-CLINICAL</td>
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<td>RADIOLOGY-ROBOTIC</td>
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<td>$2,043,610</td>
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<td>RADIOPHYSICSE</td>
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<td>28</td>
<td>CT SCAN</td>
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<td>$2,112,173</td>
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<td>29</td>
<td>MRI</td>
<td>$1,420,588.00</td>
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<tr>
<td>30</td>
<td>RADIOLOGIC GASTEROGRAPHY</td>
<td>$2,500,281.00</td>
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<td>$0.00</td>
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<td>31</td>
<td>LABORATORY</td>
<td>$115,712,728.00</td>
<td>$17,978</td>
<td>$115,890,706</td>
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<td>32</td>
<td>RESPIRATORY THERAPY</td>
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<td>$260,382</td>
<td>$3,166,295</td>
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<td>33</td>
<td>PHYSICAL THERAPY</td>
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<td>$2,923,317</td>
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<td>34</td>
<td>OCCUPATIONAL THERAPY</td>
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<td>35</td>
<td>SPEECH PATHOLOGY</td>
<td>$183,124.00</td>
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<td>36</td>
<td>ELETRONIC SCOPICOSPANIC</td>
<td>$3,418,581.00</td>
<td>$392,317</td>
<td>$3,810,898</td>
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<td>37</td>
<td>MEDICAL SUPPLIES CHARGED TO PAY</td>
<td>$14,766,737</td>
<td>$10,222,345</td>
<td>$24,989,082</td>
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<tr>
<td>38</td>
<td>NURSING CHARGED TO PATIENTS</td>
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<td>$12,786,424</td>
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<tr>
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<td>DRUGS CHARGED TO PATIENTS</td>
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<td>$20,022,645</td>
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<tr>
<td>40</td>
<td>CANCER CENTER</td>
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<td>$1,473,888</td>
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<td>41</td>
<td>EMERGENCY</td>
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<td>$575,900</td>
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<td>OBSERVATION BED-DISTINCT</td>
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<td>43</td>
<td>TOTAL Ancillary</td>
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<td>$7,919,015</td>
<td>$175,278,437</td>
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</table>

#### 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.
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.

Enter in Medicaid days and total routine charges. Per diem costs amounts carry over from Section G cost report data.
### H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Medicaid Cost to Charge Ratio for Ancillary Cost Centers</th>
<th>In-State Medicaid FFS Primary</th>
<th>In-State Medicaid Managed Care Primary</th>
<th>In-State Medicare FFS Cross-Covers (with Medicaid Secondary)</th>
<th>In-State Other Medicaid Eligibles (Not Included Elsewhere)</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Observation (Non-District)</td>
<td>0.7203548</td>
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<tr>
<td>23</td>
<td>Operating Room</td>
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</tr>
<tr>
<td>24</td>
<td>Recovery Room</td>
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<tr>
<td>25</td>
<td>Delivery Room &amp; Labor Room</td>
<td>0.64330</td>
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<tr>
<td>26</td>
<td>Anesthesiology</td>
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<td>27</td>
<td>Radiology-Diagnostic</td>
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<tr>
<td>28</td>
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<td>29</td>
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<td>CT Scan</td>
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<td>32</td>
<td>Cardiac Catheterization</td>
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<td>33</td>
<td>Laboratory</td>
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<td>Respiratory Therapy</td>
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<td>36</td>
<td>Occupational Therapy</td>
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<tr>
<td>37</td>
<td>Speech Pathology</td>
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<tr>
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<td>Medical Supplies Charged to Pay</td>
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<td>Infl. Dev. Charged to Patients</td>
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<td>Intensive Care Unit</td>
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<tr>
<td>45</td>
<td>Wound Care</td>
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<td>46</td>
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<tr>
<td>49</td>
<td>Observation Bed/Unit</td>
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</tr>
</tbody>
</table>

Enter in all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.
DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

• Medicaid Payments Include:
  • Claim payments.
  • 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).
Enter in all Medicaid, Medicare, Private Insurance, Self-Pay, Medicaid Managed Care, Medicare, and Managed Care payments from the claims data.
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:

#### Hospital ABC

**Cost Report Year (2/2012-6/2012)**

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Medicaid Per Diem Cost for Routine Cost Centers</th>
<th>Medicaid Cost to Charge Ratio for Ancillary Cost Centers</th>
<th>Uninsured (See Exhibit A)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>From Section G</td>
<td>From Hospital's Internal Analysis</td>
<td>From Hospital's Internal Analysis</td>
</tr>
<tr>
<td>1</td>
<td>03000 ADULTS &amp; PEDIATRICS</td>
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<td>2</td>
<td>03100 INTERVENTION UNIT</td>
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<tr>
<td>3</td>
<td>03200 CORONARY CARE UNIT</td>
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<td>4</td>
<td>03300 MEDICAL INTENSIVE CARE UNIT</td>
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<td>5</td>
<td>03400 SURGICAL INTENSIVE CARE UNIT</td>
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<td>6</td>
<td>03500 OTHER SPECIAL CARE UNIT</td>
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<tr>
<td>7</td>
<td>04000 SUBRODERG</td>
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<td>8</td>
<td>04100 SUBRODERG</td>
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<td>04200 OTHER PROVIDER</td>
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<td>04300 OTHER PROVIDER</td>
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**Total Days**

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**Routine Charges**

<table>
<thead>
<tr>
<th>Ancillary Cost Centers (from WBC)</th>
<th>(from Section G)</th>
<th>Ancillary Charges</th>
<th>Ancillary Charges</th>
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</thead>
<tbody>
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</table>

**Totals & Payments**

<table>
<thead>
<tr>
<th>Line</th>
<th>Total Charges (Excludes organ acquisition from Section J)</th>
<th>(Agrees to Exhibit A)</th>
<th>Unrecorded Charges (Excludes Variance)</th>
<th>(Agrees to Exhibit A)</th>
<th>Total Calculated Cost (Includes organ acquisition from Section J)</th>
<th>(Agrees to Exhibit A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>129</td>
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<td>130</td>
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<tr>
<td>131</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

#### Notes:

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

- 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 as UPL, GME, outlier, and supplemental payments.
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.
2014 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.
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.
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.
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.
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.
### In-State organ acquisitions.

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

<table>
<thead>
<tr>
<th>Organ Acquisitions</th>
<th>Total Organ Acquisition Cost</th>
<th>Additional Add'l Invoiced/Reimb. Cost</th>
<th>Total Adjusted Organ Acquisition Cost</th>
<th>Revenue for Medicare Cross-Over / Uninsured Organ Sold</th>
<th>Total Usable Organs (Count)</th>
<th>In-State Medicaid PFS Primary</th>
<th>In-State Medicaid Managed Care Primary</th>
<th>In-State Other Medicaid Eligibles (not included elsewhere)</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>93.90</td>
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<tr>
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<td>$</td>
<td>$</td>
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<tr>
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</tr>
<tr>
<td>Heart</td>
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<td>$</td>
<td>$</td>
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<td></td>
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<tr>
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<td></td>
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<tr>
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<td>$</td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>

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

**Note B:** Enter Organ Acquisition Payments in Section C as part of your in-State Medicaid total payments.

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

### Out-of-State organ acquisitions.

#### K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

<table>
<thead>
<tr>
<th>Organ Acquisitions</th>
<th>Total Organ Acquisition Cost</th>
<th>Additional Add'l Invoiced/Reimb. Cost</th>
<th>Total Adjusted Organ Acquisition Cost</th>
<th>Revenue for Medicare Cross-Over / Uninsured Organ Sold</th>
<th>Total Usable Organs (Count)</th>
<th>Out-of-State Medicaid PFS Primary</th>
<th>Out-of-State Medicaid Managed Care Primary</th>
<th>Out-of-State Other Medicaid Eligibles (not included elsewhere)</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>93.90</td>
<td>$</td>
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</tr>
<tr>
<td>Kidney</td>
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<td>$</td>
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</tr>
<tr>
<td>Liver</td>
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<td>$</td>
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<td></td>
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<tr>
<td>Heart</td>
<td>93.90</td>
<td>$</td>
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<tr>
<td>Intestinal</td>
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<td>$</td>
<td>$</td>
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<tr>
<td>Spleen</td>
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<td>$</td>
<td>$</td>
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<tr>
<td>Totals</td>
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<td>$</td>
<td>$</td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Note B:** Enter Organ Acquisition Payments in Section C as part of your Out-of-State Medicaid total payments.
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).
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.
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 (charges).
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

**Worksheet A Provider Tax Assessment Reconciliation**:

<table>
<thead>
<tr>
<th>Worksheet A Provider Tax Assessment Reconciliation</th>
<th>Dollar Amount</th>
<th>W/S A Cost Center Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Gross Provider Tax Assessment (from general ledger)*</td>
<td></td>
<td>W/T A Account #1</td>
</tr>
<tr>
<td>Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment</td>
<td></td>
<td>(Where is the cost included on W/S A?)</td>
</tr>
<tr>
<td>Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3 Difference (Explain Here ——) $  

Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report) |               |               |
4 Reclassification Code  
5 Reclassification Code  
6 Reclassification Code  
7 Reclassification Code  

DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report) |               |               |
8 Reason for adjustment  
9 Reason for adjustment  
10 Reason for adjustment  
11 Reason for adjustment  

DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report) |               |               |
12 Reason for adjustment  
13 Reason for adjustment  
14 Reason for adjustment  
15 Reason for adjustment  

16 Total Net Provider Tax Assessment Expense Included in the Cost Report $  

**DSH UCC Provider Tax Assessment Adjustment**:

<table>
<thead>
<tr>
<th>DSH UCC Provider Tax Assessment Adjustment</th>
<th>Dollar Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 Gross Allowable Assessment Not Included in the Cost Report</td>
<td></td>
</tr>
<tr>
<td>Apportionment of Provider Tax Assessment Adjustment to Medicaid &amp; uninsured:</td>
<td></td>
</tr>
</tbody>
</table>
| Medicare Hospital Charges  
| Uninsured Hospital Charges  
| Total Hospital Charges  
| 21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC | 0.00% |
| 22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC | 0.00% |
| 23 Medicaid Provider Tax Assessment Adjustment to DSH UCC |               |
| 24 Uninsured Provider Tax Assessment Adjustment to DSH UCC |               |
| 25 Provider Tax Assessment Adjustment to DSH UCC |               |

*Tax allocation to UCC is estimate here but is submit to examination.*

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

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

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

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

---

**DEDICATED TO GOVERNMENT HEALTH PROGRAMS**

56
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 discharge dates in the cost report fiscal year.
  - Line item data must be at patient date of service level with multiple lines showing revenue code level charges.
EXHIBIT A - UNINSURED

- Exhibit A:
  
  - Include *Primary Payor Plan, 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.
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).
### Exhibit A - Uninsured Charges

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Primary Payor</th>
<th>Secondary Payor Plan (C)</th>
<th>Hospital’s Medicaid Provider # (D)</th>
<th>Patient Identifier Number (PCN) (E)</th>
<th>Patient’s Birth Date (F)</th>
<th>Patient’s Social Security Number (G)</th>
<th>Patient’s Gender (H)</th>
<th>Name (I)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured Charges</td>
<td>Charity</td>
<td>Self-Pay</td>
<td>12345</td>
<td>2222222</td>
<td>1/1/1960</td>
<td>999-99-959</td>
<td>Female</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>Uninsured Charges</td>
<td>Charity</td>
<td>Self-Pay</td>
<td>12345</td>
<td>2222222</td>
<td>1/1/1960</td>
<td>999-99-959</td>
<td>Female</td>
<td>Doe, Jane</td>
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<tr>
<td>Uninsured Charges</td>
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<td>Self-Pay</td>
<td>12345</td>
<td>2222222</td>
<td>1/1/1960</td>
<td>999-99-959</td>
<td>Female</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>Uninsured Charges</td>
<td>Charity</td>
<td>Self-Pay</td>
<td>12345</td>
<td>2222222</td>
<td>1/1/1960</td>
<td>999-99-959</td>
<td>Female</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>Uninsured Charges</td>
<td>Charity</td>
<td>Self-Pay</td>
<td>12345</td>
<td>2222222</td>
<td>1/1/1960</td>
<td>999-99-959</td>
<td>Female</td>
<td>Doe, Jane</td>
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<tr>
<td>Uninsured Charges</td>
<td>Charity</td>
<td>Self-Pay</td>
<td>12345</td>
<td>2222222</td>
<td>1/1/1960</td>
<td>999-99-959</td>
<td>Female</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>Uninsured Charges</td>
<td>Medicare</td>
<td>12345</td>
<td>4444444</td>
<td>7/12/1985</td>
<td>999-99-959</td>
<td>Male</td>
<td>Jones, James</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>Uninsured Charges</td>
<td>Blue Cross</td>
<td>12345</td>
<td>1111111</td>
<td>3/5/2000</td>
<td>999-99-959</td>
<td>Male</td>
<td>Smith, Mike</td>
<td>Doe, Jane</td>
</tr>
</tbody>
</table>

### Exhibit A - Uninsured charges/days

<table>
<thead>
<tr>
<th>Admit Date (J)</th>
<th>Discharge Date (K)</th>
<th>Service Indicator (Inpatient / Outpatient) (L)</th>
<th>Revenue Code (M)</th>
<th>Total Charges for Services Provided (N)</th>
<th>Routine Days of Care (O)</th>
<th>Total Patient Payments for Services Provided (P)</th>
<th>Total Private Insurance Payments for Services Provided (Q)</th>
<th>Claim Status (Exhausted, Non-Covered Service) (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/1/2010</td>
<td>3/11/2010</td>
<td>Inpatient</td>
<td>110</td>
<td>$4,000.00</td>
<td>7</td>
<td></td>
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<tr>
<td>3/1/2010</td>
<td>3/11/2010</td>
<td>Inpatient</td>
<td>300</td>
<td>$2,700.00</td>
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<tr>
<td>3/1/2010</td>
<td>3/11/2010</td>
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<td>360</td>
<td>$15,000.75</td>
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<tr>
<td>3/1/2010</td>
<td>3/11/2010</td>
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<td>450</td>
<td>$1,000.25</td>
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<tr>
<td>6/15/2010</td>
<td>6/15/2010</td>
<td>Outpatient</td>
<td>250</td>
<td>$150.00</td>
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<td>$500.00</td>
<td>Exhausted</td>
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<tr>
<td>6/15/2010</td>
<td>6/15/2010</td>
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<td>$500.00</td>
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<tr>
<td>8/10/2010</td>
<td>8/10/2010</td>
<td>Outpatient</td>
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<td>$1,100.00</td>
<td></td>
<td>$100.00</td>
<td>Non-Covered Service</td>
<td></td>
</tr>
</tbody>
</table>
EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

• Survey form Exhibit B has been designed to assist hospitals in collecting and reporting all patient payments received on a cash basis.

• Exhibit B should include all patient payments regardless of 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.
EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Patient payments received for uninsured services need to be reported on a cash basis.

- For example, a cash payment received during the 2014 cost report year that relates to a service provided in the 2006 cost report year, must be used to reduce uninsured cost for the 2014 cost report year.
EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

• Exhibit B

  • Include Primary Payor Plan, Secondary Payor Plan, 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).
### Exhibit B - Self-Pay Payments

<table>
<thead>
<tr>
<th>Claim Type (A)</th>
<th>Primary Payer</th>
<th>Secondary Payer</th>
<th>Transaction Code</th>
<th>Hospital Provider #</th>
<th>Medicaid Provider #</th>
<th>Patient's Birth Date (G)</th>
<th>Patient's Social Security Number (H)</th>
<th>Patient's Gender</th>
<th>Name (J)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Pay Payments</td>
<td>Medicare</td>
<td>Medicaid</td>
<td>060</td>
<td>12345</td>
<td>33333333</td>
<td>2/7/2028</td>
<td>000-00-0009</td>
<td>Male</td>
<td>Jones, Anthony</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>Medicare</td>
<td>Medicaid</td>
<td>060</td>
<td>12345</td>
<td>33333333</td>
<td>2/7/2025</td>
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<td>Male</td>
<td>Jones, Anthony</td>
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<tr>
<td>Self Pay Payments</td>
<td>Medicare</td>
<td>Medicaid</td>
<td>060</td>
<td>12345</td>
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<td>2/7/2020</td>
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<td>Male</td>
<td>Jones, Anthony</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>Medicare</td>
<td>Medicaid</td>
<td>060</td>
<td>12345</td>
<td>33333333</td>
<td>2/7/2020</td>
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<td>Jones, Anthony</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>Blue Cross</td>
<td></td>
<td>150</td>
<td>12345</td>
<td>60000000</td>
<td>9/25/1970</td>
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<td>Smith, John</td>
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<td></td>
<td>150</td>
<td>12345</td>
<td>60000000</td>
<td>9/25/1970</td>
<td>000-00-0009</td>
<td>Male</td>
<td>Smith, John</td>
</tr>
<tr>
<td>Self Pay Payments</td>
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<td>7/9/2000</td>
<td>000-00-0009</td>
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<td>Cliff, Heath</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>Self-Pay</td>
<td></td>
<td>500</td>
<td>12345</td>
<td>77777777</td>
<td>7/9/2000</td>
<td>000-00-0009</td>
<td>Male</td>
<td>Cliff, Heath</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>United Healthcare</td>
<td></td>
<td>500</td>
<td>12345</td>
<td>65555555</td>
<td>2/15/1060</td>
<td>000-00-0009</td>
<td>Male</td>
<td>Johnson, Joe</td>
</tr>
</tbody>
</table>

### Exhibit B - Cash Basis Patient Payments

<table>
<thead>
<tr>
<th>Admit Date (K)</th>
<th>Discharge Date (L)</th>
<th>Date of Cash Collection (M)</th>
<th>Amount of Collection (N)</th>
<th>Indicate if Collection is a 1099 Payment (O)</th>
<th>Service Indicator (Inpatient/Outpatient) (P)</th>
<th>Total Hospital Charges for Services Provided (Q)</th>
<th>Total Physician Charges for Services Provided (R)</th>
<th>Total Other Non-Hospital Charges for Services Provided (S)</th>
<th>Insurance Status When Services Were Uninsured (Insured or Exhausted or Non-Covered Service, if applicable) (T)</th>
<th>Claim Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/12/1995</td>
<td>7/14/1995</td>
<td>1/1/2010</td>
<td>$ 60</td>
<td>No</td>
<td>Inpatient</td>
<td>$ 10,000</td>
<td>$ 900</td>
<td>-</td>
<td>Insured</td>
<td>-</td>
</tr>
<tr>
<td>7/12/1995</td>
<td>7/14/1995</td>
<td>2/1/2010</td>
<td>$ 50</td>
<td>No</td>
<td>Inpatient</td>
<td>$ 10,000</td>
<td>$ 900</td>
<td>-</td>
<td>Insured</td>
<td>-</td>
</tr>
<tr>
<td>7/12/1995</td>
<td>7/14/1995</td>
<td>3/1/2010</td>
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<td>No</td>
<td>Inpatient</td>
<td>$ 10,000</td>
<td>$ 900</td>
<td>-</td>
<td>Insured</td>
<td>-</td>
</tr>
<tr>
<td>7/12/1995</td>
<td>7/14/1995</td>
<td>4/1/2010</td>
<td>$ 50</td>
<td>No</td>
<td>Inpatient</td>
<td>$ 10,000</td>
<td>$ 900</td>
<td>-</td>
<td>Insured</td>
<td>-</td>
</tr>
<tr>
<td>12/31/2006</td>
<td>1/1/2010</td>
<td>5/15/2010</td>
<td>$ 90</td>
<td>No</td>
<td>Inpatient</td>
<td>$ 15,000</td>
<td>$ 1,000</td>
<td>50</td>
<td>Exhausted</td>
<td>Exhausted</td>
</tr>
<tr>
<td>12/31/2006</td>
<td>1/1/2010</td>
<td>5/15/2010</td>
<td>$ 90</td>
<td>No</td>
<td>Inpatient</td>
<td>$ 15,000</td>
<td>$ 1,000</td>
<td>50</td>
<td>Exhausted</td>
<td>Exhausted</td>
</tr>
<tr>
<td>9/1/2006</td>
<td>9/1/2006</td>
<td>11/12/2010</td>
<td>$ 130</td>
<td>No</td>
<td>Inpatient</td>
<td>$ 14,000</td>
<td>$ 400</td>
<td>50</td>
<td>Insured</td>
<td>Non-Covered Service</td>
</tr>
</tbody>
</table>
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.
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 “Other” Medicaid eligibles (Section H).
  • All self-reported Out-of-State Medicaid categories (Section I).
EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

• Exhibit C
  
  • Include Primary Payor Plan, Secondary Payor Plan, 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).
### Exhibit C - Medicaid MCO

<table>
<thead>
<tr>
<th>Claim Type (A)</th>
<th>Primary Payer Plan (B)</th>
<th>Secondary Payer Plan (C)</th>
<th>Hospital’s Medicaid Provider # (D)</th>
<th>Patient’s Medicaid Number (PCN) (E)</th>
<th>Patient’s Medicaid Recipient # (F)</th>
<th>Patient’s Birth Date (G)</th>
<th>Patient’s Social Security Number (H)</th>
<th>Patient’s Gender (I)</th>
<th>Name (J)</th>
<th>Admit Date (K)</th>
<th>Discharge Date (L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid MCO</td>
<td>Family Health Partners</td>
<td>Self-Pay</td>
<td>12345</td>
<td>666666</td>
<td>978654321</td>
<td>7/12/1985</td>
<td>999-99-999</td>
<td>Female</td>
<td>Jeffery, Susan</td>
<td>2/20/2010</td>
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</table>

### Exhibit C - Managed Care

<table>
<thead>
<tr>
<th>Service Indicator</th>
<th>(Inpatient / Outpatient)</th>
<th>Revenue Code (N)</th>
<th>Total Charges for Services Provided (O)</th>
<th>Total Medicare Traditional Payments for Services Provided (P)</th>
<th>Total Medicare HMO Payments for Services Provided (Q)</th>
<th>Total Medicare MCO Payments for Services Provided (R)</th>
<th>Total Private Insurance Payments for Services Provided (S)</th>
<th>Self-Pay Payments (T)</th>
<th>Sum of All Payments Received on Claim (U)</th>
<th>+ (U) + (V)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>100</td>
<td>$ 1,200</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 1,200</td>
<td>$ 50</td>
<td>$ -</td>
<td>$ 1,550</td>
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<tr>
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<td>$ -</td>
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<td>$ 50</td>
<td>$ -</td>
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</tr>
<tr>
<td>Inpatient</td>
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<td>$ 100</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 1,500</td>
<td>$ 50</td>
<td>$ -</td>
<td>$ 1,550</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
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<td>$ -</td>
<td>$ -</td>
<td>$ 1,500</td>
<td>$ 50</td>
<td>$ -</td>
<td>$ 1,550</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
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<td>$ 1,000</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 1,000</td>
<td>$ 50</td>
<td>$ -</td>
<td>$ 1,550</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>250</td>
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<td>$ -</td>
<td>$ -</td>
<td>$ 1,000</td>
<td>$ 75</td>
<td>$ 75</td>
<td>$ 1,225</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
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<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 1,000</td>
<td>$ 75</td>
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<td>$ 1,225</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>400</td>
<td>$ 1,500</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 1,000</td>
<td>$ 75</td>
<td>$ 75</td>
<td>$ 1,225</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
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<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 1,000</td>
<td>$ 75</td>
<td>$ 75</td>
<td>$ 1,225</td>
<td></td>
</tr>
</tbody>
</table>
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 email addresses and phone numbers.
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.

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

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

5. Electronic Copy of Exhibit B – Self-Pay Payments.
   - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).

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

7. Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare cross-over, Medicaid MCO, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report).

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

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

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

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

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

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

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

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

15. Revenue code cross-walk used to prepare cost report.
Submission Checklist (cont.)

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

17. A detailed revenue working trial balance by payor/contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract).

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

19. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligibles).
2014 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.
2014 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.”
2014 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 year.
  - Now that the proposed rule has been finalized, Myers and Stauffer will continue to utilize those definitions as they have been since the 2009.
  - 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.
2014 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.
2014 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 2014 DSH year 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.
SIGNIFICANT DATA ISSUES DURING 2013 PROCEDURES

• Incomplete DSH Survey Part II files.

• Days, Charges, and Payments reported in the DSH Survey Part II file(s) did not reconcile to the patient level detail report in the Exhibit A-C Hospital Provided Claims Data.

• No support or crosswalk did not accurately support the mapping of days and charges to cost centers in DSH Survey Part I Sections H & I.
Common Issues Noted During Procedures

- 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.
PRIOR YEAR DSH PROCEDURES (2013)

Common Issues Noted During Procedures

• 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.
Common Issues Noted During Procedures

- “Exhausted” / “Insurance Non-Covered” reported in uninsured incorrectly included the following:
  - Services partially exhausted.
  - Denied due to timely filing.
  - Denied for medical necessity.
  - Denials for pre-certification.
Common Issues Noted During Procedures

• Exhibit B – Patient payments didn’t always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.

• Some hospitals didn’t include their charity care patients in the uninsured even though they had no third party coverage.
Common Issues Noted During Procedures

• Other Medicare Cross-Over Payments didn’t include all Medicare payments not included in the claims data (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.
PRIOR YEAR DSH PROCEDURES (2013)

Common Issues Noted During Procedures

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

Upload completed surveys, supporting claims detail, and other request data to the secure FTP site.

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

Questions concerning the DSH Survey and Exhibits A-C can be directed to:
  Joe Lackey: JLackey@mslc.com
  Bernard Hough: BHough@mslc.com
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.
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.
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.
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.
4. Can a service be included as uninsured, if insurance didn’t pay due to improper billing, late billing, or lack of medical necessity?

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

No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the 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.
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).
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.
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)
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.
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)
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)
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”)