DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE
DSH YEAR 2011

Presented by:
Bob Hicks, CPA
Judy Hatfield, CPA
OVERVIEW

• 2011 Discussion Points
• DSH Examination Policy
• DSH Year 2011 Examination Timeline
• DSH Year 2011 Examination Impact
• Paid Claims Data Review
• Review of DSH Year 2011 Survey and Exhibits
• 2011 Clarifications / Changes
• Recap of Prior Year Examinations (2010)
• Myers and Stauffer DSH FAQ
2011 DISCUSSION POINTS

- 2011 is the 1st RECOUPMENT Year!
- Impact of DSH Examination on DSH Allotment Reductions.
- Additional Reporting Requirements for the State including hospital total cost.
- Added lines to Section F-3 of the survey to reconcile contractuals for bad debts, charity, DSH revenue, and subsidies.
• Labor & Delivery day discussion.

• Discussion related to managed care all-inclusive payments (professional fees).

• Discussion related to retroactive Medicaid payments and recoupments made after the DSH examination.
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.)

- FR Vol. 77, No. 11, Wednesday, Jan. 18, 2012, Proposed Rule
- 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.
DSH YEAR 2011 EXAMINATION TIMELINE

• Surveys mailed January 3, 2014
• Surveys returned by February 10, 2014
• February - April - desk reviews
• April - July - on-site/expanded reviews
• Draft report to the state by September 30, 2014
• Final report to CMS by December 31, 2014
DSH YEAR 2011 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 2011 examination report is the first year that may result in DSH payment recoupments.
PAID CLAIMS DATA UPDATE FOR 2011

- Medicaid fee-for-service paid claims data
  - Will be sent to hospitals with the survey.
  - Same format as last year.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Detailed data is available upon request.
  - Will exclude non-Title 19 services (such as SCHIP).
PAID CLAIMS DATA UPDATE FOR 2011

- Medicare/Medicaid cross-over paid claims data
  - Will be sent with the survey. But is incomplete due to issues with cross-over claim data.
  - eMOmed claims do not appear to have corresponding charges as in prior years.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - The hospital is responsible for including the crossover percentage of Medicare payments paid outside of the claim (i.e. bad debts, GME, MCR DSH settlement) on the survey.
PAID CLAIMS DATA UPDATE FOR 2011

- Medicaid managed care paid claims data is not available

  - If the hospital cannot obtain a paid claims listing from the MCO, the hospital should send in a detailed listing in Exhibit C format. Physician fee professional fee charges should be excluded and a portion of the payment excluded if the hospital receives a bundled payment.

  - Must EXCLUDE SCHIP and other non-Title 19 services.

  - Should be reported based on cost report year (using discharge date).
PAID CLAIMS DATA UPDATE FOR 2011

• 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.
PAID CLAIMS DATA UPDATE FOR 2011

• “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).
PAID CLAIMS DATA UPDATE FOR 2011

• Uninsured Services
  • As in previous years, 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).
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
    • Complete one copy for the DSH year
  • DSH Survey Part II – Cost Report Year Data
    • Cost reporting period-specific information
    • Complete a separate copy for each cost reporting period needed to cover the DSH year.
    • Hospitals with year end changes or that are new to DSH may have to complete 2 or 3 separate Part II surveys
DSH EXAMINATION SURVEYS

General Instruction – Survey Files

• Part II of the DSH survey only needs to be completed for cost reporting periods not submitted in a previous DSH exam year.

  • Example: Hospital A provided a survey for their year ending 12/31/10 with the DSH audit of SFY 2010 in the prior year. In the DSH year 2011 exam, Hospital A would only need to submit a survey for their year ending 12/31/11.

• Both parts of the DSH survey have Instructions tabs that have been updated for 2011 DSH year changes. Please refer to those tabs if you are unsure of what to enter in a section or contact Myers and Stauffer for additional guidance.
DSH EXAMINATION SURVEYS

General Instruction – Cost Report Data

• HCRIS data will be pre-loaded in surveys this year to ensure that all hospital cost centers are included on the DSH survey. However, the Medicare costs from Worksheet B Part I will need to be updated with Medicaid cost report values which exclude the FRA tax.

• All hospital reimbursable cost centers on which the FRA tax is assessed should be included in Section G of DSH Survey Part II.
DSH SURVEY PART I – DSH YEAR DATA

Section A
• DSH Year should already be filled in
• Hospital name should be selected (if not, select from the drop-down box)
• Verify the cost reporting period dates (should only include those that weren’t previously submitted)
  • If these are incorrect, please call Myers and Stauffer and request a new copy. The claims summaries are compiled based on the cost reporting period dates populated for each hospital. If the periods are incorrect, claims summaries will need to be rerun also.

Section B
• Answer all OB questions using drop-down boxes
DSH SURVEY PART I – DSH YEAR DATA

Section C

• Enter the hospital’s total Other Medicaid Payments for the DSH Year.

• Report any Medicaid Non-Claim Specific payments, including UPL and Direct Medicaid Payments, for the state fiscal year. Do NOT include DSH payments. The state will provide a schedule of payments which should be verified by the hospital.

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.
A. General DSH Year Information

1. DSH Year:
   - Begin: 07/01/2009
   - End: 06/30/2010

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

Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1
   - Begin Date(s): 01/01/2010
   - End Date(s): 12/31/2010

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

6. Medicaid Provider Number: 111111
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
9. Medicare Provider Number: 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 Year 07/01/2009 - 06/30/2010:

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 obstetric procedures.)

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

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

Answer all OB questions.
### C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for DSH Year 07/01/2009 - 06/30/2010
   (Should include UPF and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)
   
<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$500,000</td>
</tr>
</tbody>
</table>

### Certification:

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

   **Explanation for "No" answers:**

   [Blank space for explanation]

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

   I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. I understand that this information will be used to determine the Medicaid program’s compliance with Federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

   **Hospital CEO or CFO Signature**

   **Title**

   **Date**

   **Hospital CEO or CFO Printed Name**

   **Hospital CEO or CFO Telephone Number**

   **Hospital CEO or CFO E-Mail**

<table>
<thead>
<tr>
<th>Contact information for individuals authorized to respond to inquiries related to this survey:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Contact:</strong></td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Title</td>
</tr>
<tr>
<td>Telephone Number</td>
</tr>
<tr>
<td>E-Mail Address</td>
</tr>
<tr>
<td>Mailing Street Address</td>
</tr>
<tr>
<td>Mailing City, State, Zip</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outside Preparer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Title</td>
</tr>
<tr>
<td>Firm Name</td>
</tr>
<tr>
<td>Telephone Number</td>
</tr>
<tr>
<td>E-Mail Address</td>
</tr>
</tbody>
</table>
Submit one copy of the part II survey for each cost report period not previously submitted.

- Question #2 – An “X” should be shown in the column of the cost report year survey you are preparing. (If the survey has multiple periods listed, a separate survey must be completed for each period). If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.

- Question #3 – This question may be already answered based on pre-loaded HCRIS data. Please update this to specify the Medicaid version of the cost report used to complete Section G of the survey.
D. General Cost Report Year Information
1/1/2010 - 12/31/2010

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one 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 (either "X")
   - 1/1/2010 through 12/31/2010

3. Status of Cost Report Used for this Survey (Should be updated if available):
   - 2 - Partial Audit

4. Hospital Name:
   - Provider Number:

5. Medicaid Provider Number:
   - Medicaid Subprovider Number 1 (Psychiatric or Rehab):
   - Medicaid Subprovider Number 2 (Psychiatric or Rehab):
   - Medicare Provider Number:

6. 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.

(Provide additional data on a separate attachment)

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

Should have an "X" for the cost report year you are reporting on. Should have a separate Excel file for each year listed here.
DSH YEAR SURVEY PART II
SECTION E, MISC. PAYMENT INFO.

• 1011 Payments - Section 1011 payments should be segregated between amounts 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). Further segregate between payments for hospital services and non-hospital services (non-hospital services include physician services).

• If the hospital received DSH payments from another state (any state other than Missouri) these payments must be reported on this section of the survey. Out-of-state DSH payments should be reported based on the cost reporting period if it differs from the DSH year.

• Total cash basis patient payments should agree to the detailed Exhibit B submitted with the survey. Only the uninsured payments are utilized to calculate the uncompensated care costs.
### Disclosure of Medicaid / Uninsured Payments Received: (01/01/2010 - 12/31/2010)

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Outpatient</th>
<th>Inpatient</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Payment Related to Hospital Services Included in Exhibit B &amp; B-1 (See Note 1)</td>
<td>$6,500</td>
<td>$6,500</td>
<td>$13,000</td>
</tr>
<tr>
<td>2</td>
<td>Total Section 1011 Payments Related to Hospital Services (See Note 1)</td>
<td>$17,500</td>
<td></td>
<td>$17,500</td>
</tr>
<tr>
<td>3</td>
<td>Payment Related to Outpatient Hospital Services NOT Included in Exhibit B &amp; B-1 (See Note 1)</td>
<td></td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>5</td>
<td>Payment Related to Non-Hospital Services Included in Exhibit B &amp; B-1 (See Note 1)</td>
<td>$1,000</td>
<td></td>
<td>$1,000</td>
</tr>
<tr>
<td>6</td>
<td>Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)</td>
<td>$2,000</td>
<td></td>
<td>$2,000</td>
</tr>
<tr>
<td>7</td>
<td>Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)</td>
<td>$1,000</td>
<td></td>
<td>$1,000</td>
</tr>
<tr>
<td>8</td>
<td>Out-of-State DSH Payments (See Note 2)</td>
<td>$9,000</td>
<td></td>
<td>$9,000</td>
</tr>
</tbody>
</table>

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

Data required 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, segregate accordingly, otherwise record entire amount as unspecified. Should include any state-only or local funds received for patient care services. (i.e. county tax)

- Section F-2: Report charity care charges based on hospital financials or the definition used for state DSH payment (support must be submitted).
Section F-3: Report hospital revenues and contractual adjustments.

- Totals should agree with the cost report worksheets G-2 and G-3. If not, provide an explanation with the survey or use new lines that were added to this section in 2011 for contractual reconciliation.

- Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If the hospital maintains contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.
DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR

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

- Bad debt and charity care write-offs included in contractuals 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 netted against contractual adjustments 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.
### F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2011 - 12/31/2011)

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

1. Total Hospital Days Per Cost Report (Excluding Swing Bed, W55 S.3, Pt. 1, Col. 8, Sum of Lines 14, 16, 17, 18, less lines 5 & 6)

   |   |
   |---|---|
   | 51,528 |

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

<table>
<thead>
<tr>
<th>Subsidy Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Subsidies</td>
<td>100,000</td>
</tr>
<tr>
<td>Outpatient Hospital Subsidies</td>
<td>100,000</td>
</tr>
<tr>
<td>Unspecified UP and OIP Hospital Subsidies</td>
<td>480,900</td>
</tr>
<tr>
<td>Total Hospital Subsidies</td>
<td>680,900</td>
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<tr>
<td>Inpatient Charity Care Charges</td>
<td>390,000</td>
</tr>
<tr>
<td>Outpatient Charity Care Charges</td>
<td>390,000</td>
</tr>
<tr>
<td>Total Charity Care Charges</td>
<td>780,000</td>
</tr>
</tbody>
</table>

#### F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W5-5-3 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 UMS HCIR cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Inpatient Hospital</th>
<th>Outpatient Hospital</th>
<th>Non-Hospital</th>
<th>Inpatient Hospital</th>
<th>Outpatient Hospital</th>
<th>Non-Hospital</th>
<th>Net Hospital Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>348,982,366</td>
<td>182,520,366</td>
<td>4,837,558</td>
<td>243,777,130</td>
<td>127,497,346</td>
<td>3,447,053</td>
<td>20,330,516</td>
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<tr>
<td>Provider Type</td>
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<td></td>
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<td></td>
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<tr>
<td>Hospital</td>
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<tr>
<td>Subprovider I</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Subprovider II</td>
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</tr>
<tr>
<td>Swing Bed - SNF</td>
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<td></td>
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<tr>
<td>Swing Bed - NF</td>
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<tr>
<td>Skilled Nursing Facility</td>
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<tr>
<td>Nursing Facility</td>
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<tr>
<td>Other Long Term Care</td>
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<tr>
<td>Hospice</td>
<td></td>
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<tr>
<td>Other</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>348,982,366</td>
<td>182,520,366</td>
<td>4,837,558</td>
<td>243,777,130</td>
<td>127,497,346</td>
<td>3,447,053</td>
<td>20,330,516</td>
</tr>
<tr>
<td>Total Hospital and Non Hospital</td>
<td>351,400,286</td>
<td>195,040,726</td>
<td>5,124,115</td>
<td>247,297,286</td>
<td>130,994,692</td>
<td>3,794,098</td>
<td>20,330,516</td>
</tr>
<tr>
<td>Total Hospital State and Local Patient Care Cash Subsidies</td>
<td>100,000</td>
<td>100,000</td>
<td>480,900</td>
<td>100,000</td>
<td>100,000</td>
<td>480,900</td>
<td>100,000</td>
</tr>
</tbody>
</table>

#### New reconciling lines - these are utilized to ensure that only true contractuals are included in the calculation of the LIUR

- **30. Remove Bad Debts Included in Line 2 of W55 G-3 of Cost Report**
- **31. Remove Charity Care Write-Off Included in Line 2 of W55 G-3 of Cost Report**
- **32. Add Back Medicaid DRG Revenue Included in Line 2 of W55 G-3 of Cost Report**
- **33. Add Back State and Local Patient Care Cash Subsidies Included in Line 2 of W55 G-3 of Cost Report**
- **34. Adjusted Contractual Adjustments**
- **35. Unreconciled Difference (Should be $0)**

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

**State or Local Govt. Subsidies**

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

**Days per cost report**

**Dedicated to Government Health Programs**
DSH YEAR SURVEY PART II
SECTION G, COST REPORT DATA

• Utilized to calculate the per diems and cost-to-charge ratios used to calculated uncompensated care costs.
  • Pre-populated with hospital-specific HCRIS data.
  • Hospital should update the pre-populated HCRIS costs coming from B Part I to agree with the Medicaid version of the cost report. RCE adjustments may need to be updated also.
  • FRA tax flows from Section L and is added to cost centers.
  • All other pre-populated HCRIS data should be verified to the Medicaid version of the cost report by the hospital. Changes should be made if HCRIS values don’t agree to the Medicaid cost report.
### G. Cost Report - Cost / Days / Charges

**Cost Report Year:** 03/01/2011-12/31/2011  
**Hospital:** ABC

NOTES: 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.

#### Routine Cost Centers (List Below):

<table>
<thead>
<tr>
<th>Line</th>
<th>Cost Center Description</th>
<th>Total Allowable Cost</th>
<th>Intern &amp; Resident Costs Removed on Cost Report</th>
<th>RCE and Therapy Add-Back (If Applicable)</th>
<th>FRA Tax Assessment</th>
<th>Net Cost</th>
<th>IP</th>
<th>OIP Charges</th>
<th>Total Charges</th>
<th>Medicaid Per Diem / Cost-to-Charge Ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>02000 ADULTS &amp; PEDIATRICS</td>
<td>200,000,000</td>
<td>55,000,000</td>
<td>-</td>
<td>-</td>
<td>30,000</td>
<td>2,188,648</td>
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#### Calculation of Routine Cost Per Diems:

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<th>Non-District</th>
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<td>(Non-District)</td>
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Calculation of Observation CCR - uses per diems calculated in first section to carve out and calculate observation cost.
### G. Cost Report - Cost / Days / Charges

**Cost Report Year:** (2010/2011-2011/2012)

**Hospital ABC**

|--------|------------------------------|----------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------|---------|----|-------------|--------------|----------------------------------------|

**Ancillary Cost Centers (from WS C excluding Observation) [List Below]:

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|------|------------------------------|----------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------|---------|----|-------------|--------------|----------------------------------------|

21 OPERATING ROOM $70,000.00 $20,000.00 $30,000.00 
22 LABORATORY $55,000.00 $7,500.00 $47,500.00 
23 PATHOLOGY $40,000.00 $10,000.00 $30,000.00 
24 PHYSICAL THERAPY $4,000.00 $1,000.00 $3,000.00 
25 SPEECH PATHOLOGY $1,000.00 $500.00 $500.00 
26 RESPIRATORY THERAPY $12,000.00 $2,000.00 $10,000.00 
27 PHYSICAL THERAPY $8,000.00 $1,700.00 $6,300.00 
28 OCCUPATIONAL THERAPY $2,000.00 $6,000.00 $4,000.00 
29 LABORATORY $3,000.00 $1,000.00 $2,000.00 
30 PHYSICAL THERAPY $5,000.00 $1,000.00 $4,000.00 
31 ELECTROCARDIOGRAPHY $1,000.00 $500.00 $500.00 
32 GASTROENTEROLOGY $9,000.00 $250.00 $8,750.00 
33 MEDICAL SUPPLIES CHARGED TO PATIENT $15,000.00 $200.00 $14,800.00 
34 PHLEBOTOMY CHARGED TO PATIENT $10,000.00 $750.00 $9,250.00 
35 MEDICAL LABORATORY $20,000.00 $500.00 $19,500.00 
36 PATIENT ANALYSIS $4,000.00 $1,000.00 $3,000.00 
37 CLINICAL NUTRITION $10,000.00 $250.00 $9,750.00 
38 NURSE'S WARD $5,000.00 $250.00 $4,750.00 
39 CANCER REHABILITATION $20,000.00 $500.00 $19,500.00 
40 CLINIC $8,000.00 $250.00 $7,750.00 
41 NURSING LAB $10,000.00 $250.00 $9,750.00 
42 EMERGENCY $30,000.00 $10,000.00 $20,000.00 

|------|------------------------------|----------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------|---------|----|-------------|--------------|----------------------------------------|

21 OPERATING ROOM $70,000.00 $20,000.00 $30,000.00 
22 LABORATORY $55,000.00 $7,500.00 $47,500.00 
23 PATHOLOGY $40,000.00 $10,000.00 $30,000.00 
24 PHYSICAL THERAPY $4,000.00 $1,000.00 $3,000.00 
25 SPEECH PATHOLOGY $1,000.00 $500.00 $500.00 
26 RESPIRATORY THERAPY $12,000.00 $2,000.00 $10,000.00 
27 PHYSICAL THERAPY $8,000.00 $1,700.00 $6,300.00 
28 OCCUPATIONAL THERAPY $2,000.00 $6,000.00 $4,000.00 
29 LABORATORY $3,000.00 $1,000.00 $2,000.00 
30 PHYSICAL THERAPY $5,000.00 $1,000.00 $4,000.00 
31 ELECTROCARDIOGRAPHY $1,000.00 $500.00 $500.00 
32 GASTROENTEROLOGY $9,000.00 $250.00 $8,750.00 
33 MEDICAL SUPPLIES CHARGED TO PATIENT $15,000.00 $200.00 $14,800.00 
34 PHLEBOTOMY CHARGED TO PATIENT $10,000.00 $750.00 $9,250.00 
35 MEDICAL LABORATORY $20,000.00 $500.00 $19,500.00 
36 PATIENT ANALYSIS $4,000.00 $1,000.00 $3,000.00 
37 CLINICAL NUTRITION $10,000.00 $250.00 $9,750.00 
38 NURSE'S WARD $5,000.00 $250.00 $4,750.00 
39 CANCER REHABILITATION $20,000.00 $500.00 $19,500.00 
40 CLINIC $8,000.00 $250.00 $7,750.00 
41 NURSING LAB $10,000.00 $250.00 $9,750.00 
42 EMERGENCY $30,000.00 $10,000.00 $20,000.00 

Allocation of allowable FRA tax assessment to per diems and CCRs.

All cost report data. Calculation of ancillary cost-to-charge ratios.
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*) from state’s paid claim summaries
  - In-State Medicaid Managed Care Primary (*Medicaid MCO*) supported by an Exhibit C
  - In-State Medicare FFS Cross-Overs (*Traditional Medicare with Traditional Medicaid Secondary*) from state’s paid claim summaries or an Exhibit C.
  - In-State Other Medicaid Eligibles (*May include Medicare MCO cross-overs and other Medicaid not included elsewhere*) supported by an Exhibit C.
### In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

**Cost Report Year:** 01/01/2019 - 12/31/2019

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Medicaid Per Diem Cost for Routine Cost Centers</th>
<th>Medicaid Cost to Charge Ratio for Ancillary Cost Centers</th>
<th>In-State Medicaid FFV Primary Inpatient</th>
<th>In-State Medicaid FFV Primary Outpatient</th>
<th>In-State Medicaid Managed Care Primary Inpatient</th>
<th>In-State Medicaid Managed Care Primary Outpatient</th>
<th>In-State Medicaid FFV Cross-Over (with Medicaid Secondary) Inpatient</th>
<th>In-State Medicaid FFV Cross-Over (with Medicaid Secondary) Outpatient</th>
<th>In-State Other Medicaid Inpatient (Not Included Elsewhere) Inpatient</th>
<th>In-State Other Medicaid Inpatient (Not Included Elsewhere) Outpatient</th>
<th>In-State Other Medicaid Inpatient (Not Included Elsewhere) Total Days</th>
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**Note:** Enter in Medicaid days and total routine charges. Per diem cost amounts carry over from Section G cost report data.
### H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

#### Cost Reports: JFSQ10X (1/1/2012 - 12/31/2012) Hospital ABC

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<th>Ancillary Cost Centers (From WRS (Future Section G))</th>
<th>In-State Medicaid - FY 2 Primary</th>
<th>In-State Medicaid Managed Care Primary</th>
<th>In-State Medicare FY5 Cross-Covers (with Medical Benefits)</th>
<th>In-State Other Medicaid Eligible (Not Included in Medicaid)</th>
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<tr>
<td>031700 APOTHECARY</td>
<td>30,000.00</td>
<td>30,000.00</td>
<td>30,000.00</td>
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<tr>
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</tr>
<tr>
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<td>32,000.00</td>
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</tr>
<tr>
<td>032000 APOTHECARY</td>
<td>33,000.00</td>
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<td>33,000.00</td>
<td>33,000.00</td>
</tr>
<tr>
<td>032100 APOTHECARY</td>
<td>34,000.00</td>
<td>34,000.00</td>
<td>34,000.00</td>
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</tr>
<tr>
<td>032200 APOTHECARY</td>
<td>35,000.00</td>
<td>35,000.00</td>
<td>35,000.00</td>
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</tr>
<tr>
<td>032300 APOTHECARY</td>
<td>36,000.00</td>
<td>36,000.00</td>
<td>36,000.00</td>
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</tr>
<tr>
<td>032400 APOTHECARY</td>
<td>37,000.00</td>
<td>37,000.00</td>
<td>37,000.00</td>
<td>37,000.00</td>
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<tr>
<td>032500 APOTHECARY</td>
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<td>38,000.00</td>
<td>38,000.00</td>
<td>38,000.00</td>
</tr>
<tr>
<td>032600 APOTHECARY</td>
<td>39,000.00</td>
<td>39,000.00</td>
<td>39,000.00</td>
<td>39,000.00</td>
</tr>
<tr>
<td>032700 APOTHECARY</td>
<td>40,000.00</td>
<td>40,000.00</td>
<td>40,000.00</td>
<td>40,000.00</td>
</tr>
</tbody>
</table>

---

Enter in all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.
• Payments Include:
  • Medicaid/Medicaid MCO claim payments
  • Medicaid cost report settlements
  • Medicare claim payments (cross-overs)
  • Medicare bad debt payments (cross-overs)
  • Medicare cost report settlement payments (cross-overs)
  • Other third party payments (TPL)
### In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

<table>
<thead>
<tr>
<th></th>
<th>In-State Medicaid EFS Primary</th>
<th>In-State Medicaid Managed Care Primary</th>
<th>In-State Medicare TTG Cross Ovrs (with Medicaid Exclusions)</th>
<th>In-State Other Medicaid Eligibles (Not excluded Beneficiaries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tots/ Payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Charges (includes organ acquisition from Section B)</td>
<td>$186,630,000</td>
<td>$46,940,000</td>
<td>$58,905,000</td>
</tr>
<tr>
<td></td>
<td>Total Charges per PSSP or Other Paid Claims Summary</td>
<td>$186,630,000</td>
<td>$46,940,000</td>
<td>$58,905,000</td>
</tr>
<tr>
<td></td>
<td>Unrealized Charges (Balance Variance)</td>
<td>$186,630,000</td>
<td>$46,940,000</td>
<td>$58,905,000</td>
</tr>
<tr>
<td></td>
<td>Total Calculated Cost (includes organ acquisition from Section B)</td>
<td>$203,504,001</td>
<td>$25,979,281</td>
<td>$52,140,000</td>
</tr>
<tr>
<td></td>
<td>Total Medicaid Paid Amount (includes TPL, Co-Pay and Spend-Down)</td>
<td>$203,504,000</td>
<td>$25,979,281</td>
<td>$52,140,000</td>
</tr>
<tr>
<td></td>
<td>Other Total Third Party Liabilities (including Co-Pay and Spend-Down but excluding Medicare on crossovers)</td>
<td>$203,504,000</td>
<td>$25,979,281</td>
<td>$52,140,000</td>
</tr>
<tr>
<td></td>
<td>Total Allowed Amount from Medicaid PSSP, RA Data (All Payments)</td>
<td>$203,504,000</td>
<td>$25,979,281</td>
<td>$52,140,000</td>
</tr>
<tr>
<td></td>
<td>Medicaid Cost Settlement Payments (See Note B)</td>
<td>$203,504,000</td>
<td>$25,979,281</td>
<td>$52,140,000</td>
</tr>
<tr>
<td></td>
<td>Other Medicaid Payments Reported on Cost Report Year (See Note C)</td>
<td>$203,504,000</td>
<td>$25,979,281</td>
<td>$52,140,000</td>
</tr>
<tr>
<td></td>
<td>Medicare Paid Amount (excludes insurance/adjustments)</td>
<td>$203,504,000</td>
<td>$25,979,281</td>
<td>$52,140,000</td>
</tr>
<tr>
<td></td>
<td>Medicare Cross-Over Gross Debt Payments</td>
<td>$203,504,000</td>
<td>$25,979,281</td>
<td>$52,140,000</td>
</tr>
<tr>
<td></td>
<td>Other Medicare Cross-Over Payments (See Note D)</td>
<td>$203,504,000</td>
<td>$25,979,281</td>
<td>$52,140,000</td>
</tr>
<tr>
<td></td>
<td>Payment from Hospital Uninsured During Cost Report Year (Cash Basis)</td>
<td>$203,504,000</td>
<td>$25,979,281</td>
<td>$52,140,000</td>
</tr>
<tr>
<td></td>
<td>Section 1011 Payment Related to Inpatient Hospital Services: NCTI included in Exhibits B &amp; E1 (from Section E)</td>
<td>$203,504,000</td>
<td>$25,979,281</td>
<td>$52,140,000</td>
</tr>
<tr>
<td></td>
<td>Calculated Payment Shrinkage (Length)</td>
<td>$31,630,000</td>
<td>$6,474,000</td>
<td>$1,640,000</td>
</tr>
<tr>
<td></td>
<td>Calculated Payments as a Percentage of Cost</td>
<td>25%</td>
<td>9%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Enter in all Medicaid, TPL, and Medicare crossover payments.
DSH SURVEY PART II
SECTION H, UNINSURED

- Report uninsured services, patient days (by routine cost center) and ancillary charges by cost center from Exhibit A submitted with the survey.

- Survey form Exhibit A outlines the data elements that need to be provided to Myers and Stauffer for uninsured patient accounts.

- For uninsured payments, enter the uninsured hospital patient cash-basis payment totals from Exhibit B. Do not include the non-hospital or insured patient payments in Section H even though they are reported in Exhibit B.
### H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Medicaid Per Diem Charge (100% of Cost)</th>
<th>Medicaid Cost Limits for Ancillary (100% of Cost)</th>
<th>Uninsured Charge Limits for Ancillary (100% of Cost)</th>
<th>Inpatient (Remainder of 2006)</th>
<th>Outpatient (Remainder of 2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Uninsured charges must agree to Exhibit A**

**Uninsured days - should agree to Exhibit A**

**Uninsured cash-basis payments must agree to the UNINSURED on Exhibit B**
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 as UPL, GME, outlier, and supplemental payments.

2. The hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals.
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. The hospital total UCC is the basis for redistribution of overpayments to underpaid hospitals according to the State Plan.

2. The hospital total UCC may be used to establish future DSH payments.

3. CMS DSH allotment reductions are partially based on states targeting DSH payments to hospitals with high uninsured and Medicaid populations.
2011 CLARIFICATIONS

- **DSH Allotments**

  - Allotment reduction has been delayed until federal fiscal year 2016, through a budget agreement signed December 26, 2013. However, the legislation doubles the reduction that would otherwise have applied in that year.
PRIOR YEAR DSH EXAMINATION (2010)

- State-Specific Annual DSH Allotment Reduction Factors

  - High Volume of Medicaid Inpatients Factor (HMF)
    - Imposes larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients.

  - High Level of Uncompensated Care Factor (HUF)
    - Imposes larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care.
DSH SURVEY PART II – SECTION H, IN-STATE MEDICAID AND UNINSURED

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

• Report Out-of-State Medicaid days, ancillary charges and payments.

• Report in the same format as Section H. Days, charges and payments received must agree to the other state’s PS&R (or similar) claim payment summary. If no summary is available, submit Exhibit C (hospital data) as support.

• If your hospital provided Medicaid services to several other states, please consolidate the OOS data.
DSH SURVEY PART II – SECTIONS J & K, ORGAN ACQUISITION

• Total organ acquisition cost and total useable organs will be pre-loaded from HCRIS data. If it is incorrect or doesn’t agree to a more 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 on Worksheet D-4 as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey as those costs are included in the cost per organ amount on Section J & K.
### J. Transplant Facilities Only: Organ Acquisition Cost - In-State Medicaid and Uninsured

<table>
<thead>
<tr>
<th>Organ Acquision Cost Category</th>
<th>Total Organ Acquisition Cost</th>
<th>Added-on Cost Factor for I&amp;R, FRA tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver Acquision</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Kidney Acquision</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Pancreas Acquision</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Heart Acquision</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>Intestine Acquision</td>
<td>$150</td>
<td>$150</td>
</tr>
</tbody>
</table>

**Total Cost**

Note: These amounts must agree to your hospital's and outpatient Medicare cost report surveys. If available, fill out hospital's logic and submit with survey.

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

<table>
<thead>
<tr>
<th>Organ Acquision Cost Category</th>
<th>Total Organ Acquisition Cost</th>
<th>Added-on Cost Factor for I&amp;R, FRA tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver Acquision</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Kidney Acquision</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Pancreas Acquision</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Heart Acquision</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>Intestine Acquision</td>
<td>$150</td>
<td>$150</td>
</tr>
</tbody>
</table>

**Total Cost**

Note: These amounts must agree to your hospital's and outpatient Medicare cost report surveys. If available, fill out hospital's logic and submit with survey.
DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- Provides for add-on of the allowable provider tax, which is excluded from the Medicaid version of the 2552-10 used to complete the DSH survey.

- Assists in reconciling total provider tax expense reported in the Medicaid cost report and the amount actually incurred by a hospital (paid to the state).

  - As in the prior year, the Medicaid version of the cost report is utilized to complete the survey since all of the FRA tax is excluded in the Medicaid version.

  - The treatment of the tax and the allowable amount differs between Medicare and Medicaid, so the Medicaid version must be used to accurately capture the uninsured and Medicaid portion of the tax.
DSH SURVEY PART II
SECTION L, PROVIDER TAXES

• Complete the section using Medicaid cost report data and hospital’s own general ledger.

• Include the Worksheet A line number the tax is included on or provide a reason for the variance between the tax per the general ledger and the amount included in the cost report.

• The FRA tax expense should be reflected based on the cost reporting period rather than the DSH year.

• All permissible provider tax not included in allowable cost on the Medicaid cost report will be added into costs and allocated to the hospital reimbursable per diems and cost-to-charge ratios on through Section G of the DSH survey using cost as allocation basis.
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)
# 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 state audit survey. However, depending on how your hospital reports it on the state audit 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 Medicaid DSH cost report, the full amount of the provider tax assessment would not have been appropriated to the revenue portion 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/or supporting documentation to Myers and Stanfill, LO along with your hospital's DSH audit

<table>
<thead>
<tr>
<th>Worksheet A Provider Tax Assessment Reconciliation:</th>
<th>Dollar Amount</th>
<th>W/S A-8 Cost Center Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospital Gross Provider Tax Assessment (from general ledger)*</td>
<td>$ 8,500.0000</td>
<td>$ 8,500.0000</td>
</tr>
<tr>
<td>2. Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)</td>
<td>$ 8,500.0000</td>
<td>0.00</td>
</tr>
<tr>
<td>3. Difference (Explain Here)</td>
<td>$ 0.00</td>
<td></td>
</tr>
</tbody>
</table>

### Provider Tax Assessment Reclassifications (from W/S A-6 of the Medicare cost report)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Reclassified to)</td>
<td>(Reclassified from)</td>
<td>(Reclassified to)</td>
<td>(Reclassified from)</td>
</tr>
<tr>
<td>(Adjusted to)</td>
<td>(Adjusted from)</td>
<td>(Adjusted to)</td>
<td>(Adjusted from)</td>
</tr>
</tbody>
</table>

### DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from W/S A-8 of the Medicare cost report)

<table>
<thead>
<tr>
<th>Reason for adjustment</th>
<th>Reason for adjustment</th>
<th>Reason for adjustment</th>
<th>Reason for adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Remove FRA Tax for Medicaid)</td>
<td>$ (8,500.0000)</td>
<td>0.00</td>
<td>(Adjusted to)</td>
</tr>
</tbody>
</table>

### DSH UCC NON-AllowABLE Provider Tax Assessment Adjustments (from W/S A-8 of the Medicare cost report)

<table>
<thead>
<tr>
<th>Reason for adjustment</th>
<th>Reason for adjustment</th>
<th>Reason for adjustment</th>
<th>Reason for adjustment</th>
</tr>
</thead>
</table>

### Total Net Provider Tax Assessment Expense Included in the Cost Report

| $ |

### DSH UCC Provider Tax Assessment Adjustment:

| Gross Allowable Assessment Not Included in the Cost Report** | $ 8,500.00 |

* Assessment must exclude any non-hospital assessment including Nursing Facility

---

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

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

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

**Tax that flows to allocation on Section G of DSH Survey**

---

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

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

• Exhibit A:
  • Include *Primary Payor Plan, Secondary Payor Plan, Birth Date, SSN, and Gender* fields
  • A complete list (key) of payor plans is required to be submitted separately with the survey.
EXHIBIT A - UNINSURED

• Claim Status (Column R)– need to indicate if Exhausted / Non-Covered Insurance claims are being included under the proposed rule since that rule is not final.

• If exhausted / non-covered insurance services are included on Exhibit A, then the corresponding payments must also be included on Exhibit B for patient payments.

• Submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).
<table>
<thead>
<tr>
<th>Claim Type (A)</th>
<th>Primary Payor Plan (B)</th>
<th>Secondary Payor Plan (C)</th>
<th>Provider # (D)</th>
<th>Patient ID/Number (E)</th>
<th>Patient’s Birth Date (F)</th>
<th>Patient’s Security Number (G)</th>
<th>Patient’s Name (H)</th>
<th>Patient’s Gender (I)</th>
<th>Admit Date (J)</th>
<th>Discharge Date (K)</th>
<th>Revenue Code (L)</th>
<th>Service Indicator</th>
<th>Total Charges for Services Provided (M)</th>
<th>Total Patient Payments for Services Provided (N)</th>
<th>Total Third Party Payments for Services Provided (O)</th>
<th>Routine Days of Care (P)</th>
<th>Exhausted or Non-Covered Service, if applicable (Q)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured Charges - Charity</td>
<td>Self-Pay</td>
<td>12345</td>
<td>22222222</td>
<td>9/11/1980</td>
<td>999-000-0000</td>
<td>Female</td>
<td>Doe, Jane</td>
<td>3/1/2010</td>
<td>3/1/2010</td>
<td>Inpatient</td>
<td>300</td>
<td>6,000.00</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured Charges - Charity</td>
<td>Self-Pay</td>
<td>12345</td>
<td>22222222</td>
<td>9/11/1980</td>
<td>999-000-0000</td>
<td>Female</td>
<td>Doe, Jane</td>
<td>3/1/2010</td>
<td>3/1/2010</td>
<td>Inpatient</td>
<td>400</td>
<td>9,000.00</td>
<td>40</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Uninsured Charges - Medicare</td>
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<td>12345</td>
<td>44444444</td>
<td>7/12/1995</td>
<td>999-000-0000</td>
<td>Male</td>
<td>Jones, John</td>
<td>6/1/2010</td>
<td>6/1/2010</td>
<td>Outpatient</td>
<td>200</td>
<td>100.00</td>
<td>20</td>
<td>Exhausted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured Charges - Blue Cross</td>
<td></td>
<td>12345</td>
<td>11111111</td>
<td>9/1/2000</td>
<td>999-000-0000</td>
<td>Male</td>
<td>Smith, Mike</td>
<td>8/1/2010</td>
<td>8/1/2010</td>
<td>Outpatient</td>
<td>450</td>
<td>1,900.00</td>
<td>45</td>
<td>Non-Covered Service</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EXHIBIT A - UNINSURED CHARGES / DAYS**
EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

• Survey form Exhibit B has been designed to assist hospitals in collecting and reporting all patient payments received on a cash basis.
  
• Exhibit B should include all patient payments regardless of the patient’s insurance status.
  
• Total patient payments from this exhibit are entered in Section E of the survey.
  
• Insurance status should be noted on each patient payment so the sub-total of uninsured hospital patient payments can be entered in Section H of the survey.
EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

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

• For example, a cash payment received during the 2011 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2011 cost report year.
EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

• Exhibit B

  • Include Primary Payor Plan, Secondary Payor Plan, Birth Date, SSN, Payment Transaction Code, and Gender 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).
<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Primary Payor</th>
<th>Secondary Payor</th>
<th>Coverage Code</th>
<th>Name</th>
<th>Address Date</th>
<th>Discharge Date</th>
<th>Date of Service</th>
<th>Amount of Cms Collections (Cms)</th>
<th>Amount of Cms Collections (Cms)</th>
<th>Indicators of Collection Effort of Individual</th>
<th>Total Hospital Charges for Services Provided (Cms)</th>
<th>Total Physician Charges for Services Rendered (Cms)</th>
<th>Total Other Non-Hospital Charges Rendered (Cms)</th>
<th>Insurance Status of Services</th>
<th>Claim Status</th>
<th>Edits/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Pay &amp; Medicaid/Medical</td>
<td>Medicaid</td>
<td>Medicaid</td>
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**Exhibit B - Cash Basis Patient Payments**

**DEDICATED TO GOVERNMENT HEALTH PROGRAMS**
EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Medicaid data reported on the survey must be supported by a third-party paid claims summary such as a PS&R, Managed Care Plan provided report, or state-run paid claims report.

- If not available, the hospital must submit the detail behind the reported survey data in the Exhibit C format. Otherwise, the data may not be allowed in the final UCC.

- Medicaid fee-for-service (FFS) claims summaries provided by the state must be used to complete the DSH survey FFS section. However, the hospital has the option to reconcile the state’s claims data with its internal data and submit an Exhibit C for any claims with variances.
**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)
  - Additional or adjusted Medicaid FFS claims noted during reconciliation of state and internal hospital data (Section H)
EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

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

- Exhibit C
  - Include Birth Date, Social Security Number, and Gender fields
    - Necessary to match to state’s Medicaid eligibility files if the patient’s Medicaid number is not provided or incorrect
  - Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).
<table>
<thead>
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<th>Claim Type</th>
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<th>Patient's Birth Date</th>
<th>Service Initiation Date</th>
<th>Revenue Code</th>
<th>Revenue Description</th>
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<th>Total Medicare Payments for Services Provided</th>
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**EXHIBIT C - MANAGED CARE**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
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 audit.

• Includes Myers and Stauffer address 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

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

4. Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
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.
DSH SURVEY PART I – DSH YEAR DATA

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 crosswalk used to prepare cost report and DSH survey. (Should be the same crosswalk)
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)
2011 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.

- Based on Medicaid instructions, 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.
2011 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.
2011 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.
2011 CLARIFICATIONS / CHANGES

• Retroactive Payments/Recoupments

Diagram:
- Retroactive Payment/Recoupment Received after DSH examination is complete
  - Is it material? NO
    - No adjustment necessary or include in DSH year or cost report year paid.
  - Is it an uninsured patient payment? YES
    - Report in the cost reporting period the payment was received.
  - Is it a Medicaid outlier payment? NO
    - Report in the state year the payment was received.
  - Report in the state year the payment was received.
  - Retroactively adjust DSH examination report that payment applies to. (See list below)
### 2011 Clarifications / Changes

- **Retroactive Payments/Recoupments**

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<thead>
<tr>
<th>Types of payments resulting in retroactive adjustment:</th>
<th>Types of recoupments resulting in retroactive adjustment:</th>
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<td>Medicare paid claims payments</td>
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<td>TPL paid claims payments</td>
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<tr>
<td>UPL payments</td>
<td>Recoupment of UPL payments</td>
</tr>
<tr>
<td>Trauma add-on and trauma outlier payments</td>
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<tr>
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<td>Cost settlement payments</td>
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<td>Recoupment of Cost settlement payments</td>
</tr>
</tbody>
</table>

* Medicaid outlier payments are included for DSH purposes based on the date paid by the state regardless of the DOS. Recoupments of Medicaid outlier payments will be included for DSH purposes based on the original date of the payment— not the DOS.
2011 CLARIFICATIONS / CHANGES

- Changes to Annual Reporting Requirements
  - Medicare & Medicaid #
  - Total Hospital Cost
    - Total Hospital Cost from Section G of DSH survey (includes I&R, RCE, FRA tax)
PRIOR YEAR DSH EXAMINATION (2010)

Significant Data Issues in Final Report

- Medicaid Managed Care paid claims were not available.
- Medicaid Managed Care data may have incorrectly included non-Title 19 services such as SCHIP.
- Hospitals couldn’t obtain out-of-state Medicaid Paid Claims Summaries (PS&Rs).
- Some hospitals couldn’t document their uninsured cost/payments.
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.
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.
PRIOR YEAR DSH EXAMINATION (2010)

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 proposed rule, hospitals reported “Exhausted” / “Insurance Non-Covered” on Exhibit A (Uninsured) but did not report the payments on Exhibit B
Common Issues Noted During Examination

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

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

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

- Medicare cross-over payments didn’t include all Medicare payments (outlier, cost report settlements, lump-sum/pass-through, payments received after year end, etc.).

- Only uninsured payments are to be on cash basis – all other payor payments must include all payments made for the dates of service as of the DSH survey submission.
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 charity care charges in the LIUR section (Section F) of the survey or didn’t include a breakdown of inpatient and outpatient charity.
1. What is the definition of uninsured for Medicaid DSH purposes?

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

- CMS released a proposed rule in the January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.

- Under this proposed rule, the DSH examination will now look at whether a patient is uninsured using a “service-specific” approach as opposed to the creditable coverage approach previously employed.

- The rule is still not “final” but the survey does allow for hospitals to report “exhausted” and “insurance non-covered” services as uninsured.
1. **What is the definition of uninsured for Medicaid DSH purposes?** (Continued from previous slide)

Excluded prisoners were defined in the proposed 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 January 18, 2012 proposed rule, hospitals can report services if insurance is “exhausted” or if the service provided was “not covered” by insurance. The service must still be a hospital service that would normally be covered by Medicaid.

Since the rule is not final, these services must be segregated on Exhibits A and B of the survey.
3. **What categories of services can be included in uninsured on the DSH survey?**

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

- There has been some confusion with this issue. CMS attempts to clarify this in #24 of their FAQ titled “Additional Information on the DSH Reporting and Audit Requirements”. It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.

- **EXAMPLE:** A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is “Yes” since speech therapy is a Medicaid hospital service even though they wouldn’t cover beneficiaries over 18.
4. Can a service be included as uninsured, if insurance didn’t pay due to improper billing, late billing, or lack of medical necessity?

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

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

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

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

Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the proposed rule as an exhausted or insurance non-covered service.
8. 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 Proposed Rule, these patients may be included in the DSH UCC if Medicare is exhausted.
9. Can a hospital report services covered under automobile policies as uninsured?

Not if the automobile policy pays for the service. We interpret the phrase “who have health insurance (or other third party coverage)” to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). (Reporting pages 77911 & 77916)
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.
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)
**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)
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
11440 Tomahawk Creek Parkway
Leawood, KS 66211
(800) 374-6858
modsh@mslc.com

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