

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION

Connecticut State Fiscal Year 2013

DEDICATED TO GOVERNMENT HEALTH PROGRAMS





MYERS AND
STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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■ TRAINING OVERVIEW

- **New DSH Developments**
- **Common Examination Issues**
- **Review of DSH Survey Forms**



■ DSH PAYMENTS REFRESHER

- DSH implemented under Section 1923 of the Social Security Act (42 U.S. Code, Section 1396r-4)
- Medicaid DSH payments are intended to cover ONLY the uncompensated care costs for Medicaid and uninsured (for hospitals that qualify)
- SPRY 2011 was the first year for paybacks/redistributions



■ NEW DSH DEVELOPMENTS

MEDICAID DSH Additional Information of the DSH Reporting and Audit Requirements – Part 2 -CMS Website April 7, 2014

- #12 in the CMS document – Specifies payments made by a managed-care organization related to state-only/local-only indigent care patients must be offset against costs because the statutory exception to exclude the state-only/local government only payments is limited to payments received directly from the state or unit of government.



■ NEW DSH DEVELOPMENTS

- **#35-Hospitals opened after December 22, 1987 do not automatically meet the exemption to the obstetric services requirement.**
- Indicates that hospitals claiming the exemption to having two physicians providing obstetric services because they did not offer non-emergency obstetrical services to the general population as of December 22, 1987 cannot claim that exemption if the hospital opened after December 22, 1987.



■ NEW DSH DEVELOPMENTS

- *December 3, 2014 Final Rule Expanded Definition of Uninsured implemented in FR Vol. 79, No. 232, Wednesday, Dec. 03, 2014, Final Rule*
 - Definitions of uninsured as laid out in the January 2012 proposed rule have been finalized.
 - Myers and Stauffer has been utilizing the definitions of uninsured as stated in the January 2012 proposed rule since the 2009 DSH examinations.
 - Now that the proposed rule has been finalized, Myers and Stauffer will continue to utilize those definitions as they have been since the 2009 DSH examinations.



■ NEW DSH DEVELOPMENTS

- Under the final 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.



■ NEW DSH DEVELOPMENTS

- Under the final rule, the following may be considered uninsured:
 - Individuals with exhausted insurance benefits at the time of service
 - Individuals who have reached lifetime insurance limits for certain services
 - Individuals whose benefit package does not cover the hospital service received (must be a covered service under the Medicaid state plan)



■ NEW DSH DEVELOPMENTS

- Individuals must exhaust benefits prior to obtaining services to be considered uninsured (i.e., if individual exhausts coverage during the course of services, they cannot be considered uninsured).
- Individuals with high deductible or catastrophic plans are considered insured even in instances where policy requires individual to satisfy a deductible or share in the cost services.



■ NEW DSH DEVELOPMENTS

- Specific Exclusions Listed in the Proposed Rule:
 - Bad Debts for individuals with third party coverage
 - Unpaid coinsurance/deductibles for individuals with third party coverage
 - Prisoners (individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges)



■ NEW DSH DEVELOPMENTS

- **CMS audits of the DSH audits continue**
 - CMS goal is to audit every state over the next few years.
 - CMS audits the state and independent auditor's procedures and documentation for sufficiency.
 - A few providers in each state are also selected for further scrutiny (these providers in effect get audited twice).



■ NEW DSH DEVELOPMENTS

- **CMS audits of the DSH audits continue**
 - No formal results have yet been issued
 - CMS intends to issue formal results to provide more guidance to states, auditors and providers.
 - CMS has not announced when Connecticut will be audited



■ MSLC DSH PROCEDURES

- Continue using 2 Surveys to collect DSH Year Data
 - Allows for more transparency of the process
 - Providers can see how their data impacts the DSH calculation
- Continue using SFTP site location
<https://transfer.mslc.com/>



■ DSH YEAR 2013 EXAMINATION TIMELINE - TENTATIVE

- March 1 – 15: State MMIS FFS data reviewed, summarized and distributed
- March 18: Hospital Data due to MSLC
- April – May: Desk review examinations
- June – July: Expanded Reviews
- September 30: Draft report due to the state
- December 31: Final report due to CMS



■ COMMON 2012 EXAMINATION ISSUES

- Hospitals over DSH limits: 2 out of 34 *(may become 1)*
- Compliance with the documentation requests was generally good
- Extensions create scheduling problems.
- Less findings in 2012 than 2011; no new/different findings



■ COMMON 2012 EXAMINATION ISSUES

- The hospital submitted Medicaid data which only included total payments rather than the requested detail of payments by the various payor categories. As such, total payments were reported in the payor category to which the majority of payments would relate based on population.
- The hospital did not submit uninsured and/or Medicaid eligible days by revenue code. As such, days not directly assigned were allocated based on the Medicare cost report worksheet S-3 total days.
- The hospital failed to submit data with payments separated by payor (Medicaid, Medicare, TPL, etc.). As such, MSLC assigned payments for each population based on where majority of payments should typically be grouped for each applicable population.



■ COMMON 2012 EXAMINATION ISSUES

- The submitted Exhibit B patient payments were based on an accrual basis, rather than on a cash basis as required by the DSH rule.
- Hospitals' uninsured self-pay payments reflect payments received for uninsured dates of service within the cost reporting period and therefore do not reflect cash basis uninsured payments as required by DSH reporting regulations. Additionally, due to missing data elements in the submitted self-pay schedules, certain screening procedures designed to detect errors in the submitted data could not be performed
- Hospital did not submit a signed certification statement attesting to the accuracy of the submitted data and the underlying supporting documentation
- The hospital failed to submit reasonable information for the calculation of the Low Income Utilization Rate (LIUR). As such, the LIUR will be reported as zero for the MSP rate year.



■ PAID CLAIMS DATA UPDATE FOR 2013

- Medicaid fee-for-service paid claims data
 - Was obtained this week from the state. MSLC is currently formatting the data and send to providers to map by MSLC and entered into Survey Part II Section H. If a hospital is ready to submit its survey before MSLC sends the MMIS FFS claims data, submit survey as is and MSLC will map the FFS claims data using the hospital submitted crosswalk
 - Reported based on cost report year (using discharge date).
 - At revenue code level.



■ PAID CLAIMS DATA UPDATE FOR 2013

- Medicare/Medicaid cross-over paid claims data
 - The hospital should send in a detailed listing in Exhibit C format (consistent with prior year).
 - 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 2013

- Medicaid managed care paid claims data
 - If the hospital cannot obtain a paid claims listing from the MCO, the hospital should send in a detailed listing in Exhibit C format (consistent with prior year).
 - 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 2013

- Out-of-State Medicaid paid claims data
 - If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in Exhibit C format (consistent with prior year).
 - 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 2013

- “Other” Medicaid Eligibles
 - Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing may not be included in the state’s data. The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).
 - This would include Medicare MCO primary/Medicaid secondary claims, **private insurance primary/Medicaid secondary claims**, and any other Medicaid eligible claims not included elsewhere.
 - 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 2013

- “Other” Medicaid Eligibles (cont.)
 - 2008 DSH Rule and January, 2010 CMS FAQ #33 requires that ***all*** Medicaid eligibles are reported on the DSH survey and included in the UCC calculation.
 - Exhibit C should be submitted for this population. If no “Other” Medicaid Eligibles are submitted, we will contact you to request that they be submitted. If we still do not receive the requested Exhibit C, we may have to list the hospital as non-compliant in the 2013 DSH examination report.
 - Ensure that you ***separately report*** Medicaid, Medicaid MCO, Medicare, Medicare HMO, private insurance and self-pay payments in Exhibit C.





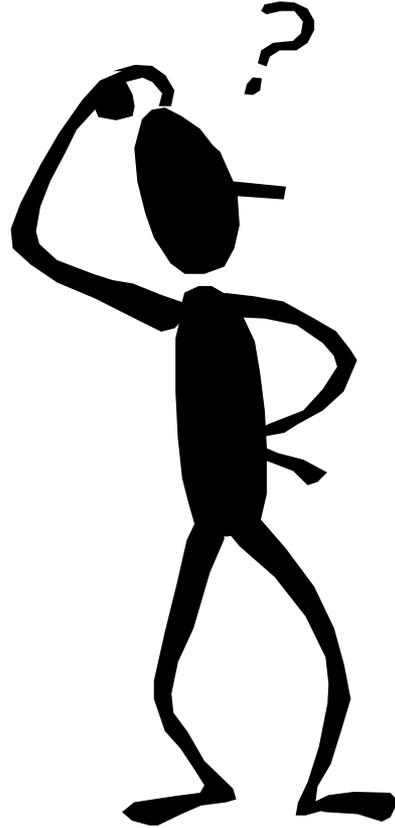
■ PAID CLAIMS DATA UPDATE FOR 2013

- Uninsured Services

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



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■ DSH EXAMINATION SURVEYS

General Instruction – Survey Files

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



■ DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- Don't complete a DSH Part II survey for a cost report year already submitted in a previous DSH exam year.
 - Example: Hospital A provided a survey for their year ending 6/30/2013 with the DSH audit of SFY 2012 in the prior year. In the DSH year 2013 exam, Hospital A would only need to submit a survey for their year ending 6/30/2014.
- 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 EXAMINATION SURVEYS

General Instruction – HCRIS Data

- Myers and Stauffer pre-loads 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.



A. General DSH Year Information

1. DSH Year:

Begin	End
10/01/2012	09/30/2013

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

[Redacted Drop-Down Menu]

Hospital name is populated

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	10/01/2012	09/30/2013
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Must also complete a separate survey

Examination FYE is populated; for 2013 no hospital has multiple years

SURVEY PART II FILES

6. Medicaid Provider Number:

Date: [Redacted]

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

0

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

0

9. Medicare Provider Number:

[Redacted]

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:

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

DSH Examination Year (10/01/12 - 09/30/13)

Answer all OB questions

[Input Fields]

Enter all supplemental payments for the DSH year. Amount should agree with state report

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for DSH Year 10/01/2012 - 09/30/2013

(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

[Input Field]



Certification:

Answer

Must answer the retain DSH question

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

Explanation for "No" answers:

Complete Certification and Contract Information

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

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

_____ Title _____ Date _____

_____ Hospital CEO or CFO Telephone Number _____ Hospital CEO or CFO E-Mail _____

Contact Information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:

Name	_____
Title	_____
Telephone Number	_____
E-Mail Address	_____
Mailing Street Address	_____
Mailing City, State, Zip	_____

Outside Preparer:

Name	_____
Title	_____
Firm Name	_____
Telephone Number	_____
E-Mail Address	_____



■ **DSH YEAR SURVEY PART II**

SECTION D – GENERAL INFORMATION

Submit one copy of the part II survey for each cost report year not previously submitted.

- **Question #2 – An “X” should be shown in the column of the cost report year survey you are preparing.**
 - If you have multiple years listed, you will need to prepare multiple surveys).
 - If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.
- **Question #3 – This question may be already answered based on pre-loaded HCRIS data. If your hospital is going to update the cost report data to a more recent version of the cost report, select the status of the cost report you are using with this drop-down box.**



D. General Cost Report Year Information **10/1/2012 - 9/30/2013**

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided:

10/1/2012 through 9/30/2013		
X		

"X" indicates the CR year you are reporting on.

2. Select Cost Report Year Covered by this Survey (enter "X"):

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

3a. Date CMS processed the HCRIS file into the HCRIS database:

Data	Correct?	If Incorrect, Proper Information
ABC Hospital		
123456		

4. Hospital Name:

5. Medicaid Provider Number:

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

8. Medicare Provider Number:

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

State Name	Provider No.

Choose CR status from the drop down menu

(List additional states on a separate attachment)



■ 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: (10/01/2012 - 09/30/2013)

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)

\$	10,000
\$	5,000
\$	2,500
	\$17,500
\$	1,000
	\$1,000

1011 Payment (undocumented patients) (Reconciliation)

8. Out-of-State DSH Payments (See Note 2)

\$	50,000
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Out-of-state DSH payments

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:

	Inpatient	Outpatient	Total
\$	250,000	1,000,000	\$1,250,000
\$	3,000,000	9,000,000	\$12,000,000
	\$3,250,000	\$10,000,000	\$13,250,000
	7.69%	10.00%	9.43%

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

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

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



■ 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.
- 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).



■ DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

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

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



■ DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

Section F-3: Reconciling Items Necessary for Proper Calculation of LIUR

- Bad debt and charity care write-offs not included on G-3, line 2 should be entered on lines 28 and 29 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 30 and 31 so they can be properly excluded in calculating net patient service revenue also.
- Medicaid Provider Tax included on G-3, line 2 should be entered on line 32 so it can be properly excluded in calculating net patient service revenue.



F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2012 - 09/30/2013)

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

- 1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.xxx less lines 5 & 6)

54,767

(See Note in Section F-3, below)

Days per cost report

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

- 2. Inpatient Hospital Subsidies
- 3. Outpatient Hospital Subsidies
- 4. Unspecified I/P and O/P Hospital Subsidies
- 5. Non-Hospital Subsidies
- 6. Total Hospital Subsidies
- 7. Inpatient Charity Care Charges
- 8. Outpatient Charity Care Charges
- 9. Non-Hospital Charity Care Charges
- 10. Total Charity Care Charges



\$	-
\$	-

State or Local gov't Subsidies

Charity care charges – ONLY used for LIUR, not UCC



Over write contractual formulas if unreasonable or if hospital has actual numbers by service center

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

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

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$160,342,737.00			\$ 121,796,684	\$ -	\$ -	\$ 38,546,053
12. Subprovider I (Psych or Rehab)	\$44,916,184.00			\$ 34,118,429	\$ -	\$ -	\$ 10,797,755
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$0.00			\$ -	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$0.00			\$ -	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$253,183,400.00	\$315,619,288.00		\$ 192,318,649	\$ 239,745,082	\$ -	\$ 136,738,956
20. Outpatient Services		\$83,674,844.00			\$ 63,559,589	\$ -	\$ 20,115,255
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$0.00			\$ -	
23. Outpatient Rehab Providers			\$0.00			\$ -	
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$0.00			\$ -	
26. Other	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
27. Total	\$ 458,442,321	\$ 399,294,132	\$ -	\$ 348,233,762	\$ 303,304,672	\$ -	\$ 206,198,019
28. Total Hospital and Non Hospital		Total from Above	\$ 857,736,453	Total from Above	\$ 651,538,434		

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	857,736,453	Total Contractual Adj. (G-3 Line 2)	650,038,434
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	500,000
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	1,000,000
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35. Adjusted Contractual Adjustments				651,538,434
36. Unreconciled Difference	Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -

Reconciliation lines to used to ensure only true contractuels are included in the calculation



■ **DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA**

- Calculation of Routine Cost Per Diems
 - Days per routine cost center
 - Cost per diem
- Calculation of Ancillary Cost-to-Charge Ratios
 - Total costs/charges per ancillary cost center
 - Ancillary cost to charge ratio per cost center



G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2012-09/30/2013)

ABC Hospital

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Provider Tax Assessment	Total Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col. 2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Allocation of Provider Tax from Section L of the Survey Based on Total Cost</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>		<i>Calculated Per Diem</i>

All Cost Report Data. Calculation of Routine Cost Per Diems.

Routine Cost Centers (list below):

1	03000 ADULTS & PEDIATRICS	\$ 200,000,000	\$ 55,000,000	\$ -	\$ 0.00	\$ 1,122,176	\$ 256,122,176	250,000		\$ 1,024.49
2	03100 INTENSIVE CARE UNIT	\$ 14,000,000	\$ 8,500,000	\$ -		\$ 99,016	\$ 22,599,016	10,000		\$ 2,259.90
3	03200 CORONARY CARE UNIT	\$ 7,500,000	\$ -	\$ -		\$ 33,005	\$ 7,533,005	5,000		\$ 1,506.60
4	03300 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	\$ -	-		\$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ 12,500,000	\$ 1,500,000	\$ -		\$ 61,610	\$ 14,061,610	8,000		\$ 1,757.70
6	03500 OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -		\$ -	\$ -	-		\$ -
7	04000 SUBPROVIDER I	\$ 12,000,000	\$ 2,000,000	\$ -		\$ 61,610	\$ 14,061,610	11,000		\$ 1,278.33
8	04100 SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	\$ -	-		\$ -
9	04200 OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	\$ -	-		\$ -
10	04300 NURSERY	\$ 2,000,000	\$ 40,000	\$ -		\$ 8,977	\$ 2,048,977	6,000		\$ 341.50
11		\$ -	\$ -	\$ -		\$ -	\$ -	-		\$ -
12		\$ -	\$ -	\$ -		\$ -	\$ -	-		\$ -
13		\$ -	\$ -	\$ -		\$ -	\$ -	-		\$ -
14		\$ -	\$ -	\$ -		\$ -	\$ -	-		\$ -
15		\$ -	\$ -	\$ -		\$ -	\$ -	-		\$ -
16		\$ -	\$ -	\$ -		\$ -	\$ -	-		\$ -
17		\$ -	\$ -	\$ -		\$ -	\$ -	-		\$ -
18	Total Routine	\$ 248,000,000	\$ 67,040,000	\$ -	\$ -	\$ 1,386,394	\$ 316,426,394	290,000		\$ 1,091.13
19	Weighted Average									

Observation Data (Non-Distinct)

20	092xx Observation (Non-Distinct)	
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Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
1,100	150	-	\$ 1,318,689	\$106,000.00	\$820,000.00	\$ 926,000	1.424070

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



G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2012-09/30/2013) ABC Hospital

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Provider Tax Assessment	Total Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col. 2 and Col. 4</i>	<i>Allocation of Provider Tax from Section L of the Survey Based on Total Cost</i>	<i>Calculated</i>	<i>Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6</i>	<i>Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7</i>	<i>Total Charges - Cost Report Worksheet C, Pt. I, Col. 8</i>	<i>Medicaid Calculated Cost-to-Charge Ratio</i>
Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
21	5000 OPERATING ROOM	\$70,000,000.00	\$ 20,000,000	\$0.00	\$ -	\$ 90,000,000	\$154,500,000.00	\$74,000,000.00	\$ 228,500,000	0.393873
22	5100 RECOVERY ROOM	\$25,000,000.00	\$ -	\$0.00	\$ -	\$ 25,000,000	\$23,000,000.00	\$37,000,000.00	\$ 60,000,000	0.416667
23	5200 DELIVERY ROOM & LABOR ROOM	\$10,000,000.00	\$ 1,300,000	\$0.00	\$ -	\$ 11,300,000	\$9,000,000.00	\$2,000,000.00	\$ 11,000,000	1.027273
24	5300 ANESTHESIOLOGY	\$13,000,000.00	\$ 7,500,000	\$0.00	\$ -	\$ 20,500,000	\$40,000,000.00	\$35,000,000.00	\$ 75,000,000	0.273333
25	5400 RADIOLOGY-DIAGNOSTIC	\$50,000,000.00	\$ 1,000,000	\$0.00	\$ -	\$ 51,000,000	\$100,000,000.00	\$195,000,000.00	\$ 295,000,000	0.172881
26	5500 RADIOLOGY-THERAPEUTIC	\$30,000,000.00	\$ -	\$0.00	\$ -	\$ 30,000,000	\$7,000,000.00	\$110,000,000.00	\$ 117,000,000	0.256410
27	5600 RADIOISOTOPE	\$4,000,000.00	\$ 170,000	\$0.00	\$ -	\$ 4,170,000	\$5,000,000.00	\$11,000,000.00	\$ 16,000,000	0.260625
28	6000 LABORATORY	\$55,000,000.00	\$ 6,400,000	\$0.00	\$ -	\$ 61,400,000	\$290,000,000.00	\$175,000,000.00	\$ 465,000,000	0.132043
29	6300 BLOOD STORING PROCESSING & TRA	\$40,000,000.00	\$ -	\$0.00	\$ -	\$ 40,000,000	\$115,000,000.00	\$35,000,000.00	\$ 150,000,000	0.266667
30	6500 RESPIRATORY THERAPY	\$17,000,000.00	\$ -	\$0.00	\$ -	\$ 17,000,000	\$60,000,000.00	\$3,000,000.00	\$ 63,000,000	0.269841
31	6600 PHYSICAL THERAPY	\$6,500,000.00	\$ -	\$0.00	\$ -	\$ 6,500,000	\$20,000,000.00	\$200,000.00	\$ 20,200,000	0.321782
32	6700 OCCUPATIONAL THERAPY	\$2,250,000.00	\$ -	\$0.00	\$ -	\$ 2,250,000	\$7,000,000.00	\$150,000.00	\$ 7,150,000	0.314685
33	6800 SPEECH PATHOLOGY	\$1,000,000.00	\$ -	\$0.00	\$ -	\$ 1,000,000	\$2,000,000.00	\$100,000.00	\$ 2,100,000	0.476190
34	6900 ELECTROCARDIOLOGY	\$9,000,000.00	\$ -	\$0.00	\$ -	\$ 9,000,000	\$46,000,000.00	\$45,000,000.00	\$ 91,000,000	0.098901
35	7000 ELECTROENCEPHALOGRAPHY	\$1,500,000.00	\$ 250,000	\$0.00	\$ -	\$ 1,750,000	\$5,500,000.00	\$750,000.00	\$ 6,250,000	0.280000
36	7100 MEDICAL SUPPLIES CHARGED TO PAT	\$97,000,000.00	\$ -	\$0.00	\$ -	\$ 97,000,000	\$185,000,000.00	\$60,000,000.00	\$ 245,000,000	0.395918
37	7200 IMPL DEV CHARGED TO PATIENTS	\$120,000,000.00	\$ -	\$0.00	\$ -	\$ 120,000,000	\$180,000,000.00	\$50,000,000.00	\$ 230,000,000	0.521739
38	7300 DRUGS CHARGED TO PATIENTS	\$120,000,000.00	\$ -	\$0.00	\$ -	\$ 120,000,000	\$270,000,000.00	\$90,000,000.00	\$ 360,000,000	0.333333
39	7400 RENAL DIALYSIS	\$4,000,000.00	\$ -	\$0.00	\$ -	\$ 4,000,000	\$17,000,000.00	\$180,000.00	\$ 17,180,000	0.232829
40	7600 CAT SCAN	\$10,000,000.00	\$ -	\$0.00	\$ -	\$ 10,000,000	\$75,000,000.00	\$115,000,000.00	\$ 190,000,000	0.052632
41	7602 ULTRASOUND	\$4,500,000.00	\$ 75,000	\$0.00	\$ -	\$ 4,575,000	\$7,000,000.00	\$20,000,000.00	\$ 27,000,000	0.169444
42	7603 CARDIAC CATHETERIZATION LABORATORY	\$12,500,000.00	\$ 500,000	\$0.00	\$ -	\$ 13,000,000	\$35,000,000.00	\$25,000,000.00	\$ 60,000,000	0.216667
43	7604 ULTRASOUND	\$9,500,000.00	\$ -	\$0.00	\$ -	\$ 9,500,000	\$10,000,000.00	\$25,000,000.00	\$ 35,000,000	0.271429
44	7607 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	\$800,000.00	\$ -	\$0.00	\$ -	\$ 800,000	\$25,000.00	\$2,800,000.00	\$ 2,825,000	0.283186
45	9000 CLINIC	\$20,000,000.00	\$ 10,600,000	\$0.00	\$ -	\$ 30,600,000	\$950,000.00	\$28,000,000.00	\$ 28,950,000	1.056995
46	9100 EMERGENCY	\$30,500,000.00	\$ 10,300,000	\$0.00	\$ -	\$ 40,800,000	\$55,500,000.00	\$76,000,000.00	\$ 131,500,000	0.310266

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*).
 - In-State Medicaid Managed Care Primary (*Medicaid MCO*).
 - In-State Medicare FFS Cross-Overs (*Traditional Medicare with Medicaid [Traditional or MCO] Secondary*).
 - In-State Other Medicaid Eligibles (*would include Medicare MCO/Medicaid secondary, private insurance/Medicaid secondary and other Medicaid not included elsewhere*).



All Medicaid Categories

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

Disproportion

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

Cost Report Year (10/01/2012-09/30/2013) ABC Hospital

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers From Section G	Medicaid Cost to Charge Ratio for Ancillary Cost Centers From Section G	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis	
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	\$ 1,024.49		29,500		11,000		22,000		5,000		
2	03100 INTENSIVE CARE UNIT	\$ 2,259.90		1,600		40		1,500		500		
3	03200 CORONARY CARE UNIT	\$ 1,506.60		500		15		600		100		
4	03300 BURN INTENSIVE CARE UNIT	\$ -										
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ 1,757.70		1,100		140		600		100		
6	03500 OTHER SPECIAL CARE UNIT	\$ -										
7	04000 SUBPROVIDER I	\$ 1,278.33		3,000		250		2,800		1,500		
8	04100 SUBPROVIDER II	\$ -										
9	04200 OTHER SUBPROVIDER	\$ -										
10	04300 NURSERY	\$ 341.50		1,255		4,000				500		
11		\$ -										
12		\$ -										
13		\$ -										
14		\$ -										
15		\$ -										
16		\$ -										
17		\$ -										
18				Total Days		36,955		15,445		27,500		7,700
19	Total Days per PS&R or Other Paid Claims Summary											
20	Unreconciled Days (Explain Variance)					36,955		15,445		27,500		7,700
21				Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21.01	Routine Charges					35,500,000		10,405,000		26,800,000		7,400,000
	Calculated Routine Charge Per Diem					\$ 960.63		\$ 673.68		\$ 974.55		\$ 961.04



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

Cost Report Year (10/01/2012-09/30/2013)

ABC Hospital

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers <i>From Section G</i>	Medicaid Cost to Charge Ratio for Ancillary Cost Centers <i>From Section G</i>	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From Hospital's Own Internal Analysis</i>	<i>From Hospital's Own Internal Analysis</i>
Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	0920x Observation (Non-Distinct)		1.424070	30,000	130,000	-	50,000	-	90,000	-	25,000
23	5000 OPERATING ROOM		0.393873	10,930,000	3,690,000	1,450,000	1,320,000	8,010,000	3,200,000	725,000	660,000
24	5100 RECOVERY ROOM		0.416667	1,650,000	2,170,000	290,000	730,000	1,340,000	1,890,000	145,000	365,000
25	5200 DELIVERY ROOM & LABOR ROOM		1.027273	940,000	260,000	3,630,000	1,040,000	110,000	20,000	1,815,000	520,000
26	5300 ANESTHESIOLOGY		0.273333	2,650,000	1,360,000	480,000	570,000	1,860,000	1,070,000	240,000	285,000
27	5400 RADIOLOGY-DIAGNOSTIC		0.172881	11,930,000	13,170,000	1,260,000	3,110,000	8,860,000	10,390,000	630,000	1,555,000
28	5500 RADIOLOGY-THERAPEUTIC		0.256410	750,000	10,540,000	60,000	1,390,000	520,000	4,790,000	30,000	695,000
29	5600 RADIOISOTOPE		0.260625	650,000	850,000	50,000	160,000	690,000	730,000	25,000	80,000
30	6000 LABORATORY		0.132043	31,920,000	15,920,000	6,140,000	6,340,000	25,430,000	10,180,000	3,070,000	3,170,000
31	6300 BLOOD STORING PROCESSING & TRA		0.266667	11,340,000	3,030,000	2,410,000	590,000	7,800,000	2,070,000	1,205,000	295,000
32	6500 RESPIRATORY THERAPY		0.269841	6,360,000	220,000	480,000	70,000	5,530,000	180,000	240,000	35,000
33	6600 PHYSICAL THERAPY		0.321782	1,070,000	20,000	120,000		990,000	10,000	60,000	-
34	6700 OCCUPATIONAL THERAPY		0.314685	650,000	20,000	100,000		620,000	20,000	50,000	-
35	6800 SPEECH PATHOLOGY		0.476190	240,000	20,000	30,000		170,000	20,000	15,000	-
36	6900 ELECTROCARDIOLOGY		0.098901	4,780,000	3,240,000	350,000	540,000	4,740,000	2,650,000	175,000	270,000
37	7000 ELECTROENCEPHALOGRAPHY		0.280000	530,000	90,000	70,000	20,000	530,000	60,000	35,000	10,000
38	7100 MEDICAL SUPPLIES CHARGED TO PAT		0.395918	23,630,000	5,400,000	3,680,000	1,120,000	20,900,000	5,120,000	1,840,000	560,000
39	7200 IMPL DEV CHARGED TO PATIENTS		0.521739								
40	7300 DRUGS CHARGED TO PATIENTS		0.333333	30,140,000	5,780,000	5,160,000	1,030,000	22,330,000	5,010,000	2,580,000	515,000
41	7400 RENAL DIALYSIS		0.232829	1,440,000	20,000	20,000		3,890,000	100,000	10,000	-
42	7600 CAT SCAN		0.052632	9,460,000	10,040,000	1,070,000	2,140,000	7,020,000	5,870,000	535,000	1,070,000
43	7602 ULTRASOUND		0.169444	950,000	2,000,000	190,000	2,050,000	680,000	670,000	95,000	1,025,000
44	7603 CARDIAC CATHETERIZATION LABORATORY		0.216667	2,260,000	1,110,000	200,000	70,000	2,850,000	1,130,000	100,000	35,000
45	7604 ULTRASOUND		0.271429	1,060,000	2,110,000	70,000	200,000	930,000	1,500,000	35,000	100,000
46	7607 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.283186		360,000		10,000	10,000	1,340,000	-	5,000
47	9000 CLINIC		1.056995	50,000	4,460,000	60,000	2,690,000	70,000	2,430,000	30,000	1,345,000
48	9100 EMERGENCY		0.310266	8,670,000	10,340,000	1,210,000	6,530,000	7,050,000	4,630,000	605,000	3,265,000

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.
 - Medicaid cost report settlements.
 - Medicare bad debt payments (cross-overs).
 - Medicare cost report settlement payments (cross-overs).
 - Other third party payments (TPL).



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

Cost Report Year (10/01/2012-09/30/2013) WATERBURY HOSPITAL

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Totals / Payments											
128	Total Charges (includes organ acquisition from Section J)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
129	Total Charges per PS&R or Other Paid Claims Summary										
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-
131	Total Calculated Cost (includes organ acquisition from Section J)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)										
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down)										
134	Private Insurance (including primary and third party liability)										
135	Self-Pay (including Co-Pay and Spend-Down)										
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			\$ -	\$ -	\$ -	\$ -				
137	Medicaid Cost Settlement Payments (See Note B)										
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)										
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)										
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)										
141	Medicare Cross-Over Bad Debt Payments										
142	Other Medicare Cross-Over Payments (See Note D)										
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)										
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)										
145	Calculated Payment Shortfall / (Longfall)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
146	Calculated Payments as a Percentage of Cost			0%	0%	0%	0%	0%	0%	0%	0%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care and Cross-Over data, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).

Error! No other eligibles reported! See ce

Enter all Medicaid, TPL (including patient) and Medicare payments.



■ DSH SURVEY PART II SECTION H, UNINSURED

- Report uninsured services, patient days (by routine cost center) and ancillary charges by cost center.
- Survey form Exhibit A shows the data elements that need to be collected and provided to Myers and Stauffer.
- For uninsured payments, enter the uninsured hospital patient payment totals from your Survey form Exhibit B. Do NOT pick up the non-hospital or insured patient payments in Section H even though they are reported in Exhibit B.



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

Cost Report Year (10/01/2012-09/30/2013)		ABC Hospital		Uninsured	
Line #	Cost Center Description	Per Diem Cost for Routine Cost	to Charge Ratio for Ancillary Cost Centers	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)
				From Section G	From Section G
Routine Cost Centers (from Section G):					
1	03000 ADULTS & PEDIATRICS	\$ 1,024.43			
2	03100 INTENSIVE CARE UNIT	\$ 2,259.30			
3	03200 CORONARY CARE UNIT	\$ 1,506.60			
4	03300 BURN INTENSIVE CARE UNIT	\$ -			
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ 1,757.70			
6	03500 OTHER SPECIAL CARE UNIT	\$ -			
7	04000 SUBPROVIDER I	\$ 1,278.33			
8	04100 SUBPROVIDER II	\$ -			
9	04200 OTHER SUBPROVIDER	\$ -			
10	04300 NURSERY	\$ 341.50			
11		\$ -			
12		\$ -			
13		\$ -			
14		\$ -			
15		\$ -			
16		\$ -			
17		\$ -			
			Total Days	1,720	
19	Total Days per PS&R or Other Paid Claims Summary				
20	Unreconciled Days (Explain Variance)				
21	Routine Charges	\$ 1,650,000			
21.01	Calculated Routine Charge Per Diem	\$ 959.30			

Uninsured days – should agree to Exhibit A

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

Cost Report Year (10/01/2012-09/30/2013)		ABC Hospital		Uninsured	
Line #	Cost Center Description	Per Diem Cost for Routine Cost	to Charge Ratio for Ancillary Cost Centers	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)
				From Section G	From Section G
Ancillary Cost Centers (from W/S C) (from Section G):					
22	092xx Observation (Non-Distinct)		1.424070		80,000
23	5000 OPERATING ROOM	0.333873		3,640,000	2,000,000
24	5100 RECOVERY ROOM	0.416667		1,160,000	1,250,000
25	5200 DELIVERY ROOM & LABOR ROOM	1.027273		100,000	30,000
26	5300 ANESTHESIOLOGY	0.273333		1,640,000	360,000
27	5400 RADIOLOGY-DIAGNOSTIC	0.172881		2,000,000	4,000,000
28	5500 RADIOLOGY-THERAPEUTIC	0.256410		140,000	1,390,000
29	5600 RADIOISOTOPE	0.260625		220,000	300,000
30	6000 LABORATORY	0.132043		5,000,000	6,000,000
31	6300 BLOOD STORING PROCESSING & TRA	0.266667		2,000,000	370,000
32	6500 RESPIRATORY THERAPY	0.263641		1,030,000	250,000
33	6600 PHYSICAL THERAPY	0.321782		300,000	10,000
34	6700 OCCUPATIONAL THERAPY	0.314685		210,000	10,000
35	6800 SPEECH PATHOLOGY	0.476190		40,000	
36	6300 ELECTROCARDIOLOGY	0.098901		580,000	550,000
37	7000 ELECTROENCEPHALOGRAPHY	0.280000		110,000	40,000
38	7100 MEDICAL SUPPLIES CHARGED TO PAT	0.335318		3,000,000	2,000,000
39	7200 IMPL DEV CHARGED TO PATIENT'S	0.521739			
40	7300 DRUGS CHARGED TO PATIENT'S	0.333333		1,800,000	1,300,000
41	7400 RENAL DIALYSIS	0.232829		90,000	2,300,000
42	7600 CAT SCAN	0.052632		3,000,000	720,000
43	7602 ULTRASOUND	0.163444		290,000	290,000
44	7603 CARDIAC CATHETERIZATION LABORATORY	0.216667		1,150,000	710,000
45	7604 ULTRASOUND	0.271423		400,000	10,000
46	7607 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.283186			
47	9000 CLINIC	1.056395		10,000	1,870,000
48	9100 EMERGENCY	0.310266		2,100,000	7,000,000
Totals / Payments					
128	Total Charges (includes charges acquisition from Section J)			\$ 31,660,000	\$ 35,240,000
129	Total Charges per PS&R or Other Paid Claims Summary			\$ 3,722,370	\$ 10,478,433
130	Unreconciled Charges (Explain Variance)				
131	Charges Acquisition from Section J				
132	Net Spend-Down (including Medicare as a resource)				
133	Detail (All Payments)				
134	Net Year (See Note C)				
135	Medicare Paid Amount (includes coinsurance/deductibles)				
	Note D)				
	Cost Report Year (Cash Basis)			\$ 250,000	\$ 1,000,000
	Hospital Services NOT Included in Exhibits B & E			\$ 5,000	\$ 2,500
	Shortfall / (Longfall) as a Percentage of Cost			\$ 3,467,370 3%	\$ 3,475,333 10%

Uninsured Charges must agree to Exhibit A

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



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

- Additional Edits
 - In the far right column, 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.



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

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

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	In-State Medicaid Managed Care Primary		Total In-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient
19	Total Days per PS&R or Other Paid Claims Summary			947			
20	Unreconciled Days (Explain Variance)						
21	Routine Charges			\$ 3,251,536		\$ 100,119,531	
21.01	Calculated Routine Charge Per Diem			\$ 3,433.58		\$ 3,715.15	
Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges	Ancillary Charge	Ancillary Charges	Ancillary Charges
22	092xx Observation (Non-Distinct)	0.346076		1,201	122.0	184,080	1,533,544
23	5000 OPERATING ROOM	0.212839		222,306,029	1,002.51	233,096,229	11,159,131
24	5100 RECOVERY ROOM	0.049172		198,784	1,001.6	6,195,054	12,520,944
25	5200 DELIVERY ROOM & LABOR ROOM	0.336805		462,257	3.3	2,459,099	27,755

ERROR: Charges exceed total!

Total Medicaid charges

IP	233,096,229
OP	11,159,131
total	244,255,360

Exceed total WS C charts \$105M

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratio
18	Total Routine	58,435			
19	Weighted Average				\$ 1,407.35
	Observation Data (Non-Distinct)				
20	092xx Observation (Non-Distinct)	\$538,169.00	\$3,736,136.00	\$ 4,274,305	0.346076
Ancillary Cost Centers (from W/S C excluding Observations)					
21	5000 OPERATING ROOM	\$52,597,019.00	\$53,377,541.00	\$ 105,974,560	0.212839
22	5100 RECOVERY ROOM	\$80,835,195.00	\$52,623,058.00	\$ 133,458,253	0.049172
23	5200 DELIVERY ROOM & LABOR ROOM	\$3,820,734.00	\$1,887,000.00	\$ 5,707,734	0.336805



■ 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.



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

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

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

In-State organ acquisitions

	Total Organ Acquisition Cost	Additional Provider Tax Add-In and Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 104 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 65 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	\$ 0.00	\$ -	\$ -	\$ -	0									
2	Kidney Acquisition	\$ 0.00	\$ -	\$ -	\$ -	0									
3	Liver Acquisition	\$ 0.00	\$ -	\$ -	\$ -	0									
4	Heart Acquisition	\$ 0.00	\$ -	\$ -	\$ -	0									
5	Pancreas Acquisition	\$ 0.00	\$ -	\$ -	\$ -	0									
6	Intestinal Acquisition	\$ 0.00	\$ -	\$ -	\$ -	0									
7	Islet Acquisition	\$ 0.00	\$ -	\$ -	\$ -	0									
8		\$ -	\$ -	\$ -	\$ -	0									
9	Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -
10	Total Cost														

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

Note B - Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.

Note C - Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (01/01/2012-12/31/2012)

Hospital ABC

Out-of-State organ acquisitions

	Total Organ Acquisition Cost	Additional Provider Tax Add-In and Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 104 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 65 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0							
12	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0							
13	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0							
14	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0							
15	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0							
16	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0							
17	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0							
18		\$ -	\$ -	\$ -	\$ -	0							
19	Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -
20	Total Cost												

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



■ **DSH SURVEY PART II SECTION L, PROVIDER TAXES**

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



■ **DSH SURVEY PART II SECTION L, PROVIDER TAXES**

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



■ **DSH SURVEY PART II SECTION L, PROVIDER TAXES**

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



■ **DSH SURVEY PART II SECTION L, PROVIDER TAXES**

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

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH audit survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (10/01/2012-09/30/2013) ABC Hospital

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 10,000,000	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	520012354 (W/TB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 10,000,000	5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)		
4 Reason for adjustment		(Reclassified to / (from))
5 Reason for adjustment		(Reclassified to / (from))
6 Reason for adjustment		(Reclassified to / (from))
7 Reason for adjustment		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
8 Reason for adjustment	Recovery offset for Medicare rules	5.00 (Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
12 Reason for adjustment	Payment to association "pool"	
13 Reason for adjustment	Payment of association fees	
14 Reason for adjustment	Nursing Home provider taxes	
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ 4,415,000	
DSH UCC Provider Tax Assessment Adjustment:		
17 Gross Allowable Assessment Not Included in the Cost Report	\$ 5,000,000	

Enter Gross provider tax (from G/L)

Enter Acct # & Type

Enter amount and CC on W/S A

Enter tax reclassifications, if any, on W/S A-6

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

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

Tax add-back to expense is estimated here but is subject to examination

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



■ 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 (discharge date basis) 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 #, **Account # (unique by visit)**, Birth Date, SSN, and Gender , Name, Admit, Discharge, Service Indicator, Revenue Code, Total Charges (by revenue code), Days (by revenue code), Patient Payments, Private Insurance, Claim Status fields, and **Medical Record #**.
 - 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).



Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Account # (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2013	6/15/2013
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2013	6/15/2013
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2013	8/10/2013

Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (by Revenue Code) (N)	Routine Days of Care (by Revenue Code) (O)	Total Patient Payments for Services Provided (P)	Total Private Insurance Payments for Services Provided (Q)	Claim Status (Exhausted or Non-Covered Service, if applicable) (R)	Medical Record Number (S)
3/11/2013	Inpatient	110	\$ 4,000.00	7				55555
3/11/2013	Inpatient	200	\$ 4,500.00	3				55555
3/11/2013	Inpatient	250	\$ 5,200.25					55555
3/11/2013	Inpatient	300	\$ 2,700.00					55555
3/11/2013	Inpatient	360	\$ 15,000.75					55555
3/11/2013	Inpatient	450	\$ 1,000.25					55555
6/15/2013	Outpatient	250	\$ 150.00		\$ 500.00		Exhausted	66666
6/15/2013	Outpatient	450	\$ 750.00		\$ 500.00		Exhausted	66666
8/10/2013	Outpatient	450	\$ 1,100.00				Non-Covered Service	77777

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 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 2013 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2013 cost report year.



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

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



Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Account # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Patient's Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	1/1/2013
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	2/1/2013
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	3/1/2013
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	4/1/2013
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	9/30/2013
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	10/31/2012
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	11/30/2012
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/15/2013
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/31/2013
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2012

Calculated Hospital Uninsured Collections If (T)="Uninsured" or (U)="Exhausted" or "Non-Covered Service", (Q)/((Q)+(R)+(S))
*(N), 0)

Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O)	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q)	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S)	Insurance Status When Services Were Provided (Insured or Uninsured) (T)	Claim Status (Exhausted or Non-Covered Service, if applicable) (U)	Medical Record Number (W)
\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		55555
\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		55555
\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		55555
\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		55555
\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	146 66666
\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	146 66666
\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	146 66666
\$ 90	No	Inpatient	\$ 15,000	\$ 1,000	\$ -	Uninsured		84 77777
\$ 90	No	Inpatient	\$ 15,000	\$ 1,000	\$ -	Uninsured		84 77777
\$ 130	No	Inpatient	\$ 14,000	\$ 400	\$ 50	Insured	Non-Covered Service	126 88888

Exhibit B – Cash Basis Patient Payments



■ EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

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



■ 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 Medicare Traditional/Medicaid cross-over data (Section H).
 - Self-reported “Other” Medicaid eligibles (Section H). This includes **Medicare MCO/Medicaid, private insurance/Medicaid**, and any other Medicaid eligible population not included elsewhere.
 - 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 #, Account # (unique by visit), Patient's MCD Recipient #, DOB, Social, Gender, Name, Admit, Discharge, Service Indicator, Rev Code, Total Charges, Days, Medicare Traditional, Medicare HMO, Medicaid, Medicaid MCO, Private Insurance Payments, Self-Pay Payments, Sum All Payments, and Medical Record #* fields.
 - A complete list (key) of payor plans is required to be submitted separately with the survey.
 - Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).



Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Account # (E)	Patient's Medicaid Recipient # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Patient's Name (J)	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2013	9/4/2013	Inpatient
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2013	9/4/2013	Inpatient
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2013	9/4/2013	Inpatient
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2013	9/4/2013	Inpatient
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2013	6/30/2013	Outpatient
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2013	6/30/2013	Outpatient
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2013	6/30/2013	Outpatient
Medicaid MCO	BCBS	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2013	2/28/2013	Outpatient
Medicaid MCO	BCBS	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2013	2/28/2013	Outpatient

Revenue Code (N)	Total Charges for Services Provided (by Revenue Code) (O)	Routine Days of Care (by Revenue Code) (P)	Total Medicare Traditional Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services Provided (T)	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)	Medical Record Number (X)	Tertiary Payor Plan (if applicable) (Y)	Fourth Payor Plan (if applicable) (Z)
120	\$ 1,200	3	\$ -	\$ -	\$ -	\$ 1,500	\$ 50	\$ -	1,550	55555		
206	\$ 1,500	1	\$ -	\$ -	\$ -	\$ 1,500	\$ 50	\$ -	1,550	55555		
250	\$ 100	-	\$ -	\$ -	\$ -	\$ 1,500	\$ 50	\$ -	1,550	55555		
300	\$ 375	-	\$ -	\$ -	\$ -	\$ 1,500	\$ 50	\$ -	1,550	55555		
450	\$ 1,500	-	\$ -	\$ -	\$ -	\$ 1,500	\$ 50	\$ -	1,550	55555		
250	\$ 100	-	\$ -	\$ -	\$ -	\$ 900	\$ -	\$ 75	975	66666		
300	\$ 375	-	\$ -	\$ -	\$ -	\$ 900	\$ -	\$ 75	975	66666		
450	\$ 1,500	-	\$ -	\$ -	\$ -	\$ 900	\$ -	\$ 75	975	66666		
300	\$ 375	-	\$ -	\$ -	\$ -	\$ 1,000	\$ 100	\$ -	1,100	77777		
450	\$ 1,500	-	\$ -	\$ -	\$ -	\$ 1,000	\$ 100	\$ -	1,100	77777		

Exhibit C – MEDICAID ELIGIBLE POPULATIONS (Example Medicaid Managed Care)



■ 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.



■ DSH SURVEY PART I – DSH YEAR DATA

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, Other Medicaid eligible, 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.



■ DSH SURVEY PART I – DSH YEAR DATA

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



■ DSH SURVEY PART I – DSH YEAR DATA

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.



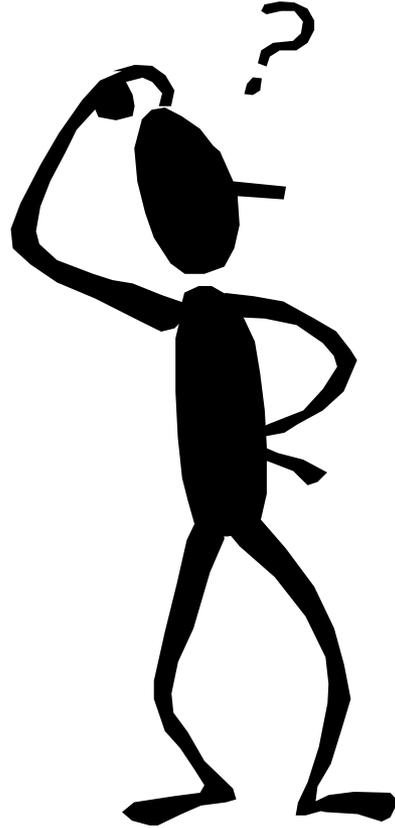
■ DSH SURVEY PART I – DSH YEAR DATA

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).



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DEDICATED TO GOVERNMENT HEALTH PROGRAMS



■ 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.



■ FAQ

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

Excluded prisoners were defined in the 2014 final DSH rule as:

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



■ FAQ

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

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



■ 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.



■ FAQ

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

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



■ FAQ

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

No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the 2014 final DSH rule. (*Reporting pg. 77911*)

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

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



■ FAQ

7. Can bad debts be considered uninsured?

Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the 2014 final DSH rule as an exhausted or insurance non-covered service (but those must be separately identified).



■ FAQ

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

- Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as uncompensated care for the uninsured. If these individuals are reported on the Medicaid eligibility rolls, they should be reported as uncompensated care for the Medicaid population. *(Reporting pg. 77929 and CMS Feb. 2010 FAQ #28 – Additional Information on the DSH Reporting and Audit Requirements)*
- Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare, they cannot be included in the DSH UCC.
- Under the 2014 final DSH rule, these patients may be included in the DSH UCC if Medicare is exhausted.



■ FAQ

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)*



■ FAQ

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

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

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

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



■ 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)*



■ 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)*



■ FAQ

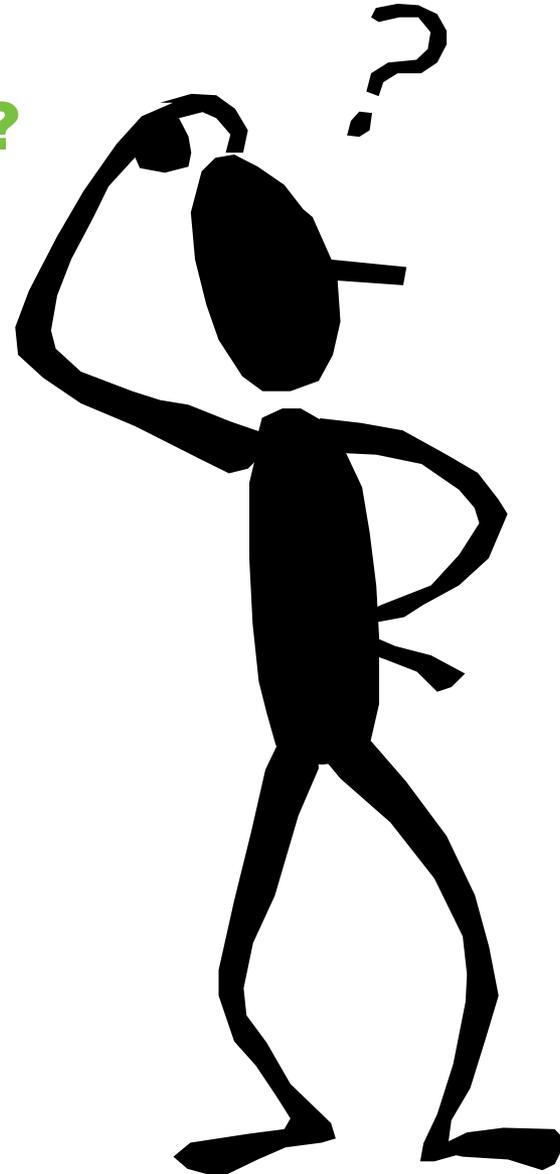
16. Do Other Medicaid Eligibles (Private Insurance/Medicaid) have to be included in the Medicaid UCC?

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



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■ **QUESTIONS/COMMENTS?**





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■ APPENDIX - WEBSITES

CMS DSH <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/dsh.html>

Final DSH Rule 12/03/2014 <https://www.gpo.gov/fdsys/pkg/FR-2014-12-03/pdf/2014-28424.pdf>

General DSH Audit and Reporting Protocol <https://downloads.cms.gov/cmsgov/archived-downloads/MedicaidGenInfo/downloads/cms2198frptprotocol.pdf>

CMS Additional Info on DSH Reporting & Audit Requirements <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/AdditionalInformationontheDSHReporting.pdf>

CMS Additional Info on DSH Reporting & Audit Requirements Part 2
<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/part-2-additional-info-on-dsh-reporting-and-auditing.pdf>