Disproportionate Share Hospital (DSH) Payment Audit Webinar

State Fiscal Year 2012

Logistics

- 2:00 to 4:00 p.m. central

- Online resources soon at www.tenncaretopics.com – “TN DSH Audit”

- Questions at end – submit online

2011 DSH Audit

- Targeted Completion: May 29, 2015
- Redistribution to follow

2015 DSH Payment

- Congressional approval for new DSH payment
- Projecting payment in June 2015

2012 Items of Note

- DSH Audit firm – Myers & Stauffer
- TennCare provides data to M&S to prepopulate your reporting forms
- Deadlines are critical
- Overpayments will be addressed

Additional Resources

www.tenncaretopics.com – “TN DSH Audit”

- Presentation
- Webinar recording
- FAQs
- Sample forms

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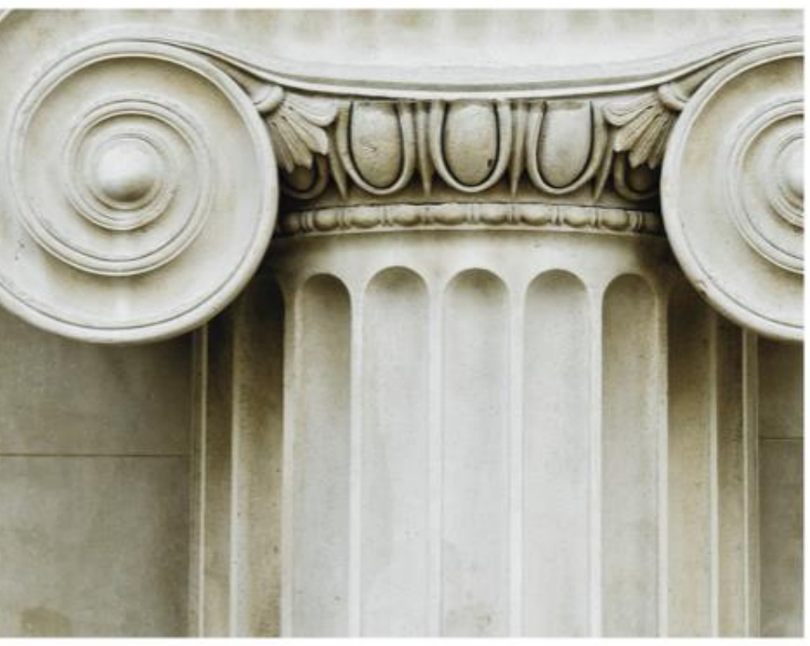
DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE

DSH YEAR 2012

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



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OVERVIEW

- Relevant DSH Examination Policy
- DSH Year 2012 Examination Timeline
- DSH Year 2012 Examination Impact
- Paid Claims Data Update for 2012
- Review of DSH Year 2012 Survey Forms
- 2012 Clarifications / Changes
- Recap of Prior Year (2011) Examination
- Examples Best Practices
- Myers and Stauffer DSH FAQ

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RELEVANT DSH POLICY

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

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RELEVANT DSH POLICY (CONT.)

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

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RELEVANT DSH POLICY (CONT.)

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

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DSH YEAR 2012 TENTATIVE EXAMINATION TIMELINE

- Primary contact confirmation by May 13th
- Surveys uploaded to SFTP May 20th
- Summary MCO data uploaded to SFTP June 19th
- Surveys returned to MSLC by June 30th
- July-Sept - desk reviews
- Sept-Nov - expanded reviews
- Draft report to the state by December 5, 2015
- Final report to CMS by December 31, 2015

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DSH YEAR 2012 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 2012 examination report is the second year that may result in DSH payment recoupments

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PAID CLAIMS DATA UPDATE FOR 2012

- Medicaid managed care paid claims data
  - Will be obtained from the state and summaries will be sent to the hospital primary secure FTP contact when available.
  - Hospital will map the summaries and enter into Survey Part II Section H.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Detailed data is available upon request once available.

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PAID CLAIMS DATA UPDATE FOR 2012

- 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).
  - Hospital is responsible for ensuring all payments are included in the final survey (Medicare, TPL, Co-pay, etc.)

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PAID CLAIMS DATA UPDATE FOR 2012

- 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).

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PAID CLAIMS DATA UPDATE FOR 2012

- "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 2012

- "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 2012 DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicare, third party liability (TPL), and self-pay payments in Exhibit C.

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PAID CLAIMS DATA UPDATE FOR 2012

- 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 regardless of the dates of service).

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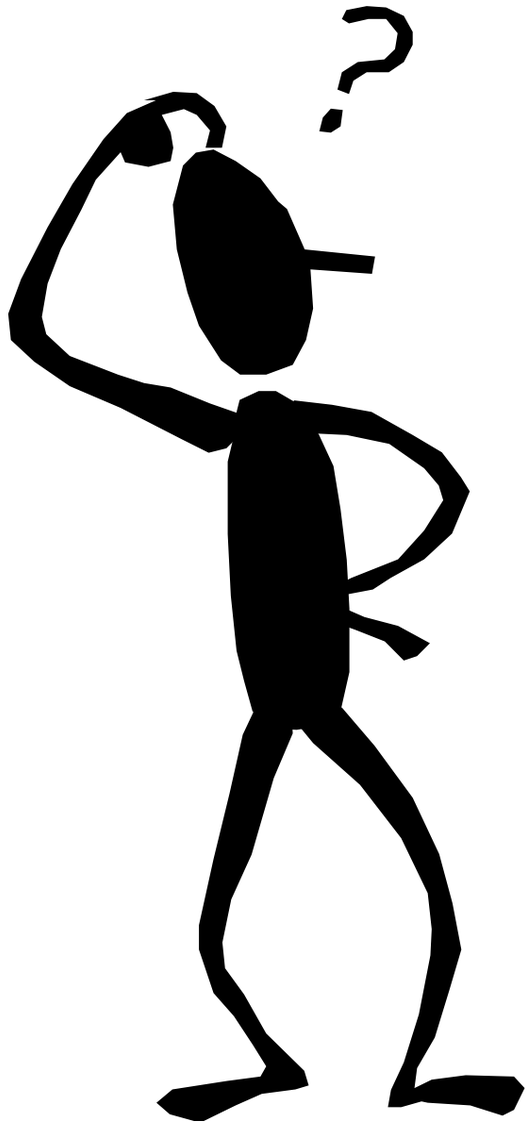

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

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

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- Don’t complete a DSH Part II survey for a cost report year already submitted in a previous DSH exam year.
  - Example: Hospital A provided a survey for their year ending 12/31/11 with the DSH audit of SFY 2011 in the prior year. In the DSH year 2012 exam, Hospital A would only need to submit a survey for their year ending 12/31/12.
- Both surveys have an Instructions tab that have 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 will pre-load certain sections of Part II of the survey using the Healthcare Cost Report Information System (HCRIS) data from CMS. However, the hospital is responsible for reviewing the data to ensure it is correct and reflects the best available cost report (audited if available).

- Hospitals that do not have a Medicare cost report on file with CMS will not see any data pre-loaded and will need to complete all lines as instructed.

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DSH SURVEY PART I – DSH YEAR DATA

Section A

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

Section B

- Answer all OB questions using drop-down boxes.

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DSH SURVEY PART I – DSH YEAR DATA

Section C

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

Certification

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

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State of
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2012

DSH Version 5.12 1/7/2015

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2011	06/30/2012

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

Select Hospital Name

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	01/01/2012	12/31/2012
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Only cost report years to be submtited will show here.
Need to prepare a separate Part II DSH Survey Excel file for each cost report year listed here.

	Data
6. Medicaid Provider Number:	111111
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	001111

6.-8. n/a for TN. See checklist item 18.

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 07/01/2011 - 06/30/2012:

	Answer
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	

Answer all OB questions.

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2011 - 06/30/2012** *(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)*	$ 500,000

Input all UPL and non-claim specific supplemental payments for the DSH year (excluding DSH)

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State of
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2012

Certification:

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

Must answer the retain DSH question

Explanation for "No" answers:

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.

Complete Certification and Contract Information

Hospital CEO or CFO Signature | Title | Date

Hospital CEO or CFO Printed Name | Hospital CEO or CFO Telephone Number | Hospital CEO or CFO E-Mail

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

Hospital Contact:

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	

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DSH YEAR SURVEY PART II
SECTION D – GENERAL INFORMATION

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

- **Question #2 – An "X" should be shown in the column of the cost report year survey you are preparing.**
  - If you have multiple years listed, you will need to prepare multiple surveys).
  - If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.

- **Question #3 – This question may be already answered based on pre-loaded HCRIS data. If your hospital is going to update the cost report data to a more recent version of the cost report, select the status of the cost report you are using with this drop-down box.**

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

DSH Version 7.10 1/13/2015

D. General Cost Report Year Information 1/1/2012 - 12/31/2012

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

1. Select Your Facility from the Drop-Down Menu Provided:	Hospital ABC		
	1/1/2012 through 12/31/2012		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	3 - Settled with Audit		
3a. Date CMS processed the HCRIS file into the HCRIS database:	12:00:00 AM		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	Hospital ABC	Yes	
5. Medicaid Provider Number:	111111	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	001111	Yes	

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

	State Name	Provider No.
9. State Name & Number	Kansas	0123
10. State Name & Number	Illinois	1244
11. State Name & Number	Iowa	1511
12. State Name & Number	Arkansas	1566
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

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

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

5.-7. n/a for TN

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DSH YEAR SURVEY PART II SECTION E, MISC. PAYMENT INFO.

- 1011 Payments - You must report your Section 1011 payments included in payments on Exhibit B (posted at the patient level), and payments received but not included in Exhibit B (not posted at the patient level), and separate the 1011 payments between hospital services and non-hospital services (non-hospital services include physician services).
- If your facility received DSH payments from another state (other than your home state) these payments must be reported on this section of the survey (calculate amount for the cost report period).
- Enter in total cash basis patient payment totals from Exhibit B as instructed. These are check totals to compare to the supporting Exhibit B.

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E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2012 - 12/31/2012)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ 10,000
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ 5,000
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ 2,500
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$17,500
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ 1,000
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$1,000
8. **Out-of-State DSH Payments (See Note 2)**	$ 50,000

1011 Payment (undocumented patients (Reconciliation

Out-of-state DSH payments

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 250,000	$ 1,000,000	$1,250,000
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 3,000,000	$ 9,000,000	$12,000,000
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$3,250,000	$10,000,000	$13,250,000
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	7.69%	10.00%	9.43%

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

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

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DSH YEAR SURVEY PART II SECTION F MIUR/LIUR

- The state must report your actual MIUR and LIUR for the DSH year - data is needed to calculate the MIUR/LIUR.
- Section F-1: Total hospital days from cost report. Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- Section F-2: If cash subsidies are specified for I/P or O/P services, record them as such, otherwise record entire amount as unspecified.
- Section F-2: Report charity care charges based on your own hospital financials or the definition used for your state DSH payment (support must be submitted).

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DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

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

- Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.

- Totals should agree with the cost report worksheets G-2 and G-3. If not, provide an explanation with the survey.

- Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If you have contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.

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DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

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

- Bad debt and charity care write-offs <u>not</u> 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 (01/01/2012 - 12/31/2012)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.xx less lines 5 & 6)	51,628

Days per cost report

(See Note in Section F-3, below)

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

2.	Inpatient Hospital Subsidies	
3.	Outpatient Hospital Subsidies	
4.	Unspecified I/P and O/P Hospital Subsidies	100,000
5.	Total Hospital Subsidies	$ 100,000
6.	Inpatient Charity Care Charges	450,000
7.	Outpatient Charity Care Charges	390,000
8.	Total Charity Care Charges	$ 840,000

State or Local Govt. Subsidies

Charity Care Charges (only used in LIUR NOT UCC)

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

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

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
9.	Hospital	$67,439,528.00			$ 46,480,429	$ -	$ -	$ 20,959,099
10.	Subprovider I (Psych or Rehab)	$1,892,975.00			$ 1,304,669	$ -	$ -	$ 588,306
11.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
12.	Swing Bed - SNF			$0.00			$ -	
13.	Swing Bed - NF			$0.00			$ -	
14.	Skilled Nursing Facility			$0.00			$ -	
15.	Nursing Facility			$0.00			$ -	
16.	Other Long-Term Care			$0.00			$ -	
17.	Ancillary Services	$279,649,863.00	$179,425,587.00		$ 192,739,271	$ 123,663,057	$ -	$ 142,673,122
18.	Outpatient Services		$1,149,822.00			$ 792,476	$ -	$ 357,346
19.	Home Health Agency			$2,780,004.00			$ 1,916,024	
20.	Ambulance			$0.00			$ -	
21.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
22.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
23.	Hospice			$2,157,554.00			$ 1,487,022	
24.	Other	$0.00	$1,944,955.00	$0.00	$ -	$ 1,340,495	$	$ 604,460
25.	Total	$ 348,982,366	$ 182,520,364	$ 4,937,558	$ 240,524,369	$ 125,796,028	$ 3,403,046	$ 165,182,333
26.	Total Hospital and Non Hospital		Total from Above	$ 536,440,288		Total from Above	$ 369,723,443	
27.	Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	536,440,288		Total Contractual Adj. (G-3 Line 2)	376,033,443	
28.	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	
29.	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	
30.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						+ 90,000	
31.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						+ 100,000	
32.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)						- 8,000,000	
34.	Adjusted Contractual Adjustments						369,723,443	
35.	Unreconciled Difference		Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -	

Reconciliation lines utilized to ensure that only true contractuals are included in the calculation

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

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DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

- Calculation of Routine Cost Per Diems
  - Days
  - Cost
- Calculation of Ancillary Cost-to-Charge Ratios
  - Charges
  - Cost

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G. Cost Report - Cost / Days / Charges

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

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	Total Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*			*Calculated Per Diem*
	Routine Cost Centers (list below):										
1	03000 ADULTS & PEDIATRICS	$ 200,000,000	$ 55,000,000	$ -	$0.00	$ 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			
19	Weighted Average										$ 1,091.13

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

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

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

Version 7.10

G. Cost Report - Cost / Days / Charges

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

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
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
Ancillary Cost Centers (from W/S C excluding Observation) (list below):											
21	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 CATHERIZATION 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.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
  - In-State Medicaid Managed Care Primary *(Medicaid MCO).*
  - In-State Medicare FFS Cross-Overs *(Traditional Medicare with Traditional Medicaid Secondary).*
  - In-State Other Medicaid Eligibles *(would include Medicare MCO/Medicaid secondary, private insurance/Medicaid secondary and other Medicaid not included elsewhere).*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

All Medicaid Categories

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

Disproporti

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

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

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Routine Cost Centers (from Section G):										
1	03000 ADULTS & PEDIATRICS	$ 1,024.49		Days 29,500		Days 11,000		Days 22,000		Days 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	
				Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			35,500,000		10,405,000		26,800,000		7,400,000	
21.01	Calculated Routine Charge Per Diem			$ 960.63		$ 673.68		$ 974.55		$ 961.04	

MYERS AND STAUFFER LC

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

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

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	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	092xx 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	6,530,000	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 CATHERIZATION 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	10,940,000	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.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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).

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

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

		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)	
	Totals / Payments								
128	**Total Charges** *(includes organ acquisition from Section J)*	$ 199,580,000	$ 96,950,000	$ 38,985,000	$ 31,770,000	$ 160,730,000	$ 65,170,000	$ 21,690,000	$ 15,885,000
129	Total Charges per PS&R or Other Paid Claims Summary	$ 199,580,000	$ 96,950,000	$ 38,985,000	$ 31,770,000	$ 160,730,000	$ 65,170,000	$ 21,690,000	$ 15,885,000
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 84,093,916	$ 25,680,092	$ 23,605,279	$ 10,315,990	$ 66,300,352	$ 17,125,793	$ 13,812,692	$ 5,157,995
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 46,300,000	$ 20,000,000	$ 15,500,000	$ 9,000,000	$ 2,100,000	$ 3,000,000	$ 350,000	$ 175,000
133	Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare on crossovers)	$ 16,000	$ 100,000	$ 600,000	$ 300,000	$ 15,000	$ 10,000	$ 9,000,000	$ 3,400,000
134	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 46,316,000	$ 20,100,000	$ 16,100,000	$ 9,300,000				
135	Medicaid Cost Settlement Payments (See Note B)								
136	Other Medicaid Payments Reported on Cost Report Year (See Note C)								
137	Medicare Paid Amount (excludes coinsurance/deductibles)					$ 60,000,000	$ 10,500,000	$ 3,000,000	$ 1,000,000
138	Medicare Cross-Over Bad Debt Payments					$ 2,000,000	$ 7,000		
139	Other Medicare Cross-Over Payments (See Note D)					$ 8,200,000	$ 1,200,000		
140	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)								
141	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)								
142	**Calculated Payment Shortfall / (Longfall)**	$ 37,777,916	$ 5,580,092	$ 7,505,279	$ 1,015,990	$ (6,014,648)	$ 2,408,793	$ 1,462,692	$ 582,995
143	**Calculated Payments as a Percentage of Cost**	55%	78%	68%	90%	109%	86%	89%	89%

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).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).

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

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II SECTION H, UNINSURED

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

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

Cost Report Year (01/01/2012-12/31/2012) | Hospital ABC

	Line #	Cost Center Description	Per Diem Cost for Routine Cost	to Charge Ratio for Ancillary Cost Centers	Uninsured: Inpatient (See Exhibit A)	Uninsured: Outpatient (See Exhibit A)
			From Section G	*From Section G*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Routine Cost Centers (from Section G):				**Days**	
1	03000	ADULTS & PEDIATRICS	$ 1,024.49		1,000	
2	03100	INTENSIVE CARE UNIT	$ 2,259.90		80	
3	03200	CORONARY CARE UNIT	$ 1,506.60		60	
4	03300	BURN INTENSIVE CARE UNIT	$ -			
5	03400	SURGICAL INTENSIVE CARE UNIT	$ 1,757.70		120	
6	03500	OTHER SPECIAL CARE UNIT	$ -			
7	04000	SUBPROVIDER I	$ 1,278.33		400	
8	04100	SUBPROVIDER II	$ -			
9	04200	OTHER SUBPROVIDER	$ -			
10	04300	NURSERY	$ 341.50		60	
11			$ -			
12			$ -			
13			$ -			
14			$ -			
15			$ -			
16			$ -			
17			$ -			
18				**Total Days**	1,720	
19		Total Days per PS&R or Other Paid Claims Summary				
20		Unreconciled Days (Explain Variance)				
21		Routine Charges			**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 (01/01/2012-12/31/2012) | Hospital ABC

	Line #	Cost Center Description	Per Diem Cost for Routine Cost	to Charge Ratio for Ancillary Cost Centers	Uninsured: Inpatient (See Exhibit A)	Uninsured: Outpatient (See Exhibit A)
	Ancillary Cost Centers (from W/S C) (from Section G):				**Gross Charges**	**Gross Charges**
22	092xx	Observation (Non-Distinct)		1.424070		80,000
23	5000	OPERATING ROOM		0.393873	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	960,000
27	5400	RADIOLOGY-DIAGNOSTIC		0.172881	2,000,000	4,000,000
28	5500	RADIOLOGY-THERAPEUTIC		0.256410	140,000	1,330,000
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	970,000
32	6500	RESPIRATORY THERAPY		0.269841	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	6900	ELECTROCARDIOLOGY		0.098901	580,000	550,000
37	7000	ELECTROENCEPHALOGRAPHY		0.280000	110,000	40,000
38	7100	MEDICAL SUPPLIES CHARGED TO PAT		0.395918	3,000,000	2,000,000
39	7200	IMPL.DEV CHARGED TO PATIENTS		0.521739		
40	7300	DRUGS CHARGED TO PATIENTS		0.333333	1,800,000	1,300,000
41	7400	RENAL DIALYSIS		0.232829	90,000	2,900,000
42	7600	CAT SCAN		0.052632	3,000,000	720,000
43	7602	ULTRASOUND		0.169444	290,000	290,000
44	7603	CARDIAC CATHERIZATION LABORATORY		0.216667	1,150,000	710,000
45	7604	ULTRASOUND		0.271429	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 organ acquisition from Section J)*			$ 31,660,000 [Agrees to Exhibit A]	$ 35,240,000 [Agrees to Exhibit A]
129		Total Charges per PS&R or Other Paid Claims Summary				
130		Unreconciled Charges (Explain Variance)				
131		**Total Calculated Cost (includes organ acquisition from Section J)**			$ 9,722,370	$ 10,478,433
132		Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				
133		Other Total Third Party Liability (excluding Co-Pay and Spend-Down but excluding Medicare or equivalent)				
134		Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)				
135		Medicaid Cost Settlement Payments (See Note B)				
136		Other Medicaid Payments Reported on Cost Report Year (See Note C)				
137		Medicare Paid Amount (excludes coinsurance/deductibles)				
138		Medicare Cross-Over Bad Debt Payments			[Agrees to Exhibit B and B-1]	[Agrees to Exhibit B and B-1]
139		Other Medicare Cross-Over Payments (See Note D)				
140		Payment from Hospital Uninsured During Cost Report Year (Cash Basis)			$ 250,000	$ 1,000,000
141		Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1			$ 5,000	$ 2,500
142		**Calculated Payment Shortfall / (Longfall)**			$ 9,467,370	$ 9,475,933
143		**Calculated Payments as a Percentage of Cost**			3%	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.

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DSH SURVEY PART II
SECTION I, OUT OF STATE MEDICAID

- Report Out-of-State Medicaid days, ancillary charges and payments.
- Report in the same format as Section H. Days, charges and payments received must agree to the other state's PS&R (or similar) claim payment summary. If no summary is available, submit Exhibit C (hospital data) as support.
- If your hospital provided services to several other states, please consolidate your data and provide support for your survey responses.

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DSH SURVEY PART II – SECTIONS J & K, ORGAN ACQUISITION

- Total organ acquisition cost and total useable organs will be pre-loaded from HCRIS data. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured.
- Summary claims data (PS&R) or similar documents and provider records (organ counts) must be provided to support the charges and useable organ counts reported on the survey. The data for uninsured organ acquisitions should be reported separately from the Exhibit A.

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DSH SURVEY PART II - SECTIONS J & K, ORGAN ACQUISITION

- All organ acquisition charges should be reported in Sections J & K of the survey and should be EXCLUDED from Section H & I of the survey. (days should also be excluded from H & I)
- Medicaid and uninsured charges/days included in the cost report D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey.

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

Cost Report Year (01/01/2012-12/31/2012) | Hospital ABC

In-State organ acquisitions

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

			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 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):																
1		Lung Acquisition	$0.00	$ -	$ -		0										
2		Kidney Acquisition	$0.00	$ -	$ -		0										
3		Liver Acquisition	$0.00	$ -	$ -		0										
4		Heart Acquisition	$0.00	$ -	$ -		0										
5		Pancreas Acquisition	$0.00	$ -	$ -		0										
6		Intestinal Acquisition	$0.00	$ -	$ -		0										
7		Islet Acquisition	$0.00	$ -	$ -		0										
8				$ -	$ -												
9		Totals	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10		Total Cost							-		-		-		-		

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (01/01/2012-12/31/2012) | 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 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):														
11		Lung Acquisition	$ -	$ -	$ -	$ -	0								
12		Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13		Liver Acquisition	$ -	$ -	$ -	$ -	0								
14		Heart Acquisition	$ -	$ -	$ -	$ -	0								
15		Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16		Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17		Islet Acquisition	$ -	$ -	$ -	$ -	0								
18			$ -	$ -	$ -	$ -	0								
19		Totals	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20		Total Cost							-		-		-		-

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

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

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

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

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

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

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

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

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

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

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

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

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

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

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

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

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

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

MYERS AND STAUFFER LC

L. Provider Tax Assessment Reconciliation / Adjustment

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

Enter 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

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

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*	$ 10,000,000		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*	Expense	520012354	*(WTB 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	*Reclassification Code*			*(Reclassified to / (from))*
5	*Reclassification Code*			*(Reclassified to / (from))*
6	*Reclassification Code*			*(Reclassified to / (from))*
7	*Reclassification Code*			*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)			
8	*Reason for adjustment*	Recovery offset for Medicare rules	$ (5,000,000)	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"	$ (50,000)	
13	*Reason for adjustment*	Payment of association fees	$ (35,000)	
14	*Reason for adjustment*	Nursing Home provider taxes	$ (500,000)	
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

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

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EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

- Survey form Exhibit A has been designed to assist hospitals in collecting and reporting all uninsured charges and routine days needed to cost out the uninsured services.
- Total hospital charges / routine days from Exhibit A must agree to the total entered in Section H of the survey.
- Must be for 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, 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, TPL, Claim Status fields, and **Medical Record #.**
  - A complete list (key) of payor plans is required to be submitted separately with the survey.

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EXHIBIT A - UNINSURED

- Claim Status (Column R) is the same as the prior year – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the December 3, 2014 final DSH rule.
  - If exhausted / non-covered insurance services are included on Exhibit A, then they must also be included on Exhibit B for patient payments.
- Submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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EXHIBIT A - UNINSURED

- If Exhibit A data was pulled based on information that is not part of the requested format this information should be included in the next available column to the right of the standard format.
- For example if listing was pulled based on a financial status rather than Primary and Secondary Payer this information should be included in the next available column to the right of the standard format and appropriate key be provided. Also, the basis should be identified in the Logic submitted for the Exhibit.

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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)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (by Revenue	Routine Days of Care (by Revenue Code) (O)	Total Patient Payments for Services Provided (P)	Total Third Party Payments for Services Provided (Q)	Claim Status (Exhausted or Non-Covered Service, if applicable) (R)	Medical Record Number (S)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7				55555
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3				55555
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25					55555
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00					55555
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75					55555
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25					55555
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00		Exhausted	66666
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00		Exhausted	66666
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010	Outpatient	450	$ 1,100.00				Non-Covered Service	77777

Exhibit A – Uninsured Charges/Days

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

- Survey form Exhibit B has been designed to assist hospitals in collecting and reporting all patient payments received on a cash basis.
- Exhibit B should include all patient payments regardless of their insurance status.
- Total patient payments from this exhibit are entered in Section E of the survey.
- Insurance status should be noted on each patient payment so you can sub-total the uninsured hospital patient payments and enter them in Section H of the survey.

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

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

- For example, a cash payment received during the 2012 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2012 cost report year.

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

- Exhibit B
  - Include *Primary Payor Plan*, *Secondary Payor Plan*, *Payment Transaction Code, Provider #, 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).

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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)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O)	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q)	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S)	Insurance Status When Services Were Provided (Insured or Uninsured) (T)	Claim Status (Exhausted or Non-Covered Service, if applicable) (U)	Hospital Uninsured Collections If (T)="Uninsured" or (U)="Exhausted" or "Non-Covered Service", (Q)/((Q)+(R)+(S))*(N), 0)	Medical Record Number (W)
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	333-33-333	Male	Jones, Anthony	7/12/1935	7/14/1935	1/1/2010	$ 50	No	Inpatient	$ 10,000	$ 300	$ -	Insured		$ -	55555
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	333-33-333	Male	Jones, Anthony	7/12/1935	7/14/1935	2/1/2010	$ 50	No	Inpatient	$ 10,000	$ 300	$ -	Insured		$ -	55555
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	333-33-333	Male	Jones, Anthony	7/12/1935	7/14/1935	3/1/2010	$ 50	No	Inpatient	$ 10,000	$ 300	$ -	Insured		$ -	55555
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	333-33-333	Male	Jones, Anthony	7/12/1935	7/14/1935	4/1/2010	$ 50	No	Inpatient	$ 10,000	$ 300	$ -	Insured		$ -	55555
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	333-33-333	Male	Smith, John	9/21/2000	9/21/2000	9/30/2010	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146	66666
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	333-33-333	Male	Smith, John	9/21/2000	9/21/2000	10/31/2010	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146	66666
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	333-33-333	Male	Smith, John	9/21/2000	9/21/2000	11/30/2010	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146	66666
Self Pay Payments	Self-Pay		500	12345	7777777	7/3/2000	333-33-333	Male	Cliff, Heath	12/31/2009	1/1/2010	5/15/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84	77777
Self Pay Payments	Self-Pay		500	12345	7777777	7/3/2000	333-33-333	Male	Cliff, Heath	12/31/2009	1/1/2010	5/31/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84	77777
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	333-33-333	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2010	$ 130	No	Inpatient	$ 14,000	$ 400	$ 50	Insured	Non-Covered Service	$ 126	88888

Exhibit B – Cash Basis Patient Payments

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

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

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that may require an Exhibit C are as follows:
  - Self-reported Medicaid/Medicare 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).

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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 Payments, Medicaid Payments, TPL 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).

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - If Exhibit C data was pulled based on information that is not part of the requested format this information should be included in the next available column to the right of the standard format.
  - For example if listing was pulled based on a Tertiary or Quaternary payer in addition to the Primary and Secondary Payer this information should be included in the next available column to the right of the standard format. Also, the basis should be identified in the Logic submitted for the Exhibit.

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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)	Name (J)	Admit Date (K)	Discharg e Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Charges for Services Provided (by Revenue Code) (O)	Routine Days of Care (by Revenue Code) (P)	Total Medicare Payments for Services Provided (Q)	Total Medicaid Payments for Services Provided (R)	Party Liability Payments for Services Provided (S)	Self-Pay Payments (T)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)	Medical Record Number (V)
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	120	$ 1,200	3	$ -	$ 1,500	$ 50	$ -	$ 1,550	55555
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	206	$ 1,500	1	$ -	$ 1,500	$ 50	$ -	$ 1,550	55555
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	250	$ 100	-	$ -	$ 1,500	$ 50	$ -	$ 1,550	55555
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	300	$ 375	-	$ -	$ 1,500	$ 50	$ -	$ 1,550	55555
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	450	$ 1,500	-	$ -	$ 1,500	$ 50	$ -	$ 1,550	55555
Medicaid MCO	Family Health Partners		12345	666666	378654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	250	$ 100	-	$ -	$ 300	$ -	$ 75	$ 375	66666
Medicaid MCO	Family Health Partners		12345	666666	378654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	300	$ 375	-	$ -	$ 300	$ -	$ 75	$ 375	66666
Medicaid MCO	Family Health Partners		12345	666666	378654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	450	$ 1,500	-	$ -	$ 300	$ -	$ 75	$ 375	66666
Medicaid MCO	BCBS Blue Advantage	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	300	$ 375	-	$ -	$ 1,000	$ 100	$ -	$ 1,100	77777
Medicaid MCO	BCBS Blue Advantage	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	450	$ 1,500	-	$ -	$ 1,000	$ 100	$ -	$ 1,100	77777

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

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DSH SURVEY PART I – DSH YEAR DATA

Checklist

- Separate tab in Part I of the survey.
- Should be completed after Part I and Part II surveys are prepared.
- Includes list of all supporting documentation that needs to be submitted with the survey for audit.
- Includes Myers and Stauffer address and phone numbers.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist

1. Electronic copy of the DSH Survey Part I – DSH Year Data.

2. Electronic copy of the DSH Survey Part II – Cost Report Year Data.

3. 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.

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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.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

7. Electronic copy of Exhibit C for hospital-generated data (includes Medicare cross-over, 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.

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

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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

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

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

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

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

16. 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).

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

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

19. A listing of all NPI numbers and Tax IDs associated with each cost reporting year.

20. Each item on the checklist includes a drop down box. All items must be completed with an “x” or N/A. Blanks are not acceptable.

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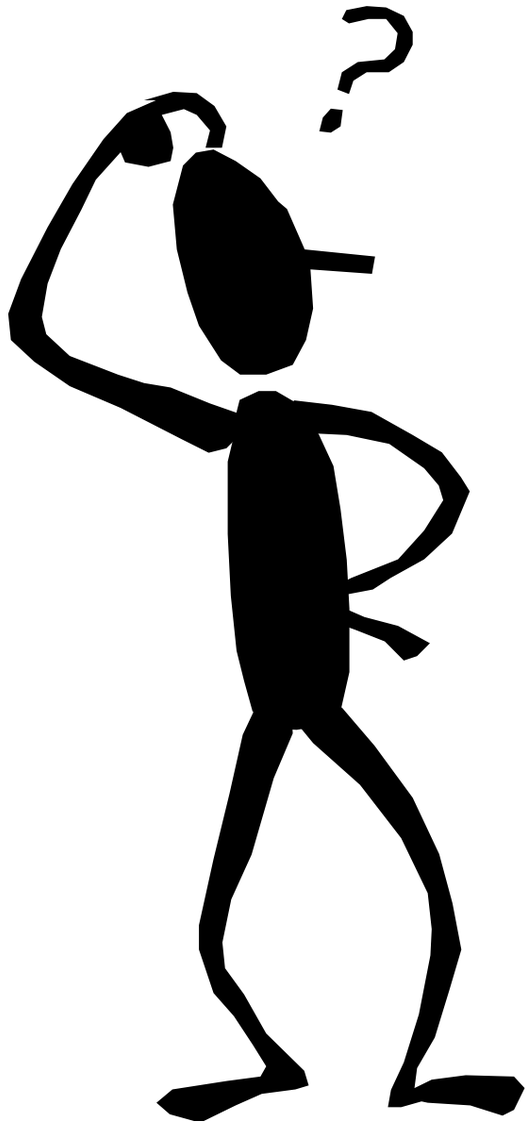

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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2012 CLARIFICATIONS / CHANGES

- *December 3, 2014 Final Rule*
  - Definitions of uninsured as laid out in the January 2012 proposed rule have been finalized.
  - Myers and Stauffer has been utilizing the definitions of uninsured as stated in the January 2012 proposed rule since the 2010 DSH examination in Tennessee.
  - Now that the proposed rule has been finalized, Myers and Stauffer will continue to utilize those definitions as they have been since the 2010 DSH examinations.
  - Under the final rule, the DSH examination will look at whether a patient is uninsured using a “service-specific” approach as opposed to the creditable coverage approach.

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2012 CLARIFICATIONS / CHANGES (C0NT.)

- 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)
- 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 consider 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.

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2012 CLARIFICATIONS / CHANGES (CONT.)

- 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 institutions or are otherwise involuntarily in secure custody as a result of criminal charges)
- For further details and examples of the definition of uninsured based on the December 3, 2014 Final Rule, see the “Uninsured Definitions” tab of DSH Survey Part II.

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2012 CLARIFICATIONS / CHANGES (CONT.)

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

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

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

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

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2012 CLARIFICATIONS / CHANGES (CONT.)

- This does **not** change how Myers and Stauffer or any other independent CPA firm must calculate a hospital's uncompensated care cost for the 2012 DSH examinations at this time.

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

- However, we do recommend that you submit your Other Medicaid Eligibles exactly as requested in Exhibit C. Specifically, ensure that you **separately identify** each claims Medicaid, Medicare, Third Party Liability (TPL), and Self-Pay payments into their individual columns as laid out in the Exhibit A-C template.

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RECAP OF PRIOR YEAR EXAMINATION

- Common Issues Noted During Examination
  - Hospitals didn't report their charity care in the LIUR section of the survey or didn't include a break-down of inpatient and outpatient charity.
  - Medicare cross-over payments didn't include all Medicare payments (outlier, cost report settlements, lump-sum/pass-through, payments received after year end, etc.).
  - Exhibit B – Patient payments didn't always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.
  - Exhibit B – Patient payments were submitted on accrual basis rather than cash basis.

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RECAP OF PRIOR YEAR EXAMINATION, (CONT.)

- Hospitals had duplicate claims in the uninsured and state's Medicaid MCO data.
- Hospitals had duplicate patient claims between submitted data sets.
- Hospitals failed to submit Exhibit logic and payor plan listings.
- Checklist was not completed and submitted.
- Exhibit C payments were not reported by payor category. Payments were submitted in total.
- Other Medicaid eligible patients submitted in Medicare primary/Medicaid secondary Exhibit C.
- In lieu of summary out-of-state PS&R, large .pdf document including all EOBs for out-of-state patients submitted. We are unable to accumulate data from EOBs. Submission of data in this format will not be accepted.

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EXAMPLES BEST PRACTICES - REVENUE CODE CROSSWALK

- Revenue Codes should be mapped to Cost Centers on your cost report. There are two different options for crosswalks.

Example A			Example B		
Revenue Code	**Cost Center**		**Revenue Code**	**Cost Center**	**Percentage**
110	30		**110**	30	100.00%
120	30		**120**	30	88.84%
250	73		**120**	43	11.16%
258	71		**250**	73	100.00%
270	71		**258**	71	100.00%
272	71		**270**	71	100.00%
278	72		**272**	71	100.00%
301	60		**278**	72	100.00%
305	60		**301**	60	100.00%
360	50		**305**	60	100.00%
370	53		**360**	50	100.00%
403	76.03		**370**	53	100.00%
636	73		**403**	76.03	100.00%
637	73		**636**	73	100.00%
710	51		**637**	73	100.00%
730	69		**710**	51	100.00%
750	76		**730**	69	100.00%
801	76.02		**750**	76	68.85%
			750	76.01	31.15%
			801	76.02	100.00%

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REVENUE CODE CROSSWALK EXAMPLE B

Easy steps to building a crosswalk based on Exhibit

Note additional data has been added in columns to the right of the standard format.

Claim Type (A) **	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Account #	Medicaid Recipient # (F)	Patient's Birth Date (G)	Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Charges for Services Provided (O)	e Days of Care	Payments for Services Provided (Q)	Payments for Services Provided (R)	Liability Payments for Services Provided (S)	Self-Pay Payments (T)	Payments Received on Claim (Q)+(R)+(S)+(T)	Medical Record Number	dept	cc
Crossover	Medicare	Medicaid	444444444	24564978	537752311A	9/21/2010	555555555	F	Jovie Cassidy	02/22/12	02/22/12	O	272	546	0	675	0	0	0	675	685C9875D	6689	71
Crossover	Medicare	Medicaid	444444444	24564978	537752311A	9/21/2010	555555555	F	Jovie Cassidy	02/22/12	02/22/12	O	250	415	0	0	0	0	0	0	685C9875D	3356	73
Crossover	Medicare	Medicaid	444444444	24564978	537752311A	9/21/2010	555555555	F	Jovie Cassidy	02/22/12	02/22/12	O	750	3568	0	0	0	0	0	0	685C9875D	5549	76
Crossover	Medicare	Medicaid	444444444	68954635	689756238A	4/16/1966	111111111	M	Sarah James	01/08/12	01/08/12	O	270	15	0	1856	0	0	0	1856	74598643C	6689	71
Crossover	Medicare	Medicaid	444444444	68954635	689756238A	4/16/1966	111111111	M	Sarah James	01/08/12	01/08/12	O	272	354	0	0	0	0	0	0	74598643C	6689	71
Crossover	Medicare	Medicaid	444444444	68954635	689756238A	4/16/1966	111111111	M	Sarah James	01/08/12	01/08/12	O	250	60	0	0	0	0	0	0	74598643C	3356	73
Crossover	Medicare	Medicaid	444444444	68954635	689756238A	4/16/1966	111111111	M	Sarah James	01/08/12	01/08/12	O	750	5864	0	0	0	0	0	0	74598643C	5549	76
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	110	1600	2	15264	0	0	0	15264	856475HJ5	8945	30
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	360	6584	0	0	0	0	0	0	856475HJ5	8659	50
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	710	1234.5	0	0	0	0	0	0	856475HJ5	2185	51
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	370	1896	0	0	0	0	0	0	856475HJ5	4586	53
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	301	357	0	0	0	0	0	0	856475HJ5	5621	60
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	305	684	0	0	0	0	0	0	856475HJ5	5621	60
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	730	300	0	0	0	0	0	0	856475HJ5	1295	69
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	258	524	0	0	0	0	0	0	856475HJ5	2845	71
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	270	268	0	0	0	0	0	0	856475HJ5	6689	71
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	272	1340	0	0	0	0	0	0	856475HJ5	6689	71
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	278	1356	0	0	0	0	0	0	856475HJ5	7458	72
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	250	2008	0	0	0	0	0	0	856475HJ5	3356	73
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	636	485	0	0	0	0	0	0	856475HJ5	3356	73
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	637	45	0	0	0	0	0	0	856475HJ5	3356	73
Crossover	Medicare	Medicaid	444444444	75648256	710962713A	6/17/1955	222222222	M	Anne Elizabeth Harris	01/28/12	01/30/12	I	801	1486.5	0	0	0	0	0	0	856475HJ5	7521	76.02
Crossover	Medicare	Medicaid	444444444	89561123	409330737A	1/11/1922	333333333	F	Dan Smith	01/12/12	01/12/12	O	403	652	0	84	0	0	0	84	956745TFD	6935	76.03
Crossover	Medicare	Medicaid	444444444	92311144	415722885A	4/21/1979	444444444	M	Michael McCallister	01/22/12	01/22/12	O	258	178	0	564	0	0	0	564	54123RS12	2845	71
Crossover	Medicare	Medicaid	444444444	92311144	415722885A	4/21/1979	444444444	M	Michael McCallister	01/22/12	01/22/12	O	272	234	0	0	0	0	0	0	54123RS12	6689	71
Crossover	Medicare	Medicaid	444444444	92311144	415722885A	4/21/1979	444444444	M	Michael McCallister	01/22/12	01/22/12	O	250	201	0	0	0	0	0	0	54123RS12	3356	73
Crossover	Medicare	Medicaid	444444444	92311144	415722885A	4/21/1979	444444444	M	Michael McCallister	01/22/12	01/22/12	O	750	4268	0	0	0	0	0	0	54123RS12	5549	76.01

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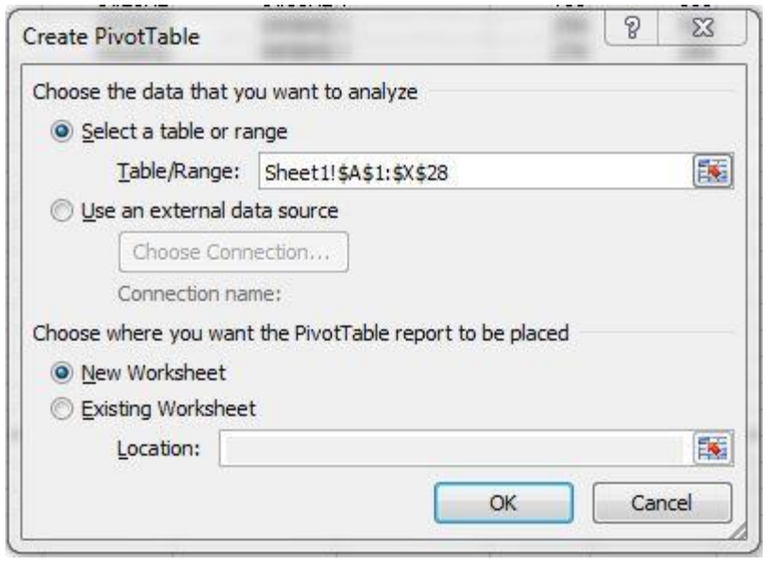
REVENUE CODE CROSSWALK EXAMPLE B

- Select all of the data in the Exhibit and insert a pivot table based on the data.



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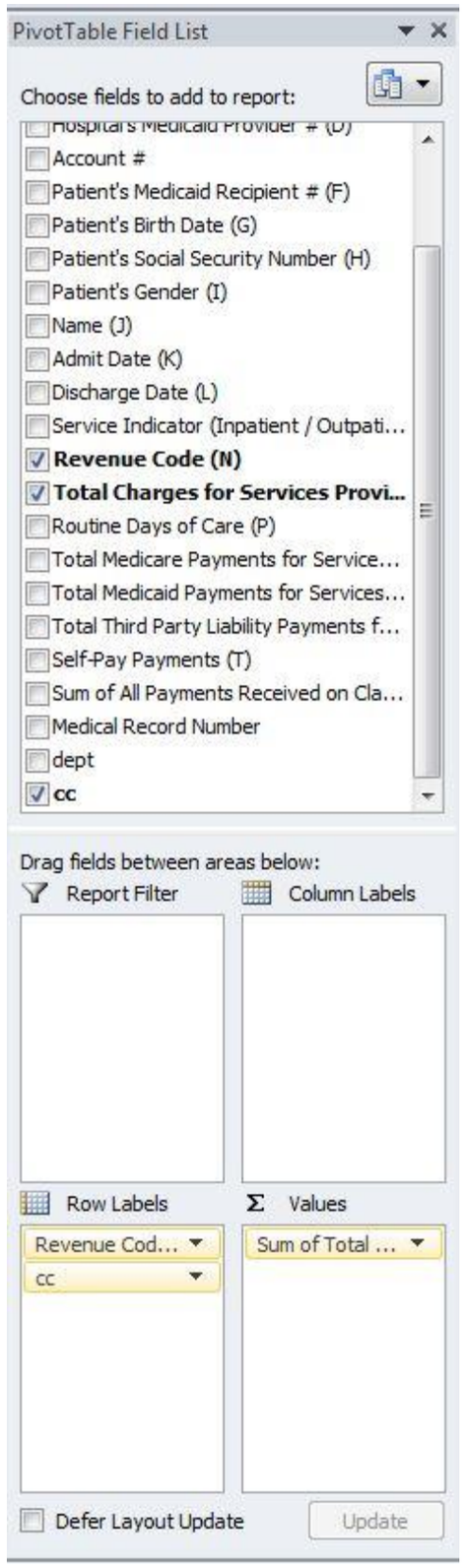
REVENUE CODE CROSSWALK EXAMPLE B

- Select Row Labels
  - Revenue Code
  - Cost Center
- ∑ Values
  - Total Charges for Services Provided by Revenue Code



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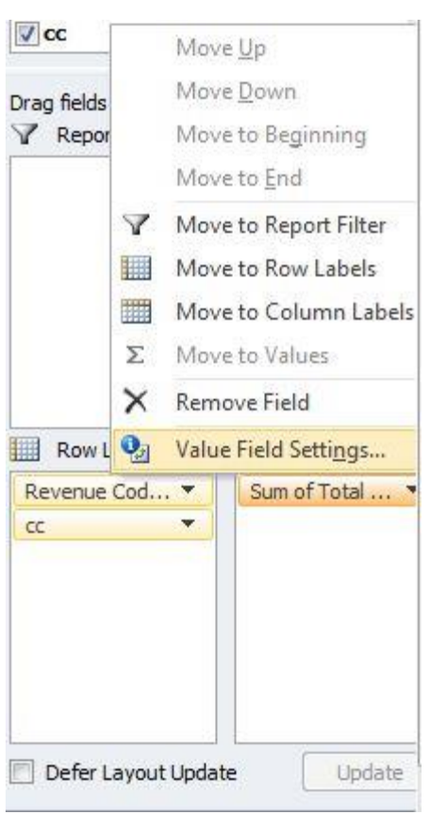
REVENUE CODE CROSSWALK EXAMPLE B

- ∑ Values
  - Total Charges for Services Provided by Revenue Code

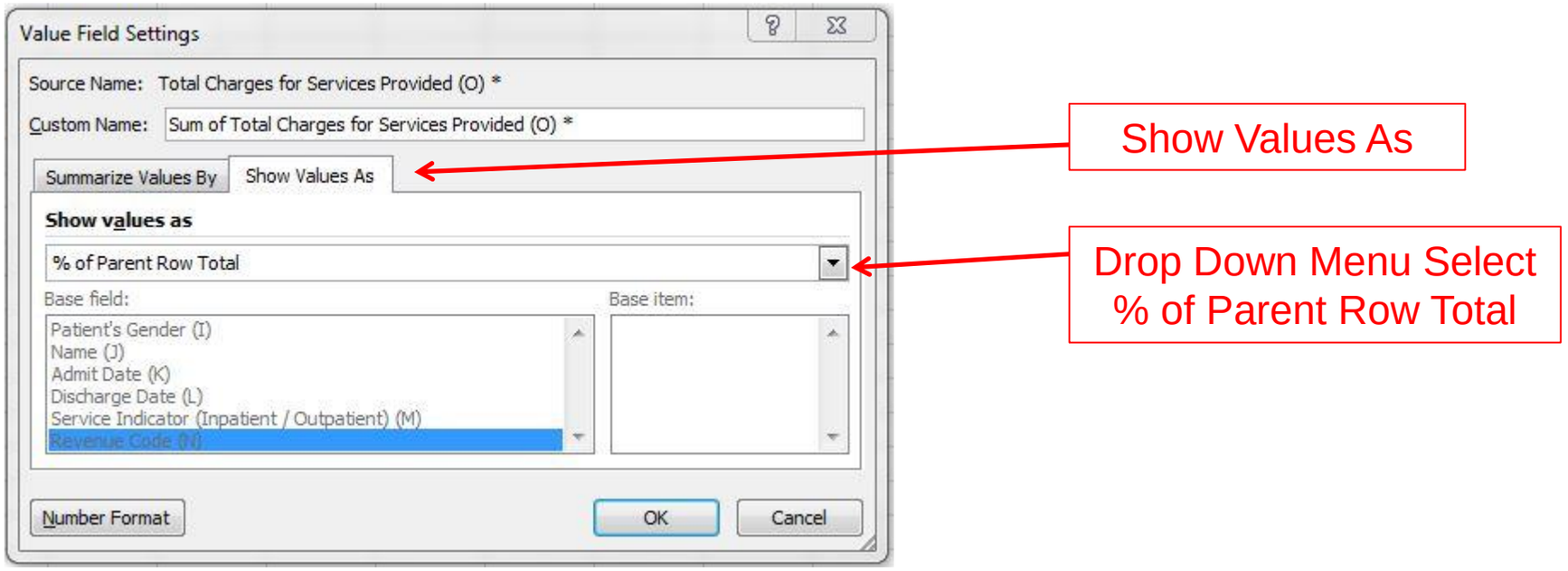
Needs to be formatted

Left click on Field and Select Value Field Settings



REVENUE CODE CROSSWALK EXAMPLE B

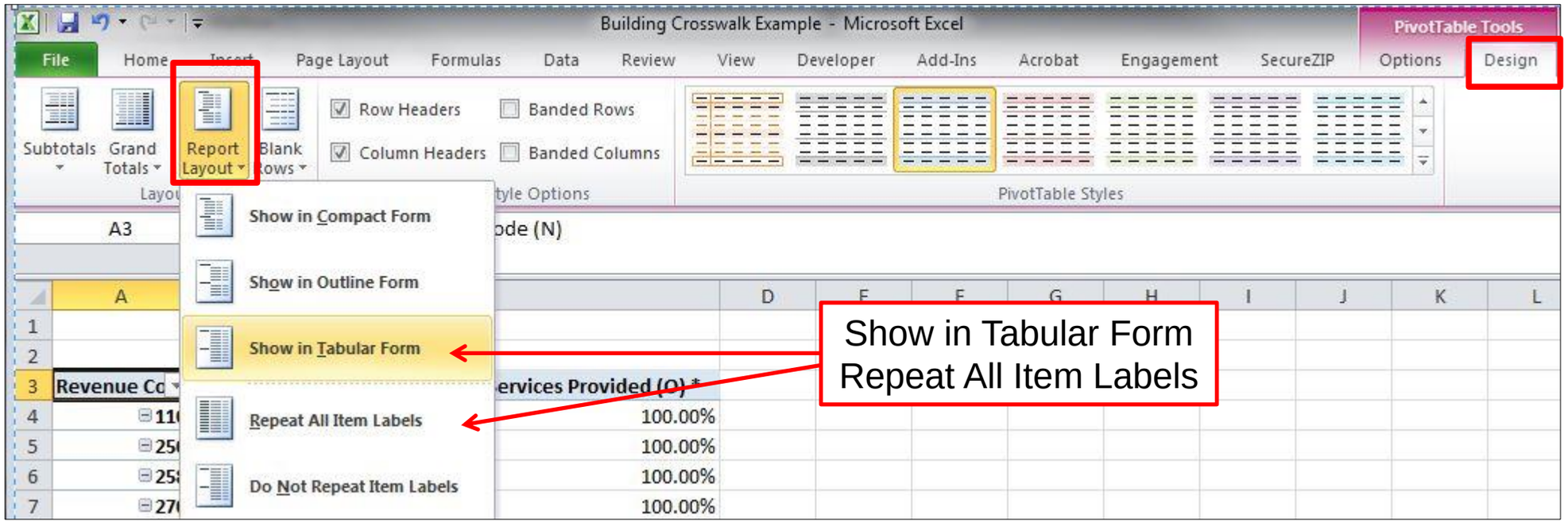
- From the Dialogue Box select the Show Values As Tab and Choose % of Parent Row Total from the Drop Down Menu



Once these selections have been made Excel will calculate percentages

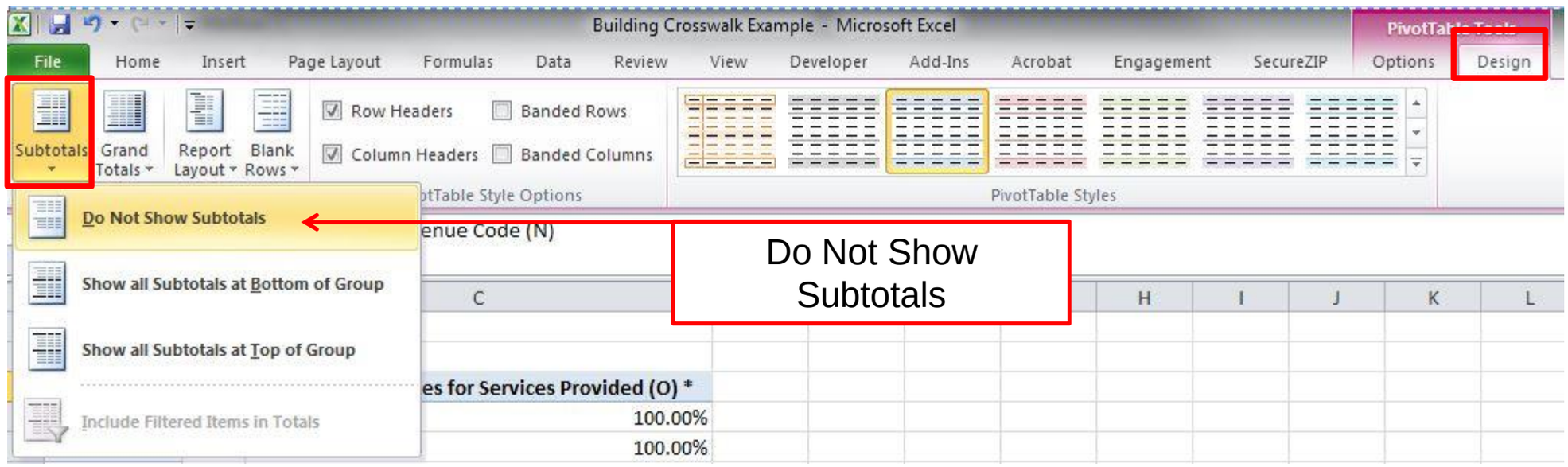
REVENUE CODE CROSSWALK EXAMPLE B

- The next steps will format the pivot table into a usable format.
- On the Design Tab, Select the Report Layout button
- Choose the Show in Tabular Form and Repeat All Item Labels



REVENUE CODE CROSSWALK EXAMPLE B

- The next steps will format the pivot table into a usable format.
- On the Design Tab, Select the Subtotals button
- Choose Do Not Show Subtotals



REVENUE CODE CROSSWALK EXAMPLE B

- The following is the resulting pivot table
- The table has calculated the percentages for each revenue code

Revenue Cc	cc	Sum of Total Charges for Services Provided (O) *
110	30	100.00%
250	73	100.00%
258	71	100.00%
270	71	100.00%
272	71	100.00%
278	72	100.00%
301	60	100.00%
305	60	100.00%
360	50	100.00%
370	53	100.00%
403	76.03	100.00%
636	73	100.00%
637	73	100.00%
710	51	100.00%
730	69	100.00%
750	76	68.85%
750	76.01	31.15%
801	76.02	100.00%

Calculated based on Charges

EXAMPLE BEST PRACTICES – LOGIC

The following are a few reasons why MSLC requests logic

- It can be a useful tool in analyzing data for MSLC and the hospital
- It can be a good starting point for future reviews.
- If there is a change in staff at a hospital or new ownership, it could be a useful tool during this transition.

The following is an unacceptable example of Logic used for an Exhibit.

~~Exhibit A – Data was pulled based on MSLC instructions~~

Please note this is not a good example of Logic as it is not useful to MSLC or to the hospital.

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EXAMPLE BEST PRACTICES – LOGIC

The following is an acceptable example of Logic used for an Exhibit

> Exhibit A – A detailed internal report was created by financial class for claims with discharges between 7/1/2011 and 6/30/2012. Using financial classes 99 (Self Pay) and 86 (Medicaid Pending), a column has been added to the exhibit for financial classes. Resulting listing was reviewed to ensure insurance status had not changed and internal testing was performed.

This logic includes a few key elements. It informs MSLC that the listing was not selected based on the Primary and Secondary Payer but rather on the financial class as well as the date parameters.

MSLC would also accept the SQL used. Though MSLC would prefer a little narrative in addition to the SQL.

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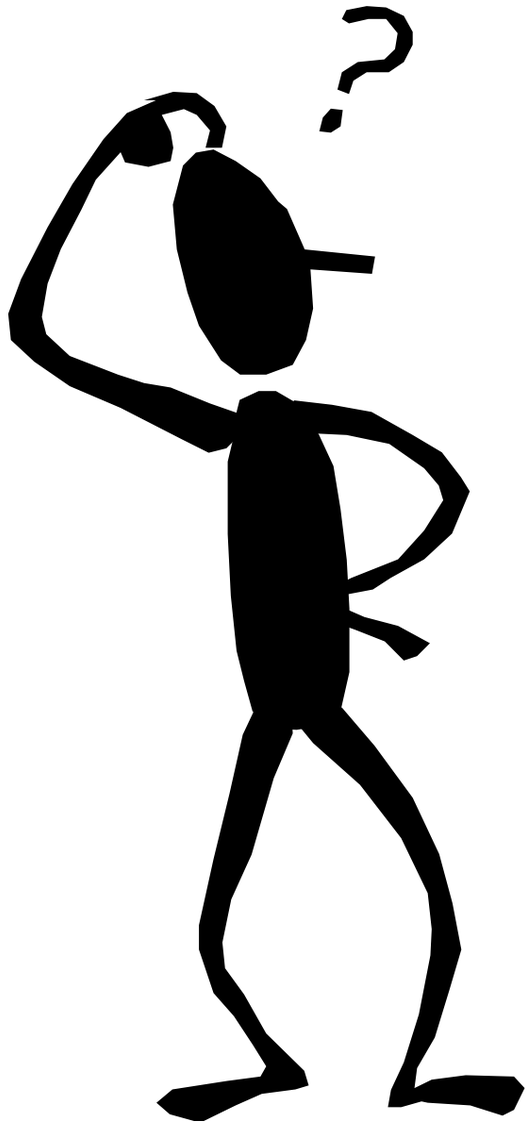

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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FAQ

1. **What is the definition of uninsured for Medicaid DSH purposes?**

   Uninsured patients are individuals with no source of third party health care coverage (insurance) for the specific inpatient or outpatient hospital service provided. Prisoners must be excluded.

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

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FAQ

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

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

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

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FAQ

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

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

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FAQ

3. **What categories of services can be included in uninsured on the DSH survey?**

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

- There has been some confusion with this issue. CMS attempts to clarify this in #24 of their FAQ titled "*Additional Information on the DSH Reporting and Audit Requirements*". It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.
    - EXAMPLE : A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is "Yes" since speech therapy is a Medicaid hospital service even though they wouldn't cover beneficiaries over 18.

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FAQ

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

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

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FAQ

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

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

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

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

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FAQ

7. Can bad debts be considered uninsured?

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

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FAQ

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

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

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

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

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FAQ

9. Can a hospital report services covered under automobile polices as uninsured?

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

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FAQ

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

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

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

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

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FAQ

12. Should we include state and local government payments for indigent in uninsured on Exhibit B?

Uninsured payments do not include payments made by State-only or local only government programs for services provided to indigent patients (no Federal share or match). *(Reporting pg. 77914)*

13. Can physician services be included in the DSH survey?

Physician costs that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital-specific DSH limit. *(Reporting pg. 77924)*

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FAQ

14. Do dual eligibles (Medicare/Medicaid) have to be included in the Medicaid UCC?

Yes. CMS believes the costs attributable to dual eligible patients should be included in the calculation of the uncompensated care costs, but in calculating the uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made. In calculating the Medicare payment, the hospital should include all Medicare adjustments (DSH, IME, GME, etc.). *(Reporting pg. 77912)*

15. Does Medicaid MCO and Out-of-State Medicaid have to be included?

Yes. Under the statutory hospital-specific DSH limit, it is necessary to calculate the cost of furnishing services to the Medicaid populations, including those served by Managed Care Organizations (MCO), and offset those costs with payments received by the hospital for those services. *(Reporting pages 77920 & 77926)*

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FAQ

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

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

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