OVERVIEW

- DSH Examination Policy
- DSH Year 2019 Examination Timeline
- DSH Year 2019 Examination Impact
- Paid Claims Data Review
- Review of DSH Year 2019 Survey and Exhibits
- 2019 Clarifications / Changes
- Recap of Prior Year Examinations (2018)
- Myers and Stauffer Q&A
**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”
• 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.
RELEVANT DSH POLICY (CONT.)

• Audit/Reporting implemented in FR Vol. 79, No. 232, Wednesday, Dec. 03, 2014, Final Rule

• “Medicare Access and CHIP Reauthorization Act” - Public Law, April 16, 2015, Sec. 412 delayed DSH reductions until FY 2018

• State DSH Hospital Allotment Reductions, July 28, 2017 FR Vol. 82, No. 144, Proposed Rule

• Bi-partisan Budget Act of 2018, enacted on February 9, 2018 delayed DSH reductions until FY 2020

• CARES Act §3813 delayed the DSH reductions until December 1, 2020

• Consolidated Appropriations Act for 2021 delayed DSH reductions until FY 2024
DSH YEAR 2019 EXAMINATION TIMELINE

• Survey files and data request uploaded to web portal on April 8th

• MMIS Data will be uploaded to web portal

• Survey’s returned by May 20, 2022

• Draft report to the state by October 31, 2022

• Final report to CMS by December 31, 2022
**DSH YEAR 2019 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 2019 examination report is a recoupment year.
PAID CLAIMS DATA UPDATE FOR 2019

• Medicaid fee-for-service paid claims data
  • Will be uploaded to web portal.
  • Same format as last year.
  • Reported based on cost report year (using discharge date).
  • At revenue code level.
  • Will exclude non-Title 19 services (such as CHIP).
PAID CLAIMS DATA UPDATE FOR 2019

- Medicare/Medicaid cross-over paid claims data
  - Will be uploaded to web portal.
  - Same format as last year.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Will exclude non-Title 19 services (such as CHIP).
PAID CLAIMS DATA UPDATE FOR 2019

• Medicare/Medicaid cross-over paid claims data (cont.)

• Hospital is responsible for ensuring all Medicare payments are included in the final survey even if the payments are not reflected in the paid claim totals. Non-claims based Medicare payments can include:

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

• Note: The expectation is that Critical Access Hospitals are reimbursed at cost after sequestration.
PAID CLAIMS DATA UPDATE FOR 2019

- Out-of-State Medicaid paid claims data should be obtained from the state making the payment
  - If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in Exhibit C format.
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).
  - In future years, request out-of-state paid claims listing at the time of your cost report filing.
PAID CLAIMS DATA UPDATE FOR 2019

- “Other” Medicaid Eligibles

- **Definition:** Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing and, as a result, may not be included in the state’s data.

- The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).

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

- Should be reported based on cost report year (using discharge date).
PAID CLAIMS DATA UPDATE FOR 2019

“Other” Medicaid Eligibles (cont.)

- 2008 DSH Rule requires that **all** Medicaid eligibles are reported on the DSH survey and included in the UCC calculation.
- Exhibit C should be submitted for this population. If no “other” Medicaid eligibles are submitted, we will contact you to request that they be submitted. If we still do not receive the requested Exhibit C or a signed statement verifying there are none to report, we may have to list the hospital as non-compliant in the 2019 DSH examination report.
- Ensure that you **separately report** Medicaid, Medicaid MCO, Medicare, Medicare HMO, private insurance, and self-pay payments in Exhibit C.
### PAID CLAIMS DATA UPDATE FOR 2019

Additional Clarification on Crossover and Other Medicaid Eligible Claims:

<table>
<thead>
<tr>
<th>In-State Medicare FFS Cross-Over Column</th>
<th>In-State Other Medicaid Eligible Column</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare FFS primary with Medicaid FFS secondary</td>
<td>Private Insurance primary with Medicaid FFS secondary</td>
</tr>
<tr>
<td>Medicare FFS primary with Medicaid HMO secondary</td>
<td>Private Insurance primary with Medicaid HMO secondary</td>
</tr>
<tr>
<td>Medicare HMO primary with Medicaid FFS secondary</td>
<td>Medicaid FFS no-pays (as long as service provided is Medicaid covered hospital service)</td>
</tr>
<tr>
<td>Medicare HMO primary with Medicaid HMO secondary</td>
<td></td>
</tr>
</tbody>
</table>

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
PAID CLAIMS DATA UPDATE FOR 2019

- Uninsured Services

- Uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.

- Exhibit A charges should be reported based on cost report year (using discharge date).

- Exhibit B patient payments will be reported based on cash basis (received during the cost report year).
FILES EACH HOSPITAL RECEIVED

• DSH data request documents:
  • Notice of the 2019 DSH Procedures
  • DSH Survey Part I – DSH year data
  • DSH Survey Part II – cost report year data
  • Exhibit A-C Hospital Provided Claims Data Template
  • DSH Survey - Revenue Code Crosswalk Template
FILES EACH HOSPITAL WILL RECEIVE

- Data received from the State to be provided to the hospitals:
  - Traditional FFS MMIS data (includes state-only program data)
  - Crossover data
  - Supplemental/Enhanced payments
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 year ends.
DSH EXAMINATION SURVEYS

General Instruction – Survey Files

• Do not 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 12/31/18 with the DSH examination of SFY 2018 in the prior year. In the DSH year 2019 exam, Hospital A would only need to submit a survey for their year ending 12/31/19.

• Both surveys have an instructions tab that has been updated. Please refer to those tabs if you are unsure of what to enter in a section. If it still is not 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.
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 were not previously submitted).

  • If these are incorrect, please call Myers and Stauffer and request a new copy.

Section B

• Answer all DSH Qualifying questions using drop-down boxes.
DSH SURVEY PART I – DSH YEAR DATA

Section C

• Item 1: Report any Medicaid supplemental payments, including UPL and Non-Claim Specific payments, for the state fiscal year. Do NOT include DSH payments.

• Item 2: Report any Medicaid Managed Care supplemental payments, including all Non-Claim Specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
  
  • Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on SFY basis.

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.
C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 10/01/2017 - 09/30/2018
   (Should include UPL and non-claim specific payments paid based on the state's fiscal year. However, DSH payments should NOT be included.)

2. Medicaid Managed Care Supplemental Payments for Hospital Services DSH Year 10/01/2017 - 09/30/2018
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplemental, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SPY basis.

3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 10/01/2017 - 09/30/2018
   $ -

Certification:

1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?
   Matching the federal share with an IG/ICPE 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 prevented the hospital from retaining its payments.

   Explanation for "No" answers:

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

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

   Hospital CEO or CFO Signature
   Title
   Date

   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

   DEDICATED TO GOVERNMENT HEALTH PROGRAMS
Submit one copy of the part II survey for each cost report year not previously submitted.

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

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

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

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

2. Select Cost Report Year Covered by this Survey (enter "X"): 1/1/2016 through 12/31/2016

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

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

4. Hospital Name:
   - Hospital ABC

5. Medicaid Provider Number:
   - 111111

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

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

8. Medicare Provider Number:
   - 111111

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

10. State Name & Number
11. State Name & Number
12. State Name & Number
13. State Name & Number
14. State Name & Number
15. State Name & Number

(List additional states on a separate attachment)

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**Notes:**
- Should have an "X" for the cost report year for which you are reporting. You will have a separate excel file for each year listed here.
- Please indicate the status of the cost report being used to complete the survey. Example: As-filed, Settled with audit, Settled without audit, Reopened, etc.
- If HCRIS data is used, the date that CMS processed the HCRIS file will populate here.
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.
If your facility received Medicaid Managed Care payments not paid at the claim level, answer “Yes” and provide the breakout of the payments applicable to hospital and non-hospital services.

If no such payments were received during the year, answer “No”.
### Disclosure of Medicaid / Uninsured Payments Received: (01/01/2015 - 12/31/2016)

| Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1) | $ |
| Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) | $ |
| Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) | $ |
| Total Section 1011 Payments Related to Hospital Services (See Note 1) | $ |
| Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1) | $ |
| Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) | $ |
| Total Section 1011 Payments Related to Non-Hospital Services (See Note 1) | $ |

<table>
<thead>
<tr>
<th>Out-of-State DSH Payments (See Note 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
</tr>
<tr>
<td>$</td>
</tr>
</tbody>
</table>

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level? Should include all non-claim specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

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

16. Total Medicaid managed care non-payments (see question 13 above) received

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**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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**Section 1011 undocumented alien payments reconciliation**

**Out-of-State DSH Payments**

**Insured and uninsured patient payments reconciliation**

Report any lump sum payments (payments not paid at the claim level) received from MCOs in this section. Examples include payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
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 does not agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.

• Section F-2: If cash subsidies are specified for I/P or O/P services, record them as such, otherwise record entire amount as unspecified. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.

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

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

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

- Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If you have contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.
Section F-3: Reconciling Items Necessary for Proper Calculation of LIUR

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

- Medicaid DSH payments and state and local patient care cash subsidies included on G-3, line 2 should be entered on line 32 and 33 so they can be properly excluded in calculating net patient service revenue also.

- Medicaid Provider Tax included on G-3, line 2 should be entered on line 34 so it can be properly excluded in calculating net patient service revenue.
**F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2017 - 06/30/2018)**

**Days per cost report**

**State and local govt. subsidies**

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

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

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

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

• Utilized to compute the per diems and cost-to-charge ratios used to calculate uncompensated care costs.

• Pre-populated with hospital-specific HCRIS data.

• Hospital should update the pre-populated HCRIS costs coming from B Part I to agree with the Medicare version of the cost report. RCE adjustments may need to be updated also.

• All other pre-populated HCRIS data should be verified to Medicare version of the cost report by the hospital.

• NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other payers will be excluded from Total Hospital Cost.
DSH YEAR SURVEY PART II
SECTION G, COST REPORT DATA

• Calculation of Routine Cost Per Diems
  • Days
  • Cost

• Calculation of Ancillary Cost-to-Charge Ratios
  • Charges
  • Cost

• NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other Payors
### G. Cost Report - Cost / Days / Charges

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

**Cost Report Year (9/1/2019 - 8/31/2020)**  
**Hospital ABC**

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Total Allowable Cost</th>
<th>Intern &amp; Resident Costs Removed on Cost Report</th>
<th>RCE and Therapy Add Back (if applicable)</th>
<th>Provider Tax Assessment</th>
<th>IP Days and IP Ancillary Charges</th>
<th>IP Routine Charges and OP Ancillary Charges</th>
<th>Total Charges</th>
<th>Medicaid Diem / Cost to Other Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>0300</td>
<td>Adults &amp; Pediatrics</td>
<td>$62,000,000</td>
<td>$3,000</td>
<td>$0.00</td>
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</tr>
<tr>
<td>0310</td>
<td>Intensive Care Unit</td>
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<td>$0.00</td>
<td>$0.00</td>
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<td>$18,500,000</td>
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</tr>
<tr>
<td>0320</td>
<td>Coronary Care Unit</td>
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<td>$0.00</td>
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<tr>
<td>0330</td>
<td>Burn Intensive Care Unit</td>
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<td>$0.00</td>
<td>$0.00</td>
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<td>$4,000</td>
<td>$9,000,000</td>
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<td>$0.00</td>
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<td>$1,000.00</td>
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<tr>
<td>0400</td>
<td>Other Special Care Unit</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$13,000,000</td>
<td>$10,000</td>
<td>$23,000,000</td>
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<tr>
<td>0410</td>
<td>Subprovider I</td>
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<td>$0.00</td>
<td>$6,000,000</td>
<td>$4,000</td>
<td>$10,000,000</td>
<td>$1,000.00</td>
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</tr>
<tr>
<td>0420</td>
<td>Subprovider II</td>
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<td>Other Subprovider</td>
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<td>$500</td>
<td>$1,500,000</td>
<td>$1,000.00</td>
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**Total Routine Weighted Average**  
$100,000,000

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<tr>
<th></th>
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<th></th>
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<th></th>
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<tbody>
<tr>
<td>0900</td>
<td>Observation (Non-Distinct)</td>
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<td>3,571.45</td>
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<td>$17,600,000</td>
<td>$19,000,000</td>
<td>0.187911</td>
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</table>

### Notes:
- **Provider tax calculation** will populate here once the Sec. L tab is filled out.
- **Routine charges** are populated here. These are strictly informational and do not flow into any calculations.
- **Routine cost per diems** - calculated based on cost report data entered above.
- **Calculation of observation CCR.** Uses per diem calculated in first section to carve out and calculate observation costs.

**DEDICATED TO GOVERNMENT HEALTH PROGRAMS**
### G. Cost Report - Cost / Days / Charges

**Cost Report Year (7/1/2019 - 6/30/2020)**

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Total Allowable Cost</th>
<th>Intern &amp; Resident Costs Removed on Cost Report</th>
<th>RCE and Therapy Add-Back (if Applicable)</th>
<th>Provider Tax Assessment</th>
<th>Total Cost</th>
<th>IP Days and IP Ancillary Charges</th>
<th>IP Routine Charges and O&amp;P Ancillary Charges</th>
<th>Total Charges</th>
<th>Medicaid Per Diem / Cost or Other Ratios</th>
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</thead>
<tbody>
<tr>
<td>21</td>
<td>OPERATING ROOM</td>
<td>$27,000,000.00</td>
<td>$80,000</td>
<td>$-</td>
<td>$27,080,000</td>
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<tr>
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<td>RECOVERY ROOM</td>
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**Ancillary Cost Centers (from W/S C excluding Observation) List Below:**

- OPERATING ROOM
- RECOVERY ROOM
- DELIVERY ROOM & LAB ROOM
- RADIOLOGY-DIAGNOSTIC
- RADIOLOGY-THERAPEUTIC
- CT SCAN
- MRI
- LABORATORY
- RESPIRATORY THERAPY
- PHYSICAL THERAPY
- OCCUPATIONAL THERAPY
- SPEECH PATHOLOGY
- ELECTROCARDIOLOGY
- MEDICAL SUPPLIES CHARGED TO PATIENT
- IMPL. DEV. CHARGED TO PATIENTS
- DRUGS CHARGED TO PATIENTS
- RENAL DIALYSIS
- ANGIOPLASTY
- DIABETES CENTER
- CARDIAC CATHETERIZATION LAB
- EMERGENCY

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

**Dedicated to Government Health Programs**
Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:

- In-State FFS Medicaid Primary (*Traditional Medicaid*) from state’s paid claims summaries.
- In-State Medicaid Managed Care Primary (*Medicaid MCO*) from submitted Exhibit C.
- In-State Medicare FFS Cross-Overs (*Traditional Medicare with Medicaid Secondary*) from state’s paid claims summaries.
- In-State Other Medicaid Eligible claims (*May include Medicare MCO cross-overs and other Medicaid not included elsewhere*) from submitted Exhibit C.
**H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:**

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Medicaid Per Diem Cost for Routine Cost Centers</th>
<th>Medicaid Cost to Charge Ratio for Ancillary Cost Centers</th>
<th>In-State Medicaid FFS Primary</th>
<th>In-State Medicaid Managed Care Primary</th>
<th>In-State Medicare FFS Cross-Overs (with Medicaid Secondary)</th>
<th>In-State Other Medicaid Eligibles (Not Included Elsewhere)</th>
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</thead>
<tbody>
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<td>From Section G</td>
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<td>Inpatient</td>
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**Routine Cost Centers (from Section G):**

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<th>Per Diem Cost</th>
<th>Charge Ratio</th>
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<td>Intensive Care Unit</td>
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<tr>
<td>03200</td>
<td>Coronary Care Unit</td>
<td>$600.06</td>
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</tr>
<tr>
<td>03300</td>
<td>Burn Intensive Care Unit</td>
<td>$1,666.67</td>
<td></td>
</tr>
<tr>
<td>03400</td>
<td>Surgical Intensive Care Unit</td>
<td>$782.61</td>
<td></td>
</tr>
<tr>
<td>03500</td>
<td>Other Special Care Unit</td>
<td>$900.00</td>
<td></td>
</tr>
<tr>
<td>04100</td>
<td>Subprovider I</td>
<td>$830.77</td>
<td></td>
</tr>
<tr>
<td>04200</td>
<td>Other Subprovider</td>
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</tr>
<tr>
<td>04300</td>
<td>Nursery</td>
<td>$782.61</td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Cost Report Year (07/01/2017-06/30/2018)</th>
<th>HOSPITAL ABC</th>
</tr>
</thead>
</table>

### Ancillary Cost Centers (from WS C) (from Section G):

<table>
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<tr>
<th>Code</th>
<th>Description</th>
<th>In-State Medicaid FFS Primary</th>
<th>In-State Medicaid Managed Care Primary</th>
<th>In-State Medicaid FFS Cross-Overs (with Medicaid Secondary)</th>
<th>In-State Other Medicaid Eligibles (Not Included Elsewhere)</th>
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<tbody>
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<tr>
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### Totals / Payments

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<tr>
<td>129</td>
<td>Total Charges per PS&amp;R or Exhibit Detail</td>
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<td>Unconciliated Charges (Explain Variance)</td>
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<tr>
<td>131</td>
<td>Total Calculated Cost (includes organ acquisition from Section J)</td>
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**Enter all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.**
DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Medicaid Payments Include:
  - Claim payments.
    - Payments should be broken out between payor sources.
  - Medicaid cost report settlements.
  - Medicare bad debt payments (cross-overs).
  - Medicare cost report settlement payments (cross-overs).
  - Other third party payments (TPL).
  - Medicaid Managed Care Quality Incentive Payments, or other lump sum payments received from Medicaid Managed Care organizations, if applicable.
Enter in all Medicaid, Medicaid Managed Care, Private Insurance, Self Pay, Cost Settlements, Medicare, Medicare Managed Care, Crossover Bad Debt, and Other Medicare Crossover Payments.
DSH SURVEY PART II
SECTION H, UNINSURED

• Report uninsured services, patient days (by routine cost center) and ancillary charges by cost center.

• Survey form Exhibit A shows the data elements that need to be collected and provided to Myers and Stauffer.

• For uninsured payments, enter the uninsured hospital patient payment totals from your Survey form Exhibit B. Do NOT pick up the non-hospital or insured patient payments in Section H even though they are reported in Exhibit B.
H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2017-06/30/2018) HOSPITAL ABC

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Medicaid Per Diem Cost for Routine Cost Centers</th>
<th>Medicaid Cost to Charge Ratio for Ancillary Cost Centers</th>
<th>Uninsured Inpatient (See Exhibit A)</th>
<th>Uninsured Outpatient (See Exhibit A)</th>
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<td>From Section G</td>
<td>From Hospital's Own Internal Analysis</td>
<td>From Hospital's Own Internal Analysis</td>
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<td>17</td>
<td></td>
<td>$-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td>$-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Total Days per PS&amp;R or Exhibit Detail</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Unreconciled Days (Explain Variance)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Routine Charges</td>
<td>Calculated Routine Charge Per Diem</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DSH SURVEY PART II
SECTION H, UNINSURED

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

1. The hospital Medicaid shortfall is greater than the hospital’s total Medicaid DSH payments for the year.

   • The shortfall is equal to all Medicaid (FFS, MCO, cross-over, In-State, Out-of-State) cost less all applicable payments in the survey and non-claim payments such as UPL, GME, outlier, and supplemental payments.

2. The hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals.
NOTE: It is important to remember that if you are not required to submit uninsured data that it may still be to the advantage of the hospital to submit it.

1. Your hospital’s total UCC may be used to redistribute overpayments from other hospitals (to your hospital).

2. Your hospital’s total UCC may be used to establish future DSH payments.

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

  • The errors occur when the cost report groupings differ from the grouping methodology used to complete the DSH survey.

  • Calculated payments as a percentage of cost by payor (at bottom).

  • Review percentage for reasonableness.
Additional Edits

On Section H and I, in the cross-over columns, there will be an edit above the days section that will pop up if you enter more cross-over days on the DSH survey than are included in Medicare days on W/S S-3 of the cost report per HCRIS data.

Please review your data if this occurs and correct the issue prior to filing the survey.
DSH SURVEY PART II - SECTION H, IN-STATE MEDICAID AND UNINSURED

- Additional Edits

  - On Section H, in column AY, there is a % Survey to Cost Report Totals column. The percentages listed in this column are calculating total in-state and out-of-state days and charges divided by total cost report days and charges by cost center, and in total.

  - Please review your data for reasonableness and correct any issues prior to filing the survey.
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.
Total organ acquisition cost and total useable organs may be pre-loaded from HCRIS data. If it is incorrect or does not 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 for transplants occurring at the hospital.

Summary claims data (PS&R) or similar documents and provider records (organ counts) must be provided to support the charges and useable organ counts reported on the survey. The data for uninsured organ acquisitions should be reported separately from the Exhibit A.
DSH SURVEY PART II - SECTIONS J & K, ORGAN ACQUISITION

- All organ acquisition charges should be reported in Sections J & K of the survey and should be EXCLUDED from Section H & I of the survey. (Days should also be excluded from H & I.)

- Medicaid and uninsured charges/days included in the cost report D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey as those costs are included in the cost per organ amount on Section J & K.
### J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

<table>
<thead>
<tr>
<th>Organ Acquisition Cost Centers (20 below)</th>
<th>Cost Report Year (07/1/2017-06/30/2019)</th>
<th>In-State Medicaid</th>
<th>In-State Medicaid Managed Care</th>
<th>Out-State Medicaid</th>
<th>Out-State Medicaid Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung Acquisition</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>Kidney Acquisition</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>Liver Acquisition</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>Heart Acquisition</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>Other Organ Sourcing</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

#### Notes:
- **Add-On Cost Factor for I&R, Provider Tax:**
- **In-State organ acquisitions:**
- **Out-of-State organ acquisitions:**
• 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.

• The Medicaid and uninsured share of the provider tax assessment is an allowable cost for Medicaid DSH even if Medicare offsets some of the tax.
The Medicaid DSH audit rule clearly indicates that the portion of permissible provider taxes applicable to Medicaid and uninsured is an allowable cost for the Medicaid DSH UCC. (FR Vol. 73, No. 245, Friday, Dec. 19, 2008, page 77923)

By "permissible", they are referring to a "valid" tax in accordance with 42 CFR §433.68(b).
DSH SURVEY PART II
SECTION L, PROVIDER TAXES

• Section L is used to report allowable Medicaid Provider Tax.

• Added to assist in reconciling total provider tax expense reported in the cost report and the amount actually incurred by a hospital (paid to the state).

• Complete the section using cost report data and hospital’s own general ledger.
DSH SURVEY PART II
SECTION L, PROVIDER TAXES

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

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

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

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

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 examination 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 survey.

<table>
<thead>
<tr>
<th>Worksheet A Provider Tax Assessment Reconciliation:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost Report Year (7/1/2019 - 6/30/2020)</strong>: Hospital ABC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Provider Tax Assessment Reclassifications (from W/S A-6 of the Medicare cost report)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospital Gross Provider Tax Assessment (from general ledger)*</td>
</tr>
<tr>
<td>1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment</td>
</tr>
<tr>
<td>2. Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)</td>
</tr>
<tr>
<td>3. Difference (Explain Here -________-)</td>
</tr>
<tr>
<td><strong>Dollar Amount</strong></td>
</tr>
<tr>
<td><strong>W/S A Cost Center Line</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from W/S A-8 of the Medicare cost report)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Reason for adjustment</td>
</tr>
<tr>
<td>9. Reason for adjustment</td>
</tr>
<tr>
<td>10. Reason for adjustment</td>
</tr>
<tr>
<td>11. Reason for adjustment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from W/S A-8 of the Medicare cost report)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Reason for adjustment</td>
</tr>
<tr>
<td>13. Reason for adjustment</td>
</tr>
<tr>
<td>14. Reason for adjustment</td>
</tr>
<tr>
<td>15. Reason for adjustment</td>
</tr>
</tbody>
</table>

| **Total Net Provider Tax Assessment Expense Included in the Cost Report**                       |
| **$ -**                                                                                           |

**DSH UCC Provider Tax Assessment Adjustment:**

| **Gross Allowable Assessment Not Included in the Cost Report** |
| **$ -**                                                       |

*Assessment must exclude any non-hospital assessment such as Nursing Facility.*
EXHIBIT A - UNINSURED CHARGES/DAYS BY REVENUE CODE

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

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

- Claim Status (Column R) is the same as the prior year – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the December 3, 2014 final DSH rule.

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

- Submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).

- Data not submitted in the correct format may be returned to the hospital with a letter to request revisions to get the data into the prescribed Exhibit A format.
### Exhibit A - Uninsured Charges

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

<table>
<thead>
<tr>
<th>Admit Date (J)</th>
<th>Discharge Date (K)</th>
<th>Service Indicator (Inpatient / Outpatient) (L)</th>
<th>Revenue Code (M)</th>
<th>Total Charges for Services Provided (N)</th>
<th>Routine Days of Care (O)</th>
<th>Total Patient Payments for Services Provided (P)</th>
<th>Total Private Insurance Payments for Services Provided (Q)</th>
<th>Claim Status (Exhausted or Non-Covered Service, if applicable) (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/1/2010</td>
<td>3/11/2010</td>
<td>Inpatient</td>
<td>110</td>
<td>$4,000.00</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/1/2010</td>
<td>3/11/2010</td>
<td>Inpatient</td>
<td>300</td>
<td>$2,700.00</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/15/2010</td>
<td>6/15/2010</td>
<td>Outpatient</td>
<td>250</td>
<td>$150.00</td>
<td>7</td>
<td>$500.00</td>
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<td>Exhausted</td>
</tr>
<tr>
<td>6/15/2010</td>
<td>6/15/2010</td>
<td>Outpatient</td>
<td>450</td>
<td>$750.00</td>
<td>7</td>
<td>$500.00</td>
<td></td>
<td>Exhausted</td>
</tr>
<tr>
<td>8/10/2010</td>
<td>8/10/2010</td>
<td>Outpatient</td>
<td>450</td>
<td>$1,100.00</td>
<td>7</td>
<td>$100.00</td>
<td></td>
<td>Non-Covered Service</td>
</tr>
</tbody>
</table>

Exhibit A - Uninsured charges/days

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
EXHIBIT B - ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

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

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

- For example, a cash payment received during the 2019 cost report year that relates to a service provided in the 2013 cost report year, must be used to reduce uninsured cost for the 2019 cost report year.
EXHIBIT B - ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Exhibit B
  - Include *Primary Payor Plan, Secondary Payor Plan, Payment Transaction Code, Provider #, PCN, Birth Date, SSN, and Gender, Admit, Discharge, Date of Collection, Amount of Collection, 1011 Indicator, Service Indicator, Hospital Charges, Physician Charges, Non-Hospital Charges, Insurance Status, Claim Status and Calculated Collection* fields.
  - A separate “key” for all payment transaction codes should be submitted with the survey.
  - Submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).
  - Data not submitted in the correct format may be returned to the hospital with a letter to request revisions to get the data into the prescribed Exhibit B format.
<table>
<thead>
<tr>
<th>Claim Type (A)</th>
<th>Primary Payor Plan (B)</th>
<th>Secondary Payor Plan (C)</th>
<th>Transaction Code (D)</th>
<th>Provider # (E)</th>
<th>Patient Identifier Number (PCN) (F)</th>
<th>Date (G)</th>
<th>Patient’s Social Security Number (H)</th>
<th>Patient’s Gender (I)</th>
<th>Name (J)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Pay Payments</td>
<td>Medicare</td>
<td>Medicaid</td>
<td>500</td>
<td>12345</td>
<td>33333333</td>
<td>2/7/2025</td>
<td>999-99-999</td>
<td>Male</td>
<td>Jones, Anthony</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>Medicare</td>
<td>Medicaid</td>
<td>500</td>
<td>12345</td>
<td>33333333</td>
<td>2/7/2025</td>
<td>999-99-999</td>
<td>Male</td>
<td>Jones, Anthony</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>Medicare</td>
<td>Medicaid</td>
<td>500</td>
<td>12345</td>
<td>33333333</td>
<td>2/7/2025</td>
<td>999-99-999</td>
<td>Male</td>
<td>Jones, Anthony</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>Medicare</td>
<td>Medicaid</td>
<td>500</td>
<td>12345</td>
<td>33333333</td>
<td>2/7/2025</td>
<td>999-99-999</td>
<td>Male</td>
<td>Jones, Anthony</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>Blue Cross</td>
<td>Medicaid</td>
<td>500</td>
<td>12345</td>
<td>99999999</td>
<td>9/25/1979</td>
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<td>Male</td>
<td>Smith, John</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>Blue Cross</td>
<td>Medicaid</td>
<td>500</td>
<td>12345</td>
<td>99999999</td>
<td>9/25/1979</td>
<td>999-99-999</td>
<td>Male</td>
<td>Smith, John</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>Blue Cross</td>
<td>Medicaid</td>
<td>500</td>
<td>12345</td>
<td>99999999</td>
<td>9/25/1979</td>
<td>999-99-999</td>
<td>Male</td>
<td>Smith, John</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>Self-Pay</td>
<td>Medicaid</td>
<td>500</td>
<td>12345</td>
<td>77777777</td>
<td>7/9/2000</td>
<td>999-99-999</td>
<td>Male</td>
<td>Cliff, Heath</td>
</tr>
<tr>
<td>Self Pay Payments</td>
<td>United Healthcare</td>
<td>Medicaid</td>
<td>500</td>
<td>12345</td>
<td>55555555</td>
<td>2/15/1960</td>
<td>999-99-999</td>
<td>Male</td>
<td>Johnson, Joe</td>
</tr>
</tbody>
</table>

**Exhibit B - Cash Basis Patient Payments**
EXHIBIT C - HOSPITAL-PROVIDED MEDICAID DATA

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

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

- Types of data that may require an Exhibit C are as follows:
  - Self-reported Medicaid MCO data (Section H).
  - Self-reported “Other” Medicaid eligibles (Section H).
  - All self-reported Out-of-State Medicaid categories (Section I).
  - Additional or adjusted Medicaid FFS/Crossover claims noted during reconciliation of state and internal hospital data (Section H).
EXHIBIT C - HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C

- Include Primary Payor Plan, Secondary Payor Plan, Hospital MCD #, PCN, Patient’s MCD Recipient #, Name, Admit, Discharge, Service Indicator, Rev Code, Total Charges, Days, Medicare Traditional Payments, Medicare Managed Care Payments, Medicaid FFS Payments, Medicaid Managed Care Payments, Private Insurance Payments, Self-Pay Payments, and Sum All Payments fields. DOB, Social, and Gender may also be requested.

- 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:
  
  • Data not submitted in the correct format may be returned to the hospital with a letter to request revisions to get the data into the prescribed Exhibit C format.
  
  • In particular, claims data submitted with days, charges, and/or payments in separate Excel files rather than combined into one Exhibit document as prescribed in Exhibit C may be sent back to the hospital to combine.
  
  • Note that payments being repeated on every line of an Exhibit C claim is acceptable and will be properly accounted for during the desk review.
<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Primary Payor Plan</th>
<th>Secondary Payor Plan</th>
<th>Hospital's Medicaid Provider #</th>
<th>Patient Identifier Number (PCN)</th>
<th>Patient's Medicaid Recipient #</th>
<th>Patient’s Medicaid Birth Date</th>
<th>Patient’s Social Security Number</th>
<th>Patient’s Gender</th>
<th>Name</th>
<th>Admit Date</th>
<th>Discharge Date</th>
</tr>
</thead>
</table>
DSH SURVEY PART I – DSH YEAR DATA

Checklist

• Separate tab in Part I of the survey.

• Should be completed after Part I and Part II surveys are prepared.

• Includes list of all supporting documentation that needs to be submitted with the survey for examination.

• Includes our email addresses and phone numbers.

• Include Item # in file name (e.g. 5(b)_Exh A Logic)
DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist

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


4. N/A
Submission Checklist (cont.)

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

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

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

6. (b). Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.
7. (a). Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare crossover, Medicaid MCO, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report)

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

7. (b). Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payer plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
8. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers).

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

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

11. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B.
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 or other documentation to support total charity care charges and subsidies reported on Section F of DSH Survey Part II.

14. Revenue code cross-walk used to prepare cost report.
DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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

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

15. (c). Worksheet A Mapping, showing how WTB accounts map to worksheet A lines on the cost report.

16. Electronic copy of all cost reports used to prepare each DSH Survey Part II)
17. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligible cost report payments)

18. Documentation supporting Medicaid Managed Care Quality Incentive Payments, or any other Medicaid Managed Care lump sum payments.
**UPDATES**

- Consolidated Appropriations Act (CAA) of 2021
  - Effective October 1, 2021
  - Allotment reductions delayed until SFY 2024-2027 ($8B reduction per year)
  - The CAA calls for the exclusion of dual eligible cost and payments from the uncompensated care cost calculation (UCC), unless the hospital qualifies for the 97th percentile SSI exception.
  - Hospital should continue to report all dual-eligible information as in previous years.
  - At this time, additional guidance is needed from CMS as to how the CAA should be applied.

Note: Due to CAA, hospitals should review query logic to ensure claims are reported in the proper payor buckets and primary/secondary payors are clearly and accurately labeled.
**UPDATES**

- Provider Relief Funds
  - Under the CARES act enacted March 27, 2020, a portion of the provider relief funds were used to reimburse health care providers who provided COVID-19 treatment for uninsured individuals with a COVID-19 primary diagnosis on or after February 4, 2020.
  - Providers could request claims reimbursement and were generally reimbursed at Medicare rates.
  - Impact to DSH and UCC survey
    - Hospitals must include all claims-based provider relief fund payments for uninsured patients
    - Must include all payments applicable to their cost report period (accrual basis)
    - Included in Exhibit B
PRIOR YEAR DSH EXAMINATION (2018)

Significant Data Issues during 2018 Examination

- Incomplete DSH Survey Part I and Part II files.
- Charges, Days and/or payment amounts reported on DSH Survey Pt. II Sec. H did not tie to detail claims data submitted in Exhibits A, B, or C.
- No Uninsured payment data submitted (Exhibit B).
- No support or crosswalk did not accurately support the mapping of days and charges to cost centers in the DSH Survey Part II file, Section H & I.
- Provided templates (e.g., Exhibit A-C, crosswalk) not utilized for data submissions
  - Please do not use the old version of the Exhibit A-C templates.
Common Issues Noted During Examination

- Hospitals had duplicate patient claims in the uninsured, cross-over, and state’s Medicaid FFS data.

- Patient payor classes that were not updated. (ex. a patient was listed as self-pay and it was determined that they later were Medicaid eligible and paid by Medicaid yet the patient was still claimed as uninsured).

- Incorrectly reporting elective (cosmetic surgeries) services, and non-Medicaid untimely filings as uninsured patient claims.
Common Issues Noted During Examination

- Charges and days reported on survey exceeded total charges and days reported on the cost report (by cost center).

- Inclusion of patients in the uninsured charges listing (Exhibit A) that are concurrently listed as insured in the payments listing (Exhibit B).

- Patients listed as both insured and uninsured in Exhibit B for the same dates of service.
PRIOR YEAR DSH EXAMINATION (2018)

Common Issues Noted During Examination

• Patient-level documentation on uninsured Exhibit A and uninsured patient payments from Exhibit B did not agree to totals on the survey.

• Some hospitals did not include their charity care patients in the uninsured even though they had no third party coverage.

• Under the December 3, 2014 final DSH rule, hospitals reported “Exhausted” / “Insurance Non-Covered” on Exhibit A (Uninsured) but did not report the payments on Exhibit B.
Common Issues Noted During Examination

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

- Only uninsured payments are to be on cash basis – all other payor payments must include all payments made for the dates of service as of the examination date.

- Exhibit B – Patient payments did not always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.

- Hospitals did not report their charity care in the LIUR section of the survey or did not include a break-down of inpatient and outpatient charity.
PRIOR YEAR DSH EXAMINATION (2018)

Common Issues Noted During Examination

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

- Liability insurance claims were incorrectly included in uninsured even when the insurance (e.g., auto policy) made a payment on the claim.
WEB PORTAL

• First Time Log-In

  • Click Forgot Password
  
  • Enter the email address and click Send Forgot Password Email.
  
  • Expect an email with a link to set the password.
  
  • Log-in to the website using email address and new password.
  
  • Review and confirm providers visible on your account.
WEB PORTAL

- Ability to upload DSH submission
  - MSLC will review
    - Accept or reject
    - Once document is approved provider is no longer able to upload to that event.
      - Will need to notify MSLC of need to revise as-filed documents.
  - Ability to include notes up to 1,000 characters
Select appropriate project
Select Cost Report Period

Provider: Select.

Fiscal Year:
- Begin Date
- End Date

Legend for available actions:
- Refresh
- Upload
- Download
- Show Fix Information
- Needs Review
- Related
- Mark as Not Applicable
- Not Applicable

Event Date | Event | Expect Date | Response Date | UserID | Action
--- | --- | --- | --- | --- | ---
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WEB PORTAL

Website: https://dsh.mslc.com

- Contact okdsh@mslc.com to request registration form or update contact information.
- Must provide valid IP address to be set up to send/receive data.
- Work From Home – Temporary public IP address
OTHER INFORMATION

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

Questions concerning the Web Portal, DSH Surveys, and Exh. A-C can be directed to:
Scott Smith: SSmith@mslc.com
Erik Grimes: EGrimes@mslc.com

Note: Exhibits A-C include protected health information and must be sent accordingly (no e-mail).
1. What is the definition of uninsured for Medicaid DSH purposes?

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

- On December 3, 2014, CMS finalized the proposed rule published on January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.

- Under this final DSH rule, the DSH examination looks at whether a patient is uninsured using a “service-specific” approach.

- Based on the 2014 final DSH rule, the survey allows for hospitals to report “fully exhausted” and “insurance non-covered” services as uninsured.
1. What is the definition of uninsured for Medicaid DSH purposes? (Continued from previous slide)

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

• Individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as a result of criminal charges. These individuals are considered to have a source of third party coverage.

• Prisoner Exception
  • If a person has been released from secure custody and is referred to the hospital by law enforcement or correction authorities, they can be included.
  • The individual must be admitted as a patient rather than an inmate to the hospital.
  • The individual cannot be in restraints or seclusion.
2. What is meant by “Exhausted” and “Non-Covered” in the uninsured Exhibits A and B?

Under the December 3, 2014 final DSH rule, hospitals can report services if insurance is “fully exhausted” or if the service provided was “not covered” by insurance. The service must still be a hospital service that would normally be covered by Medicaid.
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 would not cover beneficiaries over 18.
4. Can a service be included as uninsured, if insurance did not pay due to improper billing, late billing, or lack of medical necessity?

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

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

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

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

Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the 2014 final DSH rule as an exhausted or insurance non-covered service (but those must be separately identified).
8. How do IMDs (Institutes for Mental Disease) report patients between 22-64 that are not Medicaid-eligible due to their admission to the IMD?

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

- Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare or private insurance, 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 or private insurance is exhausted.
9. Can a hospital report services covered under automobile polices as uninsured?

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

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

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

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

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

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

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

Physician costs that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital-specific DSH limit. (Reporting pg. 77924)
14. Do dual eligible patients (Medicare/Medicaid) have to be included in the Medicaid UCC?

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

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

Yes. Under the statutory hospital-specific DSH limit, it is necessary to calculate the cost of furnishing services to the Medicaid populations, including those served by Managed Care Organizations (MCO), and offset those costs with payments received by the hospital for those services. (Reporting pages 77920 & 77926)
16. Do other Medicaid eligible claims (private insurance/Medicaid) have to be included in the Medicaid UCC?

Yes. Since Section 1923(g)(1) does not contain an exclusion for dually eligible individuals, CMS believes the costs attributable to dual eligibles should be included in the calculation of the uncompensated costs of serving Medicaid eligible individuals. (Reporting pages 77912)
Please use the DSH Part I Survey Submission Checklist when preparing to submit your surveys and supporting documentation.

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

Reach out to the Myers & Stauffer contact for your state for additional state specific information or with any questions or concerns.