

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE DSH YEAR 2023

**PLEASE STAY MUTED DURING THE PRESENTATION
TODAY'S PRESENTATION IS BEING RECORDED**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



■ OVERVIEW

- DSH Examination Policy
- DSH Year 2023 Examination Timeline
- DSH Year 2023 Examination Impact
- Paid Claims Data Review
- Review of DSH Year 2023 Survey and Exhibits
- 2023 Clarifications / Changes
- Recap of Prior Year Examinations (2022)
- Myers and Stauffer DSH FAQ



■ RELEVANT DSH POLICY

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



■ RELEVANT DSH POLICY (CONT.)

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



■ 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 until December 1, 2020
- Consolidated Appropriations Act for 2021 delayed DSH reductions until FY 2024 and then amended to FY 2025



■ **RELEVANT DSH POLICY (CONT.)**

- Medicaid DSH Third Party Payor Rule resulting from the Consolidated Appropriations Act (CAA) in FR Vol. 89, No. 37, Friday, Feb. 23, 2024, Final Rule
- Full-Year Continuing Appropriations and Extensions Act, 2025 delayed DSH reductions until FY 2025
- Sections 6105 and 6106 of the Consolidated Appropriations Act, 2026 eliminated DSH reductions for FY 2026 and 2027 and redefined the uncompensated care cost calculation.



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■ DSH YEAR 2022 EXAMINATION TIMELINE

- Survey files and data request uploaded to web portal on April 29th
- MMIS Data will be uploaded to web portal
- Survey's returned by June 12, 2026
- Draft report to the state by October 31, 2026
- Final report to CMS by December 31, 2026



■ DSH YEAR 2023 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 2023 examination report is a recoupment year.

■ PAID CLAIMS DATA UPDATE FOR 2023

- 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 2023

- Medicaid managed care paid claims data
 - Will be uploaded to web portal.
 - New this 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 2023

- 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 2023

- 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

- Medicaid secondary paid claims data
 - Identifies Medicaid claims with TPL payments (dual-eligible) members.
 - Uploaded to web portal.
 - Reported based on cost report year (using discharge date).
 - At revenue code level (including days).



MCD Secondary IP
Hospital ABC
123456789

Total payments
to transfer to
survey

	Begin Date			CR Period 1		End Date
Period	01/01/2023					12/31/2023
Claims						
	Paid Days	N/C Rev Days	Allowed Days	Total	Non-Covered	Allowed
Days	50	-	50			
Charges				\$ 50,000.00	\$ -	\$ 50,000.00
Medicaid Paid				\$ -	Charges summarized by revenue code	\$ -
Medicare Paid				\$ -		\$ -
Coins				\$ -		\$ -
TPL				\$ 9,000.00		\$ 9,000.00
CoPay				\$ -		\$ -
SpendDown				\$ -		\$ -
Deductible				\$ -		\$ -

Charges
summarized
by revenue
code

RevCodes	Paid Days	N/C Rev Days	Allowed Days	Charges	N/C Rev Charges	Allowed Amount
118	-	-	-	\$ -	\$ -	\$ -
119	-	-	-	\$ -	\$ -	\$ -
120	11	-	11	\$ 5,775.00	\$ -	\$ 5,775.00
121	-	-	-	\$ -	\$ -	\$ -
122	-	-	-	\$ -	\$ -	\$ -
123	-	-	-	\$ -	\$ -	\$ -
124	-	-	-	\$ -	\$ -	\$ -
125	-	-	-	\$ -	\$ -	\$ -
126	-	-	-	\$ -	\$ -	\$ -
127	-	-	-	\$ -	\$ -	\$ -
128	-	-	-	\$ -	\$ -	\$ -
129	-	-	-	\$ -	\$ -	\$ -
130	-	-	-	\$ -	\$ -	\$ -

Days summarized
by revenue code

■ PAID CLAIMS DATA UPDATE FOR 2023

- Medicaid FFS & MCO Exhausted and Non-Covered
 - This data was not provided last year.
 - The hospital should send in a detailed listing in Exhibit C format.
 - Must EXCLUDE CHIP and other non-Title 19 services.
 - Should be reported based on cost report year (using discharge date).



■ PAID CLAIMS DATA UPDATE FOR 2023

- 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 2023

- “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.
 - 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 2023

- “Other” Medicaid Eligibles (cont.)
 - Exhibit C should be submitted for this population. If no “other” Medicaid eligibles are submitted, we may contact you to request that they be submitted.
 - Ensure that you ***separately report*** Medicaid, Medicaid MCO, Medicare, Medicare HMO, private insurance, and self-pay payments in Exhibit C.
 - We are still required to calculate and report the MIUR which includes all Medicaid eligibles.

■ PAID CLAIMS DATA UPDATE FOR 2023

- “Other” Medicaid Eligibles (cont.)
 - An MMIS file containing Medicaid FFS and Medicaid MCO claims with Third Party Payments will be provided.
 - Due to changes in the CAA these claims must be included in “Other Medicaid Eligibles” on the Survey II.
 - Combine MMIS file with your own Exhibit C data.
 - Should be reported based on cost report year (using discharge date).

■ PAID CLAIMS DATA UPDATE FOR 2023

- 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 2023 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
 - MCO MMIS data
 - Cost Report with year ends 3/31/2024 & 6/30/2024
 - Crossover MMIS data
 - Medicaid Secondary MMIS data (Medicaid with TPL)
 - 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 that did not participate in the 2022 Exam or with a year end change may have to complete 2 Surveys.



■ 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 12/31/22 with the DSH examination of SFY 2022 in the prior year. In the DSH year 2023 exam, Hospital A would only need to submit a survey for their year ending 12/31/23.
- 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

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- If applicable to your state, Myers and Stauffer may 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 see any data pre-loaded 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 OB 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.

A. General DSH Year Information

1. DSH Year:

Begin	End
10/01/2022	09/30/2023

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:

3. Cost Report Year 1
4. Cost Report Year 2 (if applicable)
5. Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
07/01/2023	06/30/2024

Must also complete a separate survey file for

Only cost report years to be submitted will show here.

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

Data
111111111
0
0
370000

A separate Part II Survey Excel file will need to be completed for each cost report period shown here.

B. DSH Qualifying Information

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

During the DSH Examination Year:

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

Answer all OB questions.

DSH Examination Year (10/01/22 - 09/30/23)

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 10/01/2022 - 09/30/2023

(Should include UPL and non-claim specific payments paid based on the Medicaid state plan rate year. However, DSH payments should NOT be included.)

2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 10/01/2022 - 09/30/2023

(Should include 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.

NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 10/01/2022 - 09/30/2023

Input all Medicaid supplemental payments for the DSH year (SHOPP etc.) should agree to the state's report

Input all Medicaid Managed Care supplemental payments for the DSH year. Please provide support.

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 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.

Answer

Explanation for "No" answers:

Must answer the retain DSH question.

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

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

Hospital CEO or CFO Signature

Title

Date

Hospital CEO or CFO Printed Name

Hospital CEO or CFO Telephone Number

Hospital CEO or CFO E-Mail

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

Hospital Contact:

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

Outside Preparer:

Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	



■ DSH YEAR SURVEY PART II

SECTION D – GENERAL INFORMATION

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

- **Question #2 – An “X” should be shown in the column of the cost report year survey you are preparing.**
 - If you have multiple years listed, you will need to prepare multiple surveys).
 - If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.
- **Question #3 – If applicable, 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

7/1/2023 - 6/30/2024

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and self accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when

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.

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

Hospital ABC

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

7/1/2023
through
6/30/2024

X

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

1 - As Submitted

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

1/1/2026

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.

4. Hospital Name:

Hospital ABC

5. Medicaid Provider Number:

111111111

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

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

8. Medicare Provider Number:

370000

If HCRIS data is used, the date that CMS processed the HCRIS file will populate here.

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

9. State Name & Number

10. State Name & Number

11. State Name & Number

12. State Name & Number

13. State Name & Number

14. State Name & Number

15. State Name & Number

(List additional states on a separate attachment)

State Name	Provider No.



■ 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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■ **DSH YEAR SURVEY PART II**

SECTION E, MISC. PAYMENT INFO.

- 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”.



E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2023 - 06/30/2024)

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

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

9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

\$-

\$-

Inpatient

Outpatient

Total

\$-

0.00%

\$-

0.00%

\$-

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-claims payments (see question 13 above) received applicable to hospital services

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

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

\$-

Note 1: Subtitle B - Miscellaneous Provision. Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services, report that portion 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.

Section 1011
undocumented
alien payments
reconciliation

Out-of-State DSH
Payments

Insured and
uninsured patient
payments
reconciliation
(from Exhibit B)

**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 may 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).



■ DSH YEAR SURVEY PART II

SECTION F, MIUR/LIUR

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

- Myers and Stauffer may 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.



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

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

- Bad debt and charity care write-offs not included on G-3, line 2 should be entered on lines 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 (07/01/2022 - 06/30/2023)

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, 18.00-18.03, 30, 31 less lines 5 & 6)

124,110

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):

- Inpatient Hospital Subsidies
- Outpatient Hospital Subsidies
- Unspecified I/P and O/P Hospital Subsidies
- Non-Hospital Subsidies
- Total Hospital Subsidies

\$ -

State or local govt subsidies

- Inpatient Hospital Charity Care Charges
- Outpatient Hospital Charity Care Charges
- Non-Hospital Charity Care Charges
- Total Charity Care Charges

\$ -

Charity care charges (only used in LIUR)

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

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

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$393,457,300.00			\$ 339,652,608	\$ -	\$ -	\$ 53,804,692
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$27,721,713.00			\$ 23,930,811	\$ -	\$ -	\$ 3,790,902
14. Swing Bed - SNF			\$0.00			\$ -	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$0.00			\$ -	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$1,978,873,067.00	\$1,650,665,013.00		\$ 1,708,265,163	\$ 1,424,939,065	\$ -	\$ 496,333,852
20. Outpatient Services		\$264,606,280.00			\$ 228,421,771	\$ -	\$ 36,184,509
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00			\$ -	
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$0.00			\$ -	
26. Other	\$6,674.00	(\$64,382.00)	\$0.00	\$ 5,761	\$ (55,578)	\$ -	\$ (7,891)
27. Total	\$ 2,400,058,754	\$ 1,915,206,911	\$ -	\$ 2,071,854,343	\$ 1,653,305,258	\$ -	\$ 590,106,064
28. Total Hospital and Non Hospital		Total from Above	\$ 4,315,265,665	Total from Above	\$ 3,725,159,601		

29. Total Per Cost Report

Total Patient Revenues (G-3 Line 1)

4,315,265,665

Total Contractual Adj. (G-3 Line 2)

3,725,159,601

30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)

31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)

32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)

33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)

34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)

35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"

36. Adjusted Contractual Adjustments

Reconciling items to ensure that only true contractuals are included in the calculation of the LIUR

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

3,725,159,601



■ 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, **if available at the time of survey creation.**
 - 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



Cost Report Year (07/01/2022-06/30/2023)	Hospital ABC
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Routine cost per diems calculated on cost report data entered above.

Calculation of observation CCR. Uses per diem calculated in first section to carve out and calculate observation costs.



MYERS AND STAUFFER^{LC}

CERTIFIED PUBLIC ACCOUNTANTS

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
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000 OPERATING ROOM	\$36,791,245.00	\$ 71,093	\$ -	\$ -	\$ 36,862,338	\$340,272,278.00	\$363,664,891.00	\$ 703,937,169	0.052366
22	5100 RECOVERY ROOM	\$4,896,209.00	\$ -	\$ -	\$ -	\$ 4,896,209	\$35,112,199.00	\$67,620,315.00	\$ 102,732,514	0.047660
23	5200 DELIVERY ROOM & LABOR ROOM	\$11,328,176.00	\$ -	\$ -	\$ -	\$ 11,328,176	\$41,242,946.00	\$2,127,065.00	\$ 43,370,011	0.261198
24	5400 RADIOLOGY-DIAGNOSTIC	\$17,910,325.00	\$ -	\$ -	\$ -	\$ 17,910,325	\$77,903,612.00	\$181,119,607.00	\$ 259,023,219	0.069146
25	5500 RADIOLOGY-THERAPEUTIC	\$7,970,191.00	\$ -	\$ -	\$ -	\$ 7,970,191	\$2,528,021.00	\$83,912,076.00	\$ 86,440,097	0.092205
26	5700 CT SCAN	\$5,778,679.00	\$ -	\$ -	\$ -	\$ 5,778,679	\$89,642,680.00	\$108,334,941.00	\$ 197,977,621	0.029189
27	5800 MRI	\$2,897,491.00	\$ -	\$ -	\$ -	\$ 2,897,491	\$16,611,454.00	\$33,028,563.00	\$ 49,640,017	0.058370
28	6000 LABORATORY	\$21,462,501.00	\$ -	\$ -	\$ -	\$ 21,462,501	\$643,143,717.00	\$184,088,775.00	\$ 827,232,492	0.025945
29	6500 RESPIRATORY THERAPY	\$8,790,338.00	\$ -	\$ -	\$ -	\$ 8,790,338	\$127,706,660.00	\$7,940,758.00	\$ 135,647,418	0.064803
30	6600 PHYSICAL THERAPY	\$8,224,744.00	\$ -	\$ -	\$ -	\$ 8,224,744	\$11,543,748.00	\$10,558,073.00	\$ 22,101,821	0.372130
31	6700 OCCUPATIONAL THERAPY	\$3,034,640.00	\$ -	\$ -	\$ -	\$ 3,034,640	\$9,566,772.00	\$2,846,108.00	\$ 12,412,880	0.244475
32	6800 SPEECH PATHOLOGY	\$1,005,665.00	\$ -	\$ -	\$ -	\$ 1,005,665	\$5,947,001.00	\$1,215,105.00	\$ 7,162,106	0.140415
33	6900 ELECTROCARDIOLOGY	\$13,384,335.00	\$ -	\$ -	\$ -	\$ 13,384,335	\$66,243,018.00	\$76,727,975.00	\$ 142,970,993	0.093616
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$49,944,985.00	\$ -	\$ -	\$ -	\$ 49,944,985	\$85,631,515.00	\$83,891,530.00	\$ 169,523,045	0.294621
35	7200 IMPL. DEV. CHARGED TO PATIENTS	\$49,225,521.00	\$ -	\$ -	\$ -	\$ 49,225,521	\$109,224,149.00	\$56,131,817.00	\$ 165,355,966	0.297694
36	7300 DRUGS CHARGED TO PATIENTS	\$84,682,589.00	\$ -	\$ -	\$ -	\$ 84,682,589	\$199,663,546.00	\$237,783,338.00	\$ 437,446,884	0.193584
37	7400 RENAL DIALYSIS	\$2,340,246.00	\$ 115,970	\$ -	\$ -	\$ 2,456,216	\$18,019,126.00	\$675,431.00	\$ 18,694,557	0.131387
38	7600 ANCILLARY PSYCH	\$187,363.00	\$ 83,213	\$ -	\$ -	\$ 270,576	\$441,995.00	\$201,374.00	\$ 643,369	0.420561
39	7601 DIABETES CENTER	\$730,793.00	\$ -	\$ -	\$ -	\$ 730,793	\$0.00	\$884,067.00	\$ 884,067	0.826626
40	7602 CARDIAC CATHETERIZATION LAB	\$17,369,411.00	\$ -	\$ -	\$ -	\$ 17,369,411	\$98,428,629.00	\$147,913,204.00	\$ 246,341,833	0.070509
41	9100 EMERGENCY	\$16,922,314.00	\$ 1,986,656	\$ -	\$ -	\$ 18,908,970	\$81,525,419.00	\$146,835,426.00	\$ 228,360,845	0.082803
126	Total Ancillary	\$ 364,877,761	\$ 2,256,932	\$ -	\$ -	\$ 367,134,693	\$ 2,073,403,801	\$ 1,820,740,559	\$ 3,894,144,360	
127	Weighted Average									0.095972

128	Sub Totals	\$ 527,963,323	\$ 4,103,633	\$ -	\$ -	\$ 532,066,956	\$ 2,494,582,814	\$ 1,820,740,559	\$ 4,315,323,373	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)					\$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)					\$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)									
131.01	Other Cost Adjustments (support must be submitted)									
132	Grand Total					\$ 532,066,956				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.78%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

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

All cost report data for calculation of ancillary cost-to-charge ratios.



■ DSH SURVEY PART II

SECTION H, IN-STATE MEDICAID

- Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
 - In-State FFS Medicaid Primary (*Traditional Medicaid*) from state's paid claims summaries.
 - In-State Medicaid Managed Care Primary (*Medicaid MCO*) from state's paid claims summaries.
 - In-State Medicare FFS Cross-Overs (*Traditional Medicare with Medicaid Secondary*) from state's paid claims summaries.
 - In-State Other Medicaid Eligible (*Medicaid Secondary*) from state's paid claims summaries. Also includes Medicare MCO cross-overs and other Medicaid not included elsewhere submitted on Exhibit C
 - Medicaid FFS & MCO Exhausted and Non-Covered (Not to be included elsewhere).



■ **DSH SURVEY PART II SECTION H, IN-STATE MEDICAID UPDATE FOR 2023**

- Medicaid FFS & MCO Exhausted and Non-Covered
 - Medicaid-eligible patients where payment was denied, due to exhausted benefits prior to obtaining service or patient belonging to limited Medicaid benefit plan that does not cover an otherwise Medicaid-covered service, for the specific hospital service provided.
 - Includes both in-state and out-of-state claims.
 - Medicaid eligibility must be supported by exhibit C and include the patient's Medicaid ID number.



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

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

Cost Report Year (07/01/2021-06/30/2022) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)	
Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Cost to Charge Ratio for	Inpatient	Outpatient	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 PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 947.14		29,500		11,000		1,000		1,500		1,000	
2	03100 INTENSIVE CARE UNIT	\$ 1,113.09		1,000		40		500		600		250	
3	03200 CORONARY CARE UNIT	\$ 1,202.13		500		15		200		250		200	
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	\$ 1,277.27		1,100		140		100		150		200	
7	04000 SUBPROVIDER I	\$ 1,517.69		500		250		250		300		150	
8	04100 SUBPROVIDER II	\$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	\$ -		-		-		-		-		-	
10	04300 NURSERY	\$ 333.93		1,255		1,000		-		150		200	
18	Total Days			33,855		12,445		2,050		2,950		2,000	
19	Total Days per PS&R or Exhibit Detail			33,855		12,445		2,050		2,950		2,000	
20	Unreconciled Days (Explain Variance)			-		-		-		-		-	
21	Routine Charges			\$ 35,000,000		\$ 13,500,000		\$ 2,500,000		\$ 3,400,000		\$ 2,600,000	
21.01	Calculated Routine Charge Per Diem			\$ 1,033.82		\$ 1,084.77		\$ 1,219.51		\$ 1,152.54		\$ 1,300.00	



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

Cost Report Year (07/01/2021-06/30/2022) Hospital ABC

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		
Line #		Cost Center Description	Diem Cost for Routine Cost Centers	Cost to Charge Ratio for	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
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	Ancillary Charges	Ancillary Charges
22	09200	Observation (Non-Distinct)		0.526189	30,000	45,000	22,500	11,250	33,750	50,625	31,500	44,100	9,000	3,600
23	5000	OPERATING ROOM		0.546425	1,000,000	500,000	250,000	375,000	125,000	62,500	325,000	422,500	75,000	22,500
24	2100	RECOVERY ROOM		0.417408	250,000	312,500	78,125	58,594	97,656	122,070	96,875	120,125	117,188	175,781
25	5200	DELIVERY ROOM & LABOR ROOM		0.894445	30,000	48,000	28,800	11,520	46,080	73,728	47,520	78,408	5,760	1,152
26	5300	ANESTHESIOLOGY		0.111309	150,000	45,000	31,500	53,550	9,450	2,835	12,600	5,040	12,600	5,040
27	5400	RADIOLOGY - DIAGNOSTIC		0.207265	1,250,000	250,000	200,000	360,000	40,000	8,000	60,000	18,000	60,000	18,000
28	5600	RADIOISOTOPE		0.187833	500,000	800,000	480,000	192,000	768,000	1,228,800	720,000	1,080,000	720,000	1,080,000
29	5800	MRI		0.150267	250,000	425,000	297,500	89,250	505,750	859,775	59,500	11,900	59,500	11,900
30	5900	CARDIAC CATHETERIZATION		0.220981	75,000	97,500	29,250	20,475	38,025	49,433	40,950	57,330	40,950	57,330
31	6000	LABORATORY		0.160285	3,200,000	2,240,000	672,000	873,600	470,400	329,280	537,600	430,080	873,600	1,135,680
32	6300	BLOOD STORING PROCESSING & TRA		0.572445	200,000	120,000	48,000	67,200	28,800	17,280	62,400	81,120	59,520	73,805
33	6500	RESPIRATORY THERAPY		0.254689	750,000	1,200,000	720,000	288,000	1,152,000	1,843,200	1,080,000	1,620,000	1,188,000	1,960,200
34	6600	PHYSICAL THERAPY		0.954075	650,000	260,000	156,000	-	62,400	55,000	78,000	39,000	62,400	24,960
35	6700	OCCUPATIONAL THERAPY		0.294641	400,000	360,000	36,000	-	32,400	45,600	28,800	23,040	10,800	3,240
36	6800	SPEECH THERAPY		0.389581	360,000	288,000	57,600	-	46,080	35,000	40,320	28,224	86,400	129,600
37	6900	ELECTROCARDIOLOGY		0.100178	65,000	91,000	36,400	21,840	50,960	71,344	54,600	81,900	7,280	1,456
38	7100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.274681	1,250,000	1,875,000	937,500	468,750	1,406,250	2,109,375	1,312,500	1,837,500	1,312,500	1,837,500
39	7200	IMPL. DEV. CHARGED TO PATIENTS		0.550428	2,620,000	2,096,000	419,200	503,040	335,360	268,288	293,440	205,408	544,960	708,448
40	7300	DRUGS CHARGED TO PATIENTS		0.232972	3,750,000	4,875,000	1,462,500	1,023,750	1,901,250	2,471,625	1,608,750	1,769,625	1,813,500	2,248,740
41	7400	RENAL DIALYSIS		0.637495	56,800	34,080	13,632	19,085	8,179	4,908	6,816	3,408	22,493	37,113
42	7600	GASTRO INTESTINAL SERVICES		0.333926	-	-	54,000	54,000	54,000	54,000	54,000	54,000	21,600	8,640
43	76.01	CARDIAC REHABILITATION		0.196427	7,500	9,000	1,800	1,440	2,160	2,592	2,340	3,042	540	162
44	9100	EMERGENCY		0.333926	899,500	809,550	80,955	89,051	72,860	65,574	97,146	116,575	121,433	182,149
					\$ 17,743,800	\$ 16,780,630	\$ 6,113,262	\$ 4,581,394	\$ 7,286,810	\$ 9,830,831	\$ 6,650,657	\$ 8,130,325	\$ 7,225,023	\$ 9,726,996

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.



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

Cost Report Year (07/01/2021-06/30/2022) Hospital ABC

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Cost to Charge Ratio for Ancillary	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
128	Total Charges (includes organ acquisition from Section J)			\$ 52,743,800	\$ 16,780,630	\$ 19,613,262	\$ 4,581,394	\$ 9,786,810	\$ 9,830,831	\$ 10,050,657	\$ 8,130,325	\$ 9,825,023	\$ 9,726,996
129	Total Charges per PS&R or Exhibit Detail			\$ 52,743,800	\$ 16,780,630	\$ 19,613,262	\$ 4,581,394	\$ 9,786,810	\$ 9,830,831	\$ 10,050,657	\$ 8,130,325	\$ 9,825,023	\$ 9,726,996
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-
131	Total Calculated Cost (includes organ acquisition from Section J)			\$ 38,055,290	\$ 5,069,855	\$ 13,153,546	\$ 1,338,565	\$ 4,196,523	\$ 2,515,861	\$ 4,983,397	\$ 2,276,908	\$ 4,001,540	\$ 2,615,097
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			\$ 25,000,000	\$ 3,500,000	\$ -	\$ -	\$ 1,010,000	\$ 900,000	\$ 2,000,000	\$ 1,200,000		
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 150,000	\$ 25,000	\$ 6,500,000	\$ 750,000	\$ -	\$ -	\$ 150,000	\$ 75,000		
134	Private Insurance (including primary and third party liability)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,750,000	\$ 1,500,000		
135	Self-Pay (including Co-Pay and Spend-Down)			\$ 56,000	\$ 4,500	\$ 15,000	\$ 1,000	\$ 20,000	\$ 500	\$ 12,000	\$ 25,000	\$ 15,000	\$ 2,000
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			\$ 25,206,000	\$ 3,529,500	\$ 6,515,000	\$ 751,000						
137	Medicaid Cost Settlement Payments (See Note B)			\$ -	\$ -	\$ -	\$ -						
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			\$ -	\$ -	\$ -	\$ -						
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)			\$ 25,000		\$ -		\$ 2,500,000	\$ 1,100,000	\$ 15,000	\$ 82,000	\$ 2,000	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ -	\$ -	\$ 250,000	\$ 98,000		
141	Medicare Cross-Over Bad Debt Payments							\$ 75,000	\$ 65,000				
142	Other Medicare Cross-Over Payments (See Note D)							\$ 450,000	\$ 374,500				
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)												
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)												
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)			\$ 12,824,290	\$ 1,540,355	\$ 6,638,546	\$ 587,565	\$ 141,523	\$ 75,861	\$ (1,193,603)	\$ (703,092)	\$ 3,984,540	\$ 2,613,097
146	Calculated Payments as a Percentage of Cost			66%	70%	50%	56%	97%	97%	124%	131%	0%	0%
147	Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed							8,000					
148	Percent of cross-over days to total Medicare days from the cost report							26%					

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 (07/01/2022-06/30/2023)

Hospital ABC

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers From Section G	Medicaid Cost to Charge Ratio for Ancillary Cost Centers From Section G	Uninsured	
				Inpatient (See Exhibit A) From Hospital's Own Internal Analysis	Outpatient (See Exhibit A) From Hospital's Own Internal Analysis
Routine Cost Centers (from Section G):					
1	03000 ADULTS & PEDIATRICS	\$ 1,062.50			
2	03100 INTENSIVE CARE UNIT	\$ 2,218.65			
3	03200 CORONARY CARE UNIT	\$ 2,215.44			
4	03300 BURN INTENSIVE CARE UNIT	\$ 1,760.79			
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -			
6	03500 OTHER SPECIAL CARE UNIT	\$ 1,241.53			
7	04000 SUBPROVIDER I	\$ -			
8	04100 SUBPROVIDER II	\$ 1,046.79			
9	04200 OTHER SUBPROVIDER	\$ -			
10	04300 SURGERY	\$ 1,239.17			
18			Total Days	-	-
19	Total Days per PS&R or Exhibit Detail			-	-
20	Unreconciled Days (Explain Variance)			-	-
21	Routine Charges			Routine Charges	
21.01	Calculated Routine Charge Per Diem			\$ -	-
Ancillary Cost Centers (from W/S C) (from Section G)					
22	09200 Observation (Non-Distinct)		0.181923		
23	5000 OPERATING ROOM		0.052366		
24	5100 RECOVERY ROOM		0.047660		
25	5200 DELIVERY ROOM & LABOR ROOM		0.261198		
26	5400 RADIOLOGY-DIAGNOSTIC		0.069146		
27	5500 RADIOLOGY-THERAPEUTIC		0.092205		
28	5700 CT SCAN		0.029189		
29	5800 MRI		0.058370		
30	6000 LABORATORY		0.025945		
31	6500 RESPIRATORY THERAPY		0.064803		
32	6600 PHYSICAL THERAPY		0.372130		
33	6700 OCCUPATIONAL THERAPY		0.244475		
34	6800 SPEECH PATHOLOGY		0.140415		
35	6900 ELECTROCARDIOLOGY		0.093616		
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.294621		
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.297694		
38	7300 DRUGS CHARGED TO PATIENTS		0.193584		
39	7400 RENAL DIALYSIS		0.131387		
40	7600 ANCILLARY PSYCH		0.420561		
41	7601 DIABETES CENTER		0.826626		
42	7602 CARDIAC CATHETERIZATION LAB		0.070509		
43	9100 EMERGENCY		0.082803		
				\$ -	\$ -
Totals / Payments					
128	Total Charges (includes organ acquisition from Section J)			\$ - (Agrees to Exhibit A)	\$ - (Agrees to Exhibit A)
129	Total Charges per PS&R or Exhibit Detail			\$ -	\$ -
130	Unreconciled Charges (Explain Variance)			-	-
131	Total Calculated Cost (includes organ acquisition from Section J)			\$ -	\$ -

Uninsured days - must agree to Exhibit A.

Uninsured charges - must agree to Exhibit A.

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

Cost Report Year (07/01/2022-06/30/2023) Hospital ABC

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Uninsured	
				Inpatient (See Exhibit A)	Outpatient (See Exhibit A)
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				
134	Private Insurance (including primary and third party liability)				
135	Self-Pay (including Co-Pay and Spend-Down)				
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)				
137	Medicaid Cost Settlement Payments (See Note B)				
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)				
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)				
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)				
141	Medicare Cross-Over Bad Debt Payments				
142	Other Medicare Cross-Over Payments (See Note D)			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)			\$ -	\$ -
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section 1011)			\$ -	\$ -
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)			\$ -	\$ -
146	Calculated Payments as a Percentage of Cost			0%	0%

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



■ DSH SURVEY PART II SECTION H, UNINSURED

- If BOTH of the following conditions are met, a hospital is NOT required to submit any uninsured data on the survey nor Exhibits A and B:
 1. The hospital Medicaid shortfall is greater than the hospital's total Medicaid DSH payments for the year.
 - The shortfall is equal to all Medicaid (FFS, MCO, cross-over, In-State, Out-of-State) cost less all applicable payments in the survey and non-claim payments such as UPL, GME, outlier, and supplemental payments.
 2. The hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals.



■ DSH SURVEY PART II SECTION H, UNINSURED

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.



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

- 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.



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

- 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.



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

In-State organ
acquisitions.

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

Cost Report Year (07/01/2021-06/30/2022)

Hospital ABC

	Total Organ Acquisition Cost	Additional Provider Tax Add-In and Interim Resident Cost	Total Adjusted Organ Acquisition Cost	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondaries)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
					Charges	Useable Organs (Count)	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 133's Total Cost Report Organ Acquisition Cost and the Add-On Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
Organ Acquisition Cost Centers (list below):																
1	Lung Acquisition	\$ -	\$ -	0												
2	Kidney Acquisition	\$ -	\$ -	0												
3	Liver Acquisition	\$ -	\$ -	0												
4	Heart Acquisition	\$ -	\$ -	0												
5	Pancreas Acquisition	\$ -	\$ -	0												
6	Intestinal Acquisition	\$ -	\$ -	0												
7	Islet Acquisition	\$ -	\$ -	0												
8		\$ -	\$ -	0												
9	Totals	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
10	Total Cost															

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary (use hospital's logs and submit with survey).

Note B: Enter Organ Acquisition Payments in Section I as part of your In-State Medicaid total p

Note C: Enter the total revenue applicable to organs furnished to other providers, to organ proc 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 to 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 (07/01/2021-06/30/2022)

Hospital ABC

	Total Organ Acquisition Cost	Additional Provider Tax Add-In and Interim Resident Cost	Total Adjusted Organ Acquisition Cost	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondaries)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondaries)	
					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 133's Total Cost Report Organ Acquisition Cost and the Add-On Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (Note A)	From Paid Claims Data or Provider Logr (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 (use hospital's logs and submit with survey).

Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total



■ 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.
- 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.



■ 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

- 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 surveys.

Cost Report Year (01/01/2021-12/31/2021) HOSPITAL ABC

Enter in GL and
cost report total
tax amount

Worksheet A Provider Tax Assessment Reconciliation:

1 Hospital Gross Provider Tax Assessment (from general ledger)*

1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment

2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)

3 Difference (Explain Here ----->)

Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)

4 Reclassification Code

5 Reclassification Code

6 Reclassification Code

7 Reclassification Code

DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)

8 Reason for adjustment

9 Reason for adjustment

10 Reason for adjustment

11 Reason for adjustment

DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)

12 Reason for adjustment

13 Reason for adjustment

14 Reason for adjustment

15 Reason for adjustment

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

Dollar Amount
\$ -

W/S A Cost Center Line

Tax
reclassification if
any, on W/S A-6

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

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

DSH UCC Provider Tax Assessment Adjustment:

17 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.



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CERTIFIED PUBLIC ACCOUNTANTS

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

Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N)	Routine Days of Care (O)	Total Patient Payments for Services Provided (P)	Total Private Insurance Payments for Services Provided (Q)	Claim Status (Exhausted or Non-Covered Service, if applicable) (R)
3/1/2010	3/11/2010	Inpatient	110	\$ 4,000.00	7			
3/1/2010	3/11/2010	Inpatient	200	\$ 4,500.00	3			
3/1/2010	3/11/2010	Inpatient	250	\$ 5,200.25				
3/1/2010	3/11/2010	Inpatient	300	\$ 2,700.00				
3/1/2010	3/11/2010	Inpatient	360	\$ 15,000.75				
3/1/2010	3/11/2010	Inpatient	450	\$ 1,000.25				
6/15/2010	6/15/2010	Outpatient	250	\$ 150.00		\$ 500.00		Exhausted
6/15/2010	6/15/2010	Outpatient	450	\$ 750.00		\$ 500.00		Exhausted
8/10/2010	8/10/2010	Outpatient	450	\$ 1,100.00				Non-Covered Service



■ 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 2023 cost report year that relates to a service provided in the 2014 cost report year, must be used to reduce uninsured cost for the 2023 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, 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. *Birth Date, SSN, and Gender* may also be requested.
 - 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.



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CERTIFIED PUBLIC ACCOUNTANTS

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Number (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe

											Calculated Hospital Uninsured Collections If (T)="Uninsured" or (U)="Exhausted" or "Non-Covered Service", (Q)/((Q)+(R)+(S))* (N, 0)
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)	
7/12/1995	7/14/1995	1/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
7/12/1995	7/14/1995	2/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
7/12/1995	7/14/1995	3/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
7/12/1995	7/14/1995	4/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
9/21/2000	9/21/2000	9/30/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
9/21/2000	9/21/2000	10/31/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
9/21/2000	9/21/2000	11/30/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
12/31/2009	1/1/2010	5/15/2010	\$ 90	No	Inpatient	\$ 15,000	\$ 1,000	\$ -	Uninsured		\$ 84
12/31/2009	1/1/2010	5/31/2010	\$ 90	No	Inpatient	\$ 15,000	\$ 1,000	\$ -	Uninsured		\$ 84
9/1/2005	9/3/2005	11/12/2010	\$ 130	No	Inpatient	\$ 14,000	\$ 400	\$ 50	Insured	Non-Covered Service	\$ 126



■ 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 Medicare cross-over with Medicaid secondary data (Section H).
 - Self-reported “Other” Medicaid eligible data with Medicaid Secondary (Section H).
 - Self-reported Medicaid FFS & MCO Exhausted and Non-Covered (Section H).
 - All self-reported Out-of-State Medicaid categories (Section I).
 - Additional or adjusted Medicaid FFS/Medicaid MCO/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.



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Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (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)	Discharge Date (L)
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
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
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
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
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
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010
Medicaid MCO	BCBS	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010
Medicaid MCO	BCBS	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010

Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O)	Routine Days of Care (P)	Total Medicare		Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services Provided (T)	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)	Does claim have any coverage other than Medicaid Managed Care? (Y/N)	Comments
				Traditional Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)							
Inpatient	120	\$ 1,200	3	\$ -	\$ -	\$ -	\$ 1,500	\$ 50	\$ -	\$ 1,550		
Inpatient	206	\$ 1,500	1	\$ -	\$ -	\$ -	\$ 1,500	\$ 50	\$ -	\$ 1,550		
Inpatient	250	\$ 100	-	\$ -	\$ -	\$ -	\$ 1,500	\$ 50	\$ -	\$ 1,550		
Inpatient	300	\$ 375	-	\$ -	\$ -	\$ -	\$ 1,500	\$ 50	\$ -	\$ 1,550		
Inpatient	450	\$ 1,500	-	\$ -	\$ -	\$ -	\$ 1,500	\$ 50	\$ -	\$ 1,550		
Outpatient	250	\$ 100	-	\$ -	\$ -	\$ -	\$ 900	\$ -	\$ 75	\$ 975		
Outpatient	300	\$ 375	-	\$ -	\$ -	\$ -	\$ 900	\$ -	\$ 75	\$ 975		
Outpatient	450	\$ 1,500	-	\$ -	\$ -	\$ -	\$ 900	\$ -	\$ 75	\$ 975		
Outpatient	300	\$ 375	-	\$ -	\$ -	\$ -	\$ 1,000	\$ 100	\$ -	\$ 1,100		
Outpatient	450	\$ 1,500	-	\$ -	\$ -	\$ -	\$ 1,000	\$ 100	\$ -	\$ 1,100		



■ EXHIBIT C –1 HOSPITAL-PROVIDED MEDICAID DATA MEDICAID FOR INPATIENT, SECONDARY PAYOR FOR ANCILLARY

- Use the new Exhibit C-1 for inpatient claims only where Medicaid is the primary payor that have a secondary payor that only covers ancillary services.
- The Exhibit C-1 uses the same format as the other Exhibit C's.
- For column “X” please use an “X” to identify these Medicaid primary claims with a secondary payor that only covers ancillary services and should not be reclassified.



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Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (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)	Discharge Date (L)
Medicaid FFS	Medicaid	Medicare Part B	12345	3333333	1234567	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995
Medicaid FFS	Medicaid	Medicare Part B	12345	3333333	1234567	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995
Medicaid FFS	Medicaid	Medicare Part B	12345	3333333	1234567	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995
Medicaid FFS	Medicaid	Medicare Part B	12345	3333333	1234567	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995
Medicaid FFS	Medicaid	Medicare Part B	12345	9999999	1234567	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000
Medicaid FFS	Medicaid	Medicare Part B	12345	9999999	1234567	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000
Medicaid FFS	Medicaid	Medicare Part B	12345	9999999	1234567	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000
Medicaid FFS	Medicaid	Medicare Part B	12345	7777777	1234567	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010
Medicaid FFS	Medicaid	Medicare Part B	12345	7777777	1234567	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010
Medicaid FFS	Medicaid	Medicare Part B	12345	5555555	1234567	2/15/1980	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005

Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O)	Routine Days of Care (P)	Total Medicare Traditional Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services Provided (T)	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)	Does claim have any coverage other than Medicaid FFS/Medicaid Managed Care? (Y/N/X)	Comments
Inpatient	120	\$ 10,000	5	\$ -	\$ -	\$ 1,000	\$ -	\$ -	\$ -	\$ 1,000	X	
Inpatient	250	\$ 10,000	-	\$ 1,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,000	X	
Inpatient	270	\$ 10,000	-	\$ 1,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,000	X	
Inpatient	301	\$ 10,000	-	\$ 1,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,000	X	
Inpatient	120	\$ 2,000	1	\$ -	\$ -	\$ 1,000	\$ -	\$ -	\$ -	\$ 1,000	X	
Inpatient	250	\$ 2,000	-	\$ 1,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,000	X	
Inpatient	270	\$ 2,000	-	\$ 1,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,000	X	
Inpatient	120	\$ 15,000	7	\$ -	\$ -	\$ 1,000	\$ -	\$ -	\$ -	\$ 1,000	X	
Inpatient	270	\$ 15,000	-	\$ 1,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,000	X	
Inpatient	120	\$ 14,000	6	\$ -	\$ -	\$ 1,000	\$ -	\$ -	\$ -	\$ 1,000	X	

■ DSH SURVEY PART I – DSH YEAR DATA

Checklist

- Separate tab in Part I of the survey.
- Should be completed after Part I and Part II surveys are prepared.
- Includes list of all supporting documentation that needs to be submitted with the survey for examination.
- Includes Myers and Stauffer address 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.
2. Signed copy of the DSH Survey Part I – Cost Report Year Data.
3. Electronic copy of the DSH Survey Part II – Cost Report Year Data.
4. Electronic copy of the DSH Survey Part II – Second Cost Report Year Data, if needed.

■ DSH SURVEY PART I – DSH YEAR DATA

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.



■ DSH SURVEY PART I – DSH YEAR DATA

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.



■ DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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.



■ DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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)

■ DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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.



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■ UPDATES - MEDICAID DSH THIRD PARTY PAYOR RULE AND CAA

- Medicaid DSH Third Party Payor Rule resulting from Consolidated Appropriations Act (CAA)
 - Effective October 1, 2021 – Impact started with last years DSH Examination
 - Allotment reductions delayed until SFY 2028 (\$8B reduction per year) (CAA, 2026)
 - 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.
 - Hospitals should continue to report all internal dual-eligible information as in previous years.

***Note: Due to CAA, it is extremely important that hospitals review query logic to ensure claim primary/secondary payors are clearly and accurately classified in submitted exhibits and claims are reported in the proper payor buckets on DSH surveys.**



■ UPDATES - MEDICAID DSH THIRD PARTY PAYOR RULE AND CAA

- Hospitals must indicate on all claims that there is no coverage other than Medicaid by inputting Yes or No in column X in Exhibit C.
- Column Y in Exhibit C is optional, but is provided for hospitals to include an explanation for why a claim should be considered Medicaid primary.

J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O)	Routine Days of Care (P)	Total Medicare Traditional Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services Provided (T)	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)	Does claim have any coverage other than Medicaid FFS/Medicaid Managed Care? (Y/N)	Comments
1	Name (J)														

■ **UPDATES – MEDICAID DSH THIRD PARTY PAYOR RULE AND CAA**

- When reporting payor plans in columns B and C of Exhibit C, use the payor plan description rather than the payor plan code from your hospital's accounting system.
 - Example: "UHC Community Plan MCD" or "UHC Community Plan Medicaid" instead of "UHCCOMPL"
- Provide a detailed payor plan crosswalk that clearly identifies Medicaid payor plans and non-Medicaid payor plans.
- Ensure payments from commercial insurance are included in the Total Private Insurance Payments column (U) and that patient payments are included in Self-Pay Payments column (V).



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■ TAKEAWAYS FOR SFY 2023 DSH

Dual-eligible days, cost, and payments must still be reported on the DSH survey **by all hospitals**.

Grouping all claims into the proper columns on the DSH survey is extremely important to ensuring your hospital's uncompensated care cost can be accurately calculated.

■ PRIOR YEAR DSH EXAMINATION (2022)

Significant Data Issues during 2022 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 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.



■ PRIOR YEAR DSH EXAMINATION

Common Issues Noted During Examination

- Hospitals had duplicate patient claims in the Uninsured, FFS Cross-over, Other Medicaid Eligible and state's Medicaid FFS data.
- Patient payor classes that were not updated. (ex. a patient was listed as self-pay and it was determined that they later were Medicaid eligible and paid by Medicaid yet the patient was still claimed as uninsured).
- Incorrectly reporting elective (cosmetic surgeries) services, and non-Medicaid untimely filings as uninsured patient claims.



■ **PRIOR YEAR DSH EXAMINATION**

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 (2022)

Common Issues Noted During Examination

- 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.
- “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.

■ PRIOR YEAR DSH EXAMINATION (2022)

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 (2022)

Common Issues Noted During Examination

- Some hospitals didn't include their charity care patients in the uninsured even though they had no third party coverage.
- 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
 - Open the 'Welcome to your new Myers and Stauffer portal account' email.
 - Click on 'Activate Account' button within email.
 - A screen to set up your Myers and Stauffer Portal account password is displayed. Click the "Set up" button.
 - Create your password and click the "Next" button.
 - The next screen displays an option to set up an additional account security method. Click the "Set up" button.
 - Select either SMS or Voice call option. Click on the "Receive a code via SMS" button.
 - Check your mobile phone for a text with a verification code. Enter the code and click the "Verify" button.
 - After successfully setting up your password and a second account verification method, you will be directed to a "Successful User Enrollment" page.
 - To log in to the DSH Provider Web application, type the URL (<https://dsh.mslc.com>) in your web browser.

■ 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



LOG OUT



Select a Project

Project

[OK 2023 DSH Examination](#)

Version: 2.0.0.69

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Select appropriate project.



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MAIN

SEARCH PROVIDER

CHANGE PASSWORD

REPORTS

LOG OUT

Select Cost Report Period

Provider:

Fiscal Year:

Verify correct provider and cost report period

History

Legend											
Refresh	Upload	Download	Download PHI	Can't Download PHI	Review is OK	Review is Not OK	Needs Reviewed	Comparison	Show File Information	Mark as Not Applicable	Not Applicable

Legend for available actions

Event Date	Event	Expect Date	Response Date	UserID	Action
No Data For the selected Provider/Cost Report					

List of available events will show here

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Legend

											
Refresh	Upload	Download	Download PHI	Can't Download PHI	Review is Ok	Review is Not Ok	Needs Reviewed	Comparison	Show File Information	Mark as Not Applicable	Not Applicable

To download

To upload

To indicate event is N/A

Event Date	Event	Expect Date	Response Date	UserID	Action
4/24/2025	Initial DSH Data Request (please download)			EGRIMES	 
4/25/2025	DSH Survey Part I (Excel)	6/6/2025		SSMITH	 
4/25/2025	Signed certification from DSH Survey Part I	6/6/2025		SSMITH	 
4/25/2025	DSH Survey Part II (Excel) (1 copy each CR period)	6/6/2025		SSMITH	 
4/25/2025	Exhibit A (in Excel)	6/6/2025		SSMITH	 
4/25/2025	Description of logic used to compile Exhibit A	6/6/2025		SSMITH	 
4/25/2025	Exhibit B (in Excel)	6/6/2025		SSMITH	 
4/25/2025	Description of logic used to compile Exhibit B	6/6/2025		SSMITH	 
4/25/2025	Exhibit C-In-State Mcaid MCO	6/6/2025		SSMITH	 
4/25/2025	Exhibit C-In-State FFS Cross-over	6/6/2025		SSMITH	 
4/25/2025	Exhibit C-In-State Other Medicaid Eligibles	6/6/2025		SSMITH	 
4/25/2025	Exhibit C-Out-of-State Medicaid FFS	6/6/2025		SSMITH	 
4/25/2025	Exhibit C-Out-of-State Medicaid Managed Care	6/6/2025		SSMITH	 
4/25/2025	Exhibit C-Out-of-State FFS Xover	6/6/2025		SSMITH	 
4/25/2025	Exhibit C-Out-of-State Other Medicaid Eligibles	6/6/2025		SSMITH	 
4/25/2025	Description of logic used to compile Exhibit C(s)	6/6/2025		SSMITH	 



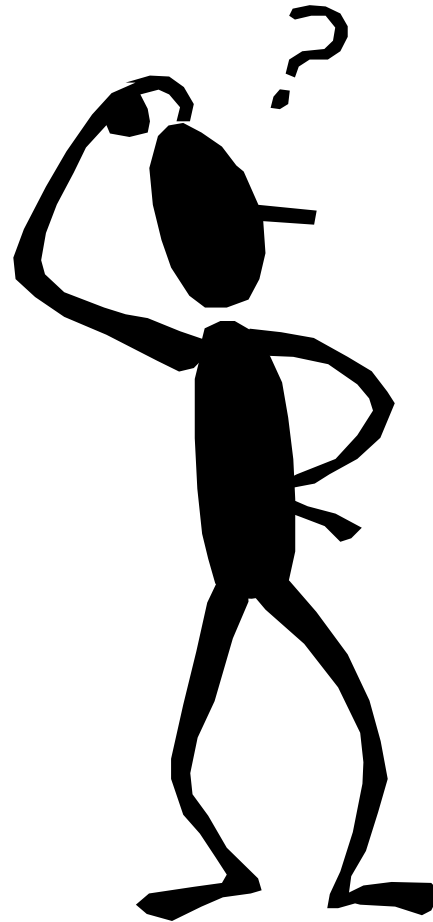
■ WEB PORTAL

Website: <https://dsh.mslc.com>

- Contact okdsh@mslc.com to request registration form or update contact information.



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■ 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).



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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.

■ 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.



■ 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 would not cover beneficiaries over 18.



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■ FAQ

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)*



■ FAQ

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

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

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

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

■ FAQ

7. Can bad debts be considered uninsured?

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



■ FAQ

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

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



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■ FAQ

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

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

■ FAQ

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

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

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

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



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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)*

■ FAQ

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

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

■ FAQ

15. Do other Medicaid eligible claims (private insurance/Medicaid) have to be included in the Medicaid UCC?

For the state plan rate year Beginning on or after October 1, 2021, the Medicaid portion of the hospital-specific DSH limit will only include costs and payments for services furnished to beneficiaries for whom Medicaid is the primary payer for such services.

There is an exception to this methodology for hospitals that are at or above the 97th percentile of all hospitals nationwide with respect to the number of Medicare SSI days or percent of Medicare SSI days to total IP days and where including Medicaid secondary costs & payments benefits them. *(Reporting pg. 13917)*



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■ OTHER INFORMATION

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.

