



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Joe Manchin III  
Governor

Bureau for Medical Services  
Commissioner's Office  
350 Capitol Street - Room 251  
Charleston, West Virginia 25301-3706  
Telephone: (304) 558-1700 Fax: (304) 558-1509

Martha Yeager Walker  
Secretary

MEMORANDUM

DATE: July 10, 2006

TO: West Virginia Medicaid Program Participating Providers:  
Inpatient Hospital Services

FROM: Nancy V. Atkins, MSN, RNC, NP  
Commissioner

A handwritten signature in black ink that reads "Leonard C. Kelley" with a stylized flourish at the end.

RE: SFY 2007 Disproportionate Share Hospital Survey Forms

Please find attached the State Fiscal Year 2007 DSH Survey forms. The data will be used to calculate each hospital's tentative July 1, 2006 to June 30, 2007 (SFY 2007) Disproportionate Share Hospital (DSH) payment. All hospitals must complete and return the attached form by September 1, 2006 to:

Attn: Robert Stewart  
Bureau for Medical Services  
350 Capitol Street, Room 251  
Charleston, West Virginia 25301

SSI coverage days may be found on the CMS website or by contacting your Medicare fiscal intermediary.

Any questions concerning the attached documents should be directed to Robert Stewart at 558-4753.

Attachments

cc:Leonard Kelley



# WEST VIRGINIA DISPROPORTIONATE SHARE WORKSHEET

For State Fiscal Year 2007

Hospital: \_\_\_\_\_

Provider #: \_\_\_\_\_

The following data will be used to determine your facility's eligibility to receive SFY 2007 DSH payments. Please submit data based on your fiscal year 2005 CMS-2552 cost report and other financial reports. New hospitals, or hospitals with significant changes in operations (Example: Conversion to Critical Access Hospital) must use data that fairly reflects their new operations. Data based on their old cost reports may result in an erroneous eligibility determination.

## C. UTILIZATION CRITERIA

1. Total Medicaid Inpatient Days \_\_\_\_\_
2. Total Inpatient Days \_\_\_\_\_
3. Non-Covered Medicaid Inpatient Days  
  - A. Non-Covered under WV Medicaid \_\_\_\_\_
  - B. Non-Covered under Out of State Medicaid \_\_\_\_\_
  - C. Total Non-Covered Medicaid Days \_\_\_\_\_
4. Medicare Covered Days for SSI Recipients \_\_\_\_\_
5. Total Medicare Covered Days \_\_\_\_\_
6. Medicaid Deliveries \_\_\_\_\_
7. Total Deliveries \_\_\_\_\_
8. Total Licensed Beds (FY 2005) \_\_\_\_\_

## D. REVENUE CRITERIA

1. Net FY 2005 Medicaid Inpatient Revenues (Less DSH Payments)  
  - A. In State \_\_\_\_\_
  - B. Out of State \_\_\_\_\_
  - C. Total \_\_\_\_\_
2. Net FY 2005 Inpatient Revenues (Less DSH Payments) \_\_\_\_\_
3. FY 2005 Cash Subsidies for Inpatient Services Received From State or Local Governments. \_\_\_\_\_
4. Total Inpatient Charity Care Charges \_\_\_\_\_
5. Gross Inpatient Revenues \_\_\_\_\_

# WEST VIRGINIA DISPROPORTIONATE SHARE WORKSHEET

For State Fiscal Year 2007

Hospital: \_\_\_\_\_

Provider #: \_\_\_\_\_

## E. FINANCIAL DATA - ALL HOSPITALS

The following data must be submitted by all hospitals. The data will be used to calculate each hospital's tentative SFY 2007 DSH payment limit.

### 1. FISCAL YEAR 2005 COST AND REVENUE DATA

Medicaid Inpatient Cost	_____	
Medicaid Outpatient Cost	_____	
Private Pay (Uninsured) Inpatient Cost	_____	
Private Pay (Uninsured) Outpatient Cost	_____	
Subtotal		_____
LESS:		
Medicaid Inpatient Payment (Less DSH Payment)	_____	
Medicaid Outpatient Payment	_____	
Private Pay (Uninsured) Inpatient Payment	_____	
Private Pay (Uninsured) Outpatient Payment	_____	
Subtotal		_____

### TOTAL - FY 2005 Cost Data

\_\_\_\_\_

Hospitals must adjust the above data to account for significant changes in current year operations, funding, etc. For example, hospitals that convert to Critical Access Hospital status. Please provide the following adjustment information (if applicable):

### 2. ADJUSTMENTS TO FISCAL YEAR 2005 COST AND REVENUE DATA

Medicaid Inpatient Cost Adjustment	_____	
Medicaid Outpatient Cost Adjustment	_____	
Private Pay (Uninsured) Inpatient Cost Adjustment	_____	
Private Pay (Uninsured) Outpatient Cost Adjustment	_____	
Subtotal		_____
Medicaid Inpatient Payment Adjustment	_____	
Medicaid Outpatient Payment Adjustment	_____	
Private Pay (Uninsured) Inpatient Payment Adjustment	_____	
Private Pay (Uninsured) Outpatient Payment Adjustment	_____	
Subtotal		_____

### TOTAL ADJUSTMENTS

\_\_\_\_\_

### 3. TOTAL - FINANCIAL DATA

\_\_\_\_\_

I declare that I have examined this form, including any accompanying schedules and statements, and to the best of my knowledge and belief it is true, correct, and complete.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date