MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

Audit Services – Disproportionate Share Hospital Services

RFQ No. MED13004

February 21, 2013

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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Signature and Certification Page

CERTIFICATION AND SIGNATURE PAGE

By signing below, I certify that I have reviewed this Solicitation in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this bid or proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

Myers and Stauffer LC

(Company)

Mark K. Hilton

(Authorized Signature)

Mark Hilton , Member

(Representative Name, Title)

410-453-5540 410-453-0914

(Phone Number) (Fax Number)

February 18, 2013

(Date)

Addendum Acknowledgment

ADDENDUM ACKNOWLEDGEMENT FORM

SOLICITATION NO.:

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:

(Check the box next to each addendum received)

[X] Addendum No. 1 [ ] Addendum No. 6

[ ] Addendum No. 2 [ ] Addendum No. 7

[ ] Addendum No. 3 [ ] Addendum No. 8

[ ] Addendum No. 4 [ ] Addendum No. 9

[ ] Addendum No. 5 [ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Myers and Stauffer LC

Company

Mark K. Hilton

Authorized Signature

February 18, 2013

Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

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ADDRESS CORRESPONDENCE TO ATTENTION OF
Robert L. Price
304-957-0218

VENDOR
Myers and Stauffer LC
9515 Deereco Road, Suite 500
Timonium, MD 21093

SHIP TO
BUREAU FOR MEDICAL SERVICES
350 CAPITOL STREET, ROOM 251
CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 2/21/2013 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 1

1. TO ANSWER VENDOR QUESTIONS PER THE ATTACHED.

REQUISITION NO.: MED13004

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 X
NO. 2 _____
NO. 3 _____
NO. 4 _____
NO. 5 _____

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Mark K. Utter	410-308-8184	2/18/13

TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE
Member	48-1164042	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
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VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.

Mark K. Hilton
SIGNATURE

Myers and Stauffer LC
COMPANY

February 18, 2013
DATE

END OF ADDENDUM NO. 1

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Mark K. Hilton	410-308-8184	2/18/13

TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE
Memeber	468-1164042	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

Transmittal Letter

February 21, 2013

Mr. Robert Price, Buyer
West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301

Dear Mr. Price:

Myers and Stauffer LC is pleased to present this quotation, including our qualifications and capabilities, to perform the examination of the Medicaid SFY 2010 Disproportionate Share Hospital (DSH) program for the West Virginia Department of Health and Human Resources' (DHHR) Bureau for Medical Services (the Bureau).

Myers and Stauffer will afford you with insight and understanding of DSH programs that other firms simply cannot. Not only does our team have direct experience working with the Department on DSH examinations (formerly as PHBV Partners and now as Myers and Stauffer), we have experience working together to serve DSH clients across the nation. In addition, our team members have served as CMS, state Medicaid, fiscal intermediaries, and hospital leaders charged specifically with addressing the full spectrum of data, calculations and regulations required for this examination. Further, Myers and Stauffer has been actively engaged with CMS, congressional staff, and state Medicaid leaders on DSH auditing since before the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) was adopted in November 2003 was adopted in November 2003. Not only do we have an unsurpassed understanding of the technical requirements, we also possess an unparalleled understanding of the communication process that will be required to be successful in meeting the tight timeline for this effort.

We have been conducting this work longer than any other firm in the nation, as we were the first firm to be engaged by a state to audit pursuant to the Draft Rule (August 2005) and Final Rule (December 2008). We have successfully completed our prior DSH engagement with West Virginia and, currently, we are engaged to perform DSH auditing and other services to 37 Medicaid programs in:

Alaska	Illinois	Mississippi
Alabama	Indiana	Missouri
Arkansas	Kansas	Montana
Colorado	Kentucky	Nebraska
Connecticut	Louisiana	Nevada
Georgia	Maryland	New Hampshire
Hawaii	Massachusetts	New Jersey
Idaho	Michigan	New Mexico

North Carolina	Rhode Island	Washington
North Dakota	South Carolina	Wisconsin
Ohio	Tennessee	Wyoming
Oklahoma	Texas	
Oregon	Virginia	

In addition to our DSH-related services, we provide auditing, consulting and accounting services to Medicaid agencies in nearly all 50 states. Our expertise is also recognized at the federal level where we are currently providing consulting and accounting services to CMS, the U.S. Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), and various U.S. Attorneys across the nation.

Myers and Stauffer's exemplary track record has led to the development of a dedicated team of professionals that are committed to providing the highest quality, responsive, personal service; staying abreast of regulatory changes; and receiving formal training as needed according to professional requirements.

We consistently surpass minimum contract requirements and exceed our clients' expectations. Our proven team of over 550 government health care professionals consistently provides clients with the support they need to effectively and efficiently communicate with the myriad of stakeholders that are impacted by the work we perform. We assist industry leaders, elected officials, program officials, and government staff in obtaining a clear understanding of health care policies, regulatory requirements, and applicable laws that impact them not only today, but into the future. Furthermore, the full breadth and depth of our firm's network of professionals is always available to each engagement team in order to augment their specific areas of expertise.

In addition, Myers and Stauffer affords every management team and client with the benefit of direct communication with high-level regulators and policy makers throughout the nation. This value-added service enables us to provide our clients with unparalleled access, timely insight, and the benefit of solid relationships that have been built through years of professional dialogue and successful service. Our services are just one example of the comprehensive, full-service, client-focused approach that our firm takes in order to surpass our competitors and to contribute to the ongoing success of each state health care agency client.

If you require any additional information regarding Myers and Stauffer or the contents of our response, please contact me at 410-453-5540 (office) or via email at MHilton@mslc.com. We look forward to continuing our relationship with the West Virginia Department of Health and Human Resources.

Sincerely,
Myers and Stauffer LC

Mark K. Hilton

Mark Hilton, CPA
Member

Mandatory/Desired Item Requirements

Our Understanding of the Project

The DSH program was established by Congress in 1981 as a provision of the Boren Amendment. It was intended to provide protection for hospitals, specifically hospitals with large caseloads of low-income and uninsured individuals.

Over the years, there has been a series of legislative amendments that have defined, refined and limited states' use and implementation of the DSH provisions, including:

- *The Omnibus Budget Reconciliation Act of 1986, which stated that HCFA had no authority to limit payment adjustments to DSH hospitals.*
- *The Omnibus Budget Reconciliation Act of 1987, that defined which hospitals, at a minimum, must be included in the DSH program.*
- *The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, which established the first upper bounds on DSH payments.*
- *The Omnibus Budget Reconciliation Act of 1993, which sought to better target DSH hospital payments and set limits on the amounts of DSH payments individual hospitals would be allowed to receive.*
- *The Medicare Prescription Drug Improvement and Modernization Act of 2003, which among other changes included a requirement that states submit a detailed annual report and an independent certified audit on their DSH payments to hospitals.*

While efforts at the federal level have been made to control total DSH expenditures, states still have considerable flexibility in designing their reimbursement systems and determining how available funds are distributed. At Myers and Stauffer, we believe DSH payment systems should be managed in conjunction with other hospital payments to ensure state goals and objectives for the entire hospital payment system are realized. As such, we have developed a DSH examination strategy that is fully compliant with the new federal requirements, while also considering the state's data needs and reporting obligations.

The final rule on auditing Medicaid DSH payments published in the Federal Register on December 19, 2008, implements the requirements of Section 1923(j) of the Social Security Act. This section requires two reports from state Medicaid programs on an annual basis:

1. An annual report from state Medicaid programs detailing information relevant to the DSH payments made under the approved state plan, along with any other information the Secretary of Health and Human Services determines necessary.
2. An independent certified audit of actual uncompensated care cost during the DSH year, along with other data reports (verifications).

The annual report primarily presents the hospital identification information, the "estimate" of the hospital-specific DSH limit, Medicaid inpatient utilization rate (MIUR) calculations, low income

utilization rate (LIUR) calculations, and the state-defined DSH qualification criteria. The final rule identified the DSH data elements that must be reported in the annual unaudited report to CMS.

The independent certified audit includes elements to be gathered for the audit process primarily the calculation of the uncompensated Medicaid costs and uncompensated uninsured costs.

Examination Plan

The state of West Virginia is seeking a contractor to provide a series of independent certified audits of hospitals that have received DSH payments from West Virginia Medicaid.

Our examination program will comply with 42 U.S.C. Section 1923(j)(2) and will be subject to the Bureau's approval prior to beginning fieldwork. We will perform all examination procedures in order to render an opinion and examination report. Please see *Section 3.1.3: Work Plan* for more details.

Compliance

We understand the audits must meet the CMS requirements as specified in 42 CFR Parts 447 and 455 and CMS guidance and requirements. With over nine years of experience conducting DSH audits – including three years as the Bureau's contractor for DSH audits – we know the ins and outs of the DSH rule and will be sure that all requirements are met.

Timing

We have very specific timelines that we adhere to ensure that the engagement is completed and reports issued on or before the CMS guidelines. For SFY 2010, we will complete our work procedures by September 30, 2013. We will then complete a draft report by October 30, 2013 and a final report by November 30, 2013.

Verifications (3.1.1)

The Final Rule requires six verifications at the state level and we will need to perform examination procedures at the hospital level in order to opine on those six verifications. The audit and reporting requirements apply to all states that make DSH payments and to each in-state hospital receiving DSH payments. In addition to issuing an independent certified audit report addressing the six verifications and all other requirements set forth in 42 CFR 447 and 455, we will compile the 18 data elements specified in the regulations for each hospital for each report. We have addressed this in detail in *Section 3.1.3: Work Plan* and have included a draft format of the schedule in *Appendix A: Hospital Schedule.*

Bound Examination Report (3.1.1.1)

We will issue a bound report that expresses an opinion on the six verifications established in the final rule and meet all CMS requirements.

Electronic Examination Audit Report (3.1.1.2)

We will provide the Bureau with an electronic version of the final report, as well as four bound hard copies. In addition, we will provide a hard copy for each hospital included in the report. We will issues these copies in a timely manner based on agreed upon dates.

Experience and Capacity (3.1.1.3)

About Myers and Stauffer

Myers and Stauffer began its government health care accounting practice in 1977. We have experience with virtually all Medicaid program service areas, including skilled nursing facilities, hospitals, federally qualified health centers, managed care delivery systems, home health agencies, physicians, pharmacies and other clinic and practitioner services. Our audit practice remains one of the firm's strongest practice areas.

In January 2013, we strengthened our practice further by acquiring the government health care practice of PHBV Partners LLP. PHBV Partners specialized in government health care accounting, consulting and compliance services. The combined firm becomes the largest CPA firm to perform regulatory health care services for government agencies. The new Myers and Stauffer not only means access to greater resources and expertise, it also means you will be served by the premier player in the regulatory health care industry.

Myers and Stauffer's national practice is focused solely on providing accounting and health care consulting services to state and federal agencies managing government-sponsored health care programs. This includes assisting in the development of state reimbursement systems, defending reimbursement rates and methodologies from health care providers' administrative and judicial challenges, program integrity development and reviews, and performing data management and analysis services. Staffed with professionals who have extensive knowledge and hands-on experience performing audits, desk reviews, and a wide array of rate setting policy, technical, and analytical services, we have earned a reputation for being creative and innovative in helping our clients adapt to an ever-changing health care delivery system.

Myers and Stauffer has 18 offices located throughout the United States, and has served 45 state Medicaid agencies and CMS.

By virtue of our experience, Myers and Stauffer and the proposed project team bring a detailed understanding of state Medicaid programs, as well as a thorough knowledge of DSH audit requirements and other features of hospital financing.

We understand Medicaid policy issues, as well as accounting principles as they apply to the Medicaid and Medicare programs. Our accountants are fully knowledgeable of generally accepted accounting principles (GAAP), generally accepted auditing standards (GAAS) and generally accepted governmental auditing standards (GAGAS). We provide additional educational opportunities for staff through attendance at national health care conferences, training courses sponsored by the American Institute of Certified Public Accountants (AICPA), state boards of accountancy, CPA societies, and periodic in-house workshops to supplement their knowledge of Medicare and Medicaid reimbursement principles.

CPA Firm
Myers and Stauffer is a registered certified public accounting firm in the United States.

Relevant Experience
Since 2010, we have worked with the West Virginia Department of Health and Human Resources to complete the DSH audit reports for state rate plan years 2005, 2006, 2007, 2008 and 2009 and provided recommendations to improve DSH program procedures.

In addition to our work in West Virginia, the following descriptions provide a brief overview of our relevant DSH experience. All of these contracts and engagements have been completed successfully or are on-going.

Myers and Stauffer: Comprehensive List of DSH Clients	
Agency and Dates of Service	**Scope of Services**
Alabama Medicaid Agency *2008-present*	*DSH Audit: W*e have been engaged to perform the 2005 through 2008 DSH audits for Alabama. For the years 2009 through 2011, we have been engaged to compile the DSH program data and calculate the DSH hospital specific limits. Prior to this, we were engaged to perform the state's Certified Public Expenditure (CPE) settlements for 2006, which include a detailed analysis of Medicaid shortfalls and the unreimbursed cost of care for uninsured individuals, which were used to claim FFP. The final reports for the 2005, 2006 and 2007 DSH audits have been completed.
Alaska Department of Health and Human Services *2009-present*	*DSH Audit:* Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. We have performed the state's 2005 through 2009 DSH audits and annual reporting . Myers and Stauffer was recently awarded a renewal of this contract to perform the 2010 DSH audit and annual reporting.
Arkansas Department of Human Services *2009-present*	*DSH Audit:* Myers and Stauffer performed the state's DSH audits for state plan rate years 2005 through 2012. The final DSH audit reports for state plan years 2005, 2006, 2007, 2008 and 2009 have been completed.
Colorado Department of Health Care Policy and Financing *2010-present*	*DSH Audit and Consulting:* Myers and Stauffer has worked on DSH-related projects including creating the DSH Audit Excel template, conducting a DSH Data Gap Analysis and creating the Population Worksheets for DSH Hospitals. In addition, we have completed the DSH audit reports for state rate plan years 2005, 2006, 2007, 2008 and 2009. We are currently working on the 2010 state rate plan year. In addition, we have been contracted to perform the 2011 and 2012 audits.

Myers and Stauffer: Comprehensive List of DSH Clients	
Agency and Dates of Service	**Scope of Services**
Connecticut Department of Social Services *2011-present*	*DSH Audit:* Myers and Stauffer has completed the DSH audits for the 2008 and 2009 state plan years and is engaged to complete 2010.
District of Columbia Department of Health Care Financing *2009-2011*	*DSH Audit:* Myers and Stauffer completed DSH audits for the state plan rates years 2005 through 2007.
Georgia Department of Community Health *2005-present*	*DSH Consulting and Upper Payment Limit (UPL) Calculation:* As the DSH audit contractor for Georgia Medicaid, Myers and Stauffer has completed the 2005-through 2009 DSH audits in compliance with the federal DSH audit regulations. The audits submitted by the state have been accepted by CMS. We also assisted with the redesign and calculation of the Medicaid DSH reimbursement system and technical and accounting issues related to the preparation of Medicare UPL findings for both its nursing facility and inpatient and outpatient hospital programs.
Hawaii Department of Human Services: Med-QUEST Division *2010-present*	*DSH Audit:* Myers and Stauffer has performed the state's 2007 and 2009 DSH audits and annual reporting. The state has recently renewed our contract to perform the 2009 through 2011 DSH audits and annual reporting.
Idaho Department of Health and Welfare *2009-present*	*DSH Audit:* Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer is engaged to perform the 2010 DSH audit and annual reporting.
Illinois Department of Healthcare and Family Services *2010-present*	*DSH Audit:* Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer is engaged to perform the 2010 DSH audit.
Indiana Office of Medicaid Policy and Planning *1995-present*	*DSH Audit, Intergovernmental Transfers, and Upper Payment Limits:* Myers and Stauffer provided consulting, coordination, and administration of disproportionate share hospital payments, hospital care for the indigent payments, intergovernmental transfers, and upper payment limits to support the Indiana Health Coverage Programs (Indiana Medicaid). Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer is engaged to perform the 2010 DSH audit and annual reporting.
Kansas Department of Health and Environment *2002-present*	*DSH Calculation and Audit:* Myers and Stauffer streamlined and improved the DSH eligibility determination process and provided technical expertise as needed. We perform the federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer is engaged to perform the 2010 DSH audit and annual reporting.

Myers and Stauffer: Comprehensive List of DSH Clients	
Agency and Dates of Service	**Scope of Services**
Kentucky Department for Medicaid Services *1998-present*	*Hospital, Long Term Care, DSH and other Facility Rate Setting:* Myers and Stauffer performs rate setting services for hospitals (Freestanding, Psych, DPU, LTAC inpatient and outpatient), long term care facilities, ICF/IDs, FQHC/RHC, and Hospice, Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer is engaged to perform the 2010 DSH audit and annual reporting. In addition to annual audit and reporting, Myers and Stauffer also consults with the state on necessary state plan and regulatory changes that may be needed for federal DSH compliance
Louisiana Department of Health and Hospitals *2005-present*	*UPL/DSH Calculations and DSH Audit:* Myers and Stauffer has assisted the Louisiana Medicaid program with UPL and DSH calculations since 2005 and DSH audits since 2010. Our services include developing data collection tools, preparing UPL and DSH calculations for review and acceptance by the Medicaid program, assisting with meetings attended by hospital representatives and their consultants and assisting with meetings and/or correspondence with CMS officials. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer has begun the 2010 DSH audit and annual reporting.
Maryland Department of Health and Mental Hygiene *2009-present*	*DSH Audits:* Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2008 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer is engaged to perform the 2009 DSH audit and annual reporting.
Massachusetts Medicine and the Center for Health Care Financing *2008-present*	*DSH Audit:* Myers and Stauffer was retained by Massachusetts to perform the DSH audits for the state plan rate year 2005. We are only performing one DSH year as Massachusetts is under a Waiver program for the remaining years. The examination report for 2005 will be submitted to CMS in accordance with the time frames established with the Commonwealth.
Michigan Department of Community Health *2008-present*	*DSH Audit:* Myers and Stauffer has been retained by Michigan to perform the DSH audits for state plan rate years 2005 through 2012. Final reports for 2005, 2006, 2007, 2008 and 2009 have been completed.
Mississippi Division of Medicaid *2009 -present*	*DSH Audit, UPL Calculations and DSH Consulting:* For the Mississippi Division of Medicaid, we have been engaged to perform the 2005, 2006, 2007, 2008 and 2009 DSH audits. In addition, we have been engaged to perform an analysis of the state's DSH program in accordance with the Final Rule as promulgated by CMS on December 19, 2008. Previously, we performed a review of DSH calculations, policies, and procedures as performed by the Mississippi Hospital Association on behalf of the Division of Medicaid. That engagement also included a review of DSH policies and procedures performed at the state level. Moreover, we continue to assist the state in developing a comprehensive plan to maximize DSH and UPL reimbursement in a compliant manner. That project also includes an extensive on-going examination of hospital-specific uninsured charges and payments for compliance with current and proposed regulations. Final reports for the 2005, 2006, 2007, 2008 and 2009 DSH audits have been completed.

Myers and Stauffer: Comprehensive List of DSH Clients	
Agency and Dates of Service	**Scope of Services**
Missouri Department of Social Services *2010-present*	*DSH Audit:* Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports were timely filed and have been accepted by CMS. Myers and Stauffer has begun work on the 2010 DSH audit. Myers and Stauffer has worked with the state and the hospital association to refine their DSH payment to more closely distribute DSH in accordance with the DSH audit rule methodology. We have also assisted the state with provider tax pooling issues that impact the DSH audit.
Montana Department of Public Health and Human Services *2009-present*	*DSH Audit:* Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer has been engaged to perform the 2010 DSH audit and annual reporting.
Nebraska Department of Health and Human Services *2009-present*	*DSH Audit:* Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer has been engaged to perform the 2010 DSH audit and annual reporting.
Nevada Department of Health and Human Services *2008-present*	*DSH Audit and Risk Assessment:* For the state of Nevada, we have completed the 2005, 2006, 2007, 2008 and 2009 DSH examination. We are in the process of completing the 2010 examination. Nevada was among the first states in the nation to meet the CMS original deadline of December 31, 2009 for the submission of the first two DSH audit years. Myers and Stauffer has also provided risk assessment and operational compliance assessment services for its DSH program. Specifically, Myers and Stauffer performs an analysis of the Department's current rules, policies and procedures, including the State Plan under Title XIX of the Social Security Act, an assessment of the risk of non-compliance with current and proposed DSH rules promulgated by CMS, an assessment of the risk that the state's current DSH program operational practices do not ensure compliance with the established policies and procedures, and an analysis and assessment of the risk that the underlying hospital cost data submitted to the Department may not be reliable.
New Hampshire Department of Health and Human Services *2009-present*	*DSH Audit:* Myers and Stauffer has been retained by the state of New Hampshire to perform the DSH audits for state plan rate years 2005 through 2009. The state has submitted the 2005 through 2009 reports to CMS.
New Jersey Department of Health and Senior Services *2010-present*	*Medicaid DSH Audit, Hospital UPL and DRG Rebasing:* Myers and Stauffer completed the 2005 through 2009 Medicaid DSH audits and is currently engaged to perform the 2010 DSH audit. We have assisted the New Jersey Medicaid program with its hospital UPL findings and recently rebased its DRG reimbursement system.
New Mexico Human Services Department *1995-present*	*UPL Calculations and DSH Consulting:* Prepared the Medicare upper limit calculation for use in conjunction with the IGT program; Assisted New Mexico with increasing its DSH allotment and developing its DSH payment plan; Developed DSH survey document for distribution to hospitals; Send DSH survey to hospitals annually and coordinate the receipt of all necessary information for the DSH calculation; Perform annual DSH payment calculations for the state; Provide training to state staff and providers on the UPL and DSH calculations; Performed the Federal DSH audit 2005 to present.

Myers and Stauffer: Comprehensive List of DSH Clients	
Agency and Dates of Service	**Scope of Services**
North Carolina Department of Health and Human Services *2009-present*	*DSH Audit:* Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer has been engaged to perform the 2010 DSH audit.
North Dakota Department of Human Services *2009-present*	*Medicaid DSH Audit:* Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer has been engaged to perform the 2010 DSH audit and annual reporting.
Ohio Department of Job and Family Services *2010-present*	*DSH Audit:* Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer has been engaged to perform the 2010 DSH audit and annual reporting.
Oklahoma Health Care Authority *2009 -present*	*DSH Audit:* Myers and Stauffer has been retained by the state of Oklahoma to perform the DSH work for state plan rate years 2005, 2006, 2007, 2008 and 2009. Final 2005, 2006, 2007, 2008 and 2009 DSH reports have been completed. We are currently under contract to conduct the DSH examinations for 2010.
Oregon Department of Human Services *2009-present*	*DSH Audit:* Myers and Stauffer has been retained by the state of Oregon to perform the DSH audits for state plan rate years 2005 through 2008 with an option for two additional years. The state has submitted the 2005 through 2009 reports to CMS.
Rhode Island Department of Human Resources *2010-present*	*DSH Audit:* Myers and Stauffer was retained by Rhode Island to perform the DSH work for state plan rate years 2005 through 2010. The final DSH reports for state plan years 2005, 2006, 2007, 2008 and 2009 have been completed.
South Carolina Department of Health and Human Services *2006 -present*	*DSH Audit:* For the state of South Carolina, Myers and Stauffer performs an independent audit of their DSH program. This engagement originally followed the guidelines established in the August 2005 proposed Final Audit Rule. Contract terms, scope, and reporting have been refined to adhere to additional guidance and best practices over the past four six years. Specifically, South Carolina currently has 70 hospitals receiving DSH payments under this Medicaid methodology. Myers and Stauffer validates the data on a hospital-specific basis in order to assess compliance with applicable federal and state regulations. We provide testing procedures at two levels - hospital desk verification and state verification. We also assess state policies and procedures to report on compliance with all applicable rules and regulations. Final reports for 2005, 2006, 2007, 2008 and 2009 DSH audits have been completed.
Tennessee: TennCare *2008-present*	*DSH Audit:* The state of Tennessee did not make DSH payments for 2005 and 2006, as their TennCare waiver included all DSH funds. We have been engaged to audit 2007 through 2008 DSH years and to conduct a study of the percentage of cost reimbursed to all hospitals in the state through Medicaid managed care and fee-for-service programs. Due to the unique nature of the TennCare system, it was recently determined that a 2007 DSH report was required and examination procedures are in process. Final submission of the 2008 and 2009 DSH audits are complete.

Myers and Stauffer: Comprehensive List of DSH Clients	
Agency and Dates of Service	**Scope of Services**
Texas Health and Human Services Commission *2009-present*	*DSH Audit:* We have been retained by the state of Texas to perform the DSH examinations for 2005, 2006, 2007 and 2008 and 2009. In addition, Myers and Stauffer has provided other engagements relating to hospital reimbursement including assessments of uncompensated care at five large hospitals as well as an agreed-upon-procedures engagement of the Upper Payment Level (UPL) program for private hospitals in Texas. As part of our work, we have identified program vulnerabilities in the DSH program and have provided our expert views on the administration and regulation of the DSH program in Texas. The final DSH examination reports for state plan years 2005, 2006, 2007,2008, and 2009 have been completed in a timely manner. In addition to merely providing the DSH reports, we have also provided HHSC with a Provider Data Summary Sheet (PDSS) for Texas to use to remain in compliance with 45 CFR § 447.299. We have also provided HHSC with a client communications letter for each MSP rate year that we have examined containing an analysis of the results of our examination that provides added value to the state as it revamps its internal procedures to bring its program into compliance with the Final Audit Rule.
Vermont Department of Human Services *2010-2011*	*DSH Audit:* Myers and Stauffer was previously retained by Vermont to perform the DSH audits for state plan rate years 2005 through 2008.
Virginia Department of Medical Assistance Services *2006-present*	*DSH Audit:* In addition to performing audits of the multi-settlement cost reports for the Virginia state teaching hospitals, which is used to determine the cost of uncompensated care provided to Medicaid Health Maintenance Organization (HMO) patients, indigent patients as defined by the state, uninsured patients based on the Federal definition, and physician's costs of providing care to these groups of patients, we have performed the DSH audits in Virginia from 2005 through 2009. We are currently conducting preliminary DSH examination procedures on all Virginia DSH hospitals for 2010.
Washington Department of Social and Health Services *2009-present*	*DSH Audit:* Myers and Stauffer has completed the DSH examinations for state plan rate years 2005, 2006, 2007 2008 and 2009. The state has submitted the 2005, 2006, 2007, 2008 and 2009 reports to CMS. We are in the preliminary stages of conducting the work for 2010.
Wisconsin Department of Health Services *2012-present*	*DSH Audit:* Myers and Stauffer was retained by Wisconsin to perform the DSH audits for state plan rate years 2009. The final DSH report for state year 2009 has been completed.
Wyoming Department of Health *2009-present*	*DSH Audit:* Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has performed the state's 2005 through 2009 DSH audits and annual reporting. All of the DSH audit reports have been accepted by CMS. Myers and Stauffer has been engaged to perform the 2010 DSH audit and annual reporting.

Organization and Ownership
Myers and Stauffer LC is a limited liability company organized in the state of Kansas.

In the fall of 1998, Myers and Stauffer entered into a transaction with Century Business Services, Inc. (CBIZ). This transaction resulted in the creation of CBIZ M&S Consulting Services, LLC, a wholly owned subsidiary of CBIZ. Through this business model, Myers and Stauffer LC obtains office space, personnel, and other business essentials from CBIZ M&S Consulting Services. These resources, including personnel, are assigned exclusively to serve the clients of Myers and Stauffer.

On January 1, 2013, Myers and Stauffer acquired the government health care practice of PHBV Partners LLP (formerly known as Clifton Gunderson Team Health Care). Like Myers and Stauffer, PHBV specialized in government health care accounting, consulting and compliance services. The combination of these talents, experiences and dedication to governmental health care program issues ensures we will have the resources and knowledge needed to meet each of our contractual obligations.

Our business model complies with American Institute of Certified Public Accountants (AICPA) alternative practice structure guidelines. AICPA professional standards provide specific guidance regarding independence within alternative practice structure firms. These professional standards are published in the Independence, Integrity and Objectivity section of the AICPA Code of Professional Conduct at ET Section 101.16. Myers and Stauffer LC is in full compliance with each of these requirements.

Staff Capacity
With more than 550 professionals who specialize in regulatory health care compliance, we feel that we have the capacity to staff this engagement without hiring additional staff. We know that our clients will not be successful unless we provide them with the highest quality, responsive, and experienced Medicaid consulting staff. We, as a firm and individually, pride ourselves on the depth of experience of our professionals and we will provide that same level of expertise to the state of West Virginia. All staff members dedicated to this contract have direct, hands-on experience performing auditing and consulting services for state Medicaid agencies. These are full time health care compliance professionals, not personnel who do state agency work only in the “slow time” of the year when they are not working on other clients. Furthermore, our supervisory staff committed to this engagement possesses direct DSH audit experience, which will enable us to commence the engagement on day one with unparalleled client service.

Please see *Section 3.1.3.7: Resumes* for an organization chart, biographies and resumes.

Schedule
We will have no issues meeting the deadlines outlined in the RFQ. Please see *Section 3.1.3.1: Timeline* for details.

Independence (3.1.1.4)
Myers and Stauffer is a CPA firm that intentionally limits its services to providing audit, rate setting and consulting services to governmental entities managing health care programs. As a result, the firm is independent of the Medicaid agency as defined by the Comptroller General of the United

States. We have detailed procedures in our Quality Control Manual to ensure compliance with independence requirements and to avoid other conflicts of interest. Our policies are extensive and designed to meet the requirements of the AICPA, the U.S. Securities and Exchange Commission (SEC), PCAOB, state licensing agencies, and Government Auditing Standards. Some of the key elements of our policies include:

- *Independence training for all professionals*
- *Annual written representations of independence from all personnel who perform client services*
- *Extensive client and engagement acceptance and continuance policies*
- *Requirements for confirming independence of outside accounting firms and independent contractors*
- *Maintenance of firm wide client list*

We have included “Chapter 2: Ethical Requirements” of our Quality Control Manual *as Appendix B: Quality Control Manual.*

GAGAS Standards (3.1.1.5)

We will conduct the audit in accordance with generally accepted governmental audit standards as defined by the Comptroller General of the United States and the AICPA's Statements on Standards for Attestation Engagements (SSAEs).

Staff Training (3.1.1.6)

Since many of the issues typically encountered during a Medicaid audit are not taught in a classroom, nor are they discussed in periodicals, it takes substantial exposure to the health care reimbursement field to provide the depth of understanding necessary to arrive at supportable conclusions. Myers and Stauffer incorporates an overview of Medicaid systems into its staff development protocol. This includes a review of pertinent federal statutes and regulations, state plan requirements and state-specific reimbursement requirements. The firm’s resource libraries contain all pertinent resource material including professional pronouncements issued by the American Institute of Certified Public Accountants (AICPA).

The training provided to professional staff is very important. It forms the foundation for high quality work standards. New staff members are given training commensurate with their experience and with their work assignments. They are assigned to our most senior auditors during the training period for supervision and on-the-job training.

As auditors begin their careers with the firm, they are assigned to work with various senior people to give them the broadest possible experience. It is only after the senior members of the firm and the new staff members agree that sufficient training has been acquired that the new staff member is assigned to field work in which he or she is the sole firm participant in the field.

In addition, our professionals routinely attend relevant national health care conferences to stay current with trends and issues. These conferences have included:

- *American Health Lawyers Association: Long Term Care and the Law*
- *American Health Lawyers Association: Institute on Medicare and Medicaid Payment Issues*
- *National Association for Medicaid Program Integrity (NAMPI)*
- *National Association of State Human Services Finance Officers (HSFO)*
- *National Association of Medicaid Directors: Annual Conference*
- *National Health Care Anti-Fraud Association: Annual Training Conference*
- *Health Care Compliance Association: Annual Meeting AICPA National Governmental Accounting and Auditing Update Conferences*

We also conduct local office training sessions that are specific to our Medicaid clients. Recent topics have included:

- *DSH Auditing Updates*
- *Proper Reporting of Insurance Expense*
- *Working Capital Interest*
- *Best Practices in Auditing: Asking the Right Questions and Documenting Accurate Results*
- *Fieldwork Basic Training*
- *Field work Job Set-up Training Basic Medicaid and Medicare Training for New Hires*
- *Appeals Training for Field Staff*
- *Adjustment Reports and Regulations*
- *Medicare Cost Reporting 101*

Our professionals who are CPAs are required to complete 40 hours annually of Continuing Professional Education (CPE). In addition, those employees who work on GAGAS engagements are required to complete in excess of 24 hours annually and 80 hours every two years of CPE as qualified under generally accepted government auditing standards. The majority of our staff exceeds these requirements.

Finally, all training is managed so that there is no disruption to the work on the contract. Staff members are assigned to a project team only after they have successfully completed a training program designed specifically to their needs.

Independence from Providers (3.1.1.7)

We have not, through direct or indirect methods, provided services to any non-state owned or operated provider facilities or facilities previously enrolled in the West Virginia Medicaid program which could potentially be subject to DSH audit or review by the Bureau.

We have no ownership interest and have not held any ownership interest in any entity currently enrolled in the West Virginia Medicaid program or any entity which was enrolled in the West Virginia Medicaid program.

Although highly unlikely, should a conflict arise, Myers and Stauffer will first determine if there is any independence impairment under AICPA independence rules. We will also notify the Bureau of any work performed for a hospital receiving DSH funds. Should an independence impairment or conflict arise, we will subcontract that work to another accounting firm, so as not to conflict with the Bureau audit.

References (3.1.1.8)

Quality of service will be a key factor as you prepare to select a CPA and consulting firm to serve the Bureau. We encourage you to contact the following client references to learn more about our experience and commitment to quality client service. In addition, in *Appendices C – E: Supporting Documentation for References* we have included a copy of the audit reports produced and documentation from CMS acceptance.

DISPROPORTIONATE SHARE HOSPITAL PAYMENT AUDIT SERVICES

PROJECT

Myers and Stauffer has been engaged by the Commonwealth of Virginia to perform the DSH audits for state plan rate years 2005, 2006, 2007, 2008, 2009 and 2010.

Conducted agreed upon procedures of Virginia's DSH program to verify the DSH payments were in compliance with the Virginia State Plan and federal laws and regulations. The engagement was performed to determine whether individual hospitals qualified for DSH payments based upon the criteria set forth in the Social Security Act and the payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act (OBRA) of 1993.

CLIENT

Virginia Department of Medical Assistance Services

William Lessard

Director, Provider Reimbursement Division

600 East Broad Street
Suite 1300
Richmond, Virginia 23219

PH 804-225-4593

William.lessard@dmas.virginia.gov

TERM OF CONTRACT

2009 – Present

SERVICES PROVIDED

- Agreed upon procedures of submitted Medicaid and uninsured claims for reasonableness and allowability under Virginia State Plan and CMS rule guidelines.
- Verification of cost-to-charge ratios from the Medicare cost report used in the calculation for DSH reimbursement.
- Verification of the DSH reimbursement methodology for compliance with the State Plan and Federal laws and regulations.
- Compared the amount of uninsured costs claimed to the amount of DSH payment received by each hospital.

DISPROPORTIONATE SHARE HOSPITAL PAYMENT AUDIT SERVICES

PROJECT

For the state of Nevada, Myers and Stauffer (formerly PHBV) has completed the 2005, 2006, 2007, 2008 and 2009 DSH examination. We are in the process of completing the 2010 examination.

Nevada was among the first states in the nation to meet the CMS original deadline of December 31, 2009 for the submission of the first two DSH audit years. Myers and Stauffer has also provided risk assessment and operational compliance assessment services for its DSH program. Specifically, Myers and Stauffer performs an analysis of the Department's current rules, policies and procedures, including the State Plan under Title XIX of the Social Security Act, an assessment of the risk of non-compliance with current and proposed DSH rules promulgated by CMS, an assessment of the risk that the state's current DSH program operational practices do not ensure compliance with the established policies and procedures, and an analysis and assessment of the risk that the underlying hospital cost data submitted to the Department may not be reliable.

CLIENT

Nevada Department of Health and Human Services

Janice Prentice
Chief, Rates and Cost Containment Unit

1100 E. William Street, Suite 119
Carson City, Nevada 89701

PH 775-684-3791
Jprentice@dhcfp.nv.gov

TERM OF CONTRACT

2009 – Present

SERVICES PROVIDED

- Agreed upon procedures of submitted Medicaid and uninsured claims for reasonableness and allowability under Nevada State Plan and DSH rule guidelines.
- Verification of cost-to-charge ratios from the Medicare cost report used in the calculation for DSH reimbursement.
- Verification of the DSH reimbursement methodology for compliance with the State Plan and Federal laws and regulations.
- Compared the amount of uninsured costs claimed to the amount of DSH payment received by each hospital.

DISPROPORTIONATE SHARE HOSPITAL PAYMENT AUDIT SERVICES

PROJECT

For the state of Missouri, Myers and Stauffer performs federally mandated independent certified audits of the state's DSH program. Myers and Stauffer has completed 2005 through 2009 DSH audits and has begun work on the 2010 DSH audit. Myers and Stauffer has always completed the audits in a timely manner so that the state has always been able to file their reports with CMS by December of each year.

Throughout the DSH audit process, Myers and Stauffer has worked closely with the state staff and the hospital association as well as providing annual training to the hospitals. This is necessary given the complexities of Missouri's DSH program and provider tax pooling arrangements.

CLIENT

Missouri Department of Social Services, MO HealthNet Division

Rebecca L. Rucker, CPA
Assistant Deputy Director

615 Howerton Court
Jefferson City, Missouri 65109

PH 573-751-3737
Rebecca.L.Rucker@dss.mo.gov

TERM OF CONTRACT

2010 – Present

SERVICES PROVIDED

- Develop DSH information tool to obtain required data elements to complete the audit.
- Extract information needed from Missouri Medicaid hospital cost reports and paid claims data.
- Participate in meetings with Missouri hospitals to inform and train on federal DSH requirements.
- Perform desk review procedures on data submitted by Missouri hospitals and assess .risk of each hospital
- Conduct fieldwork on selected hospitals.
- Prepare federally required audit reports.
- Consult with and attend meetings with the Department on modifications to the DSH program to conform with federal requirements.
- Assist the Department with transitioning their DSH payment methodology to be consistent with the DSH audit methodology.
- Technical assistance during CMS audits of the DSH audit work performed.

Exit Conference (3.1.1.9)

We will conduct an exit conference, via Web conference, with the DHHR and Bureau representatives once a preliminary typed draft of the required engagement report has been accepted by the Bureau. The exit conference will be scheduled for an agreed upon date no earlier than 15 days after the delivery of the typed draft to allow for adequate time for review and acceptance by the Bureau. The exit conference will be scheduled for an agreed upon date no later than 30 days after the delivery of the typed draft to allow for adequate time to meet the applicable CMS deadlines in RFQ Section 3.1.

In addition, we will include the Bureau's responses in the final bound report when it is issued.

Management Letter (3.1.2)

We will give the Bureau and applicable DSH hospitals an opportunity to provide a written response to management letter comments. The Bureau's and applicable DSH hospitals' identified contacts will be provided an electronic copy of comments noted during the examination and will be given a date, unless an extension has been requested and granted, by which responses should be provided. Written responses may be provided in an electronic format. Responses will be reviewed to determine if a revision to the comments is necessary.

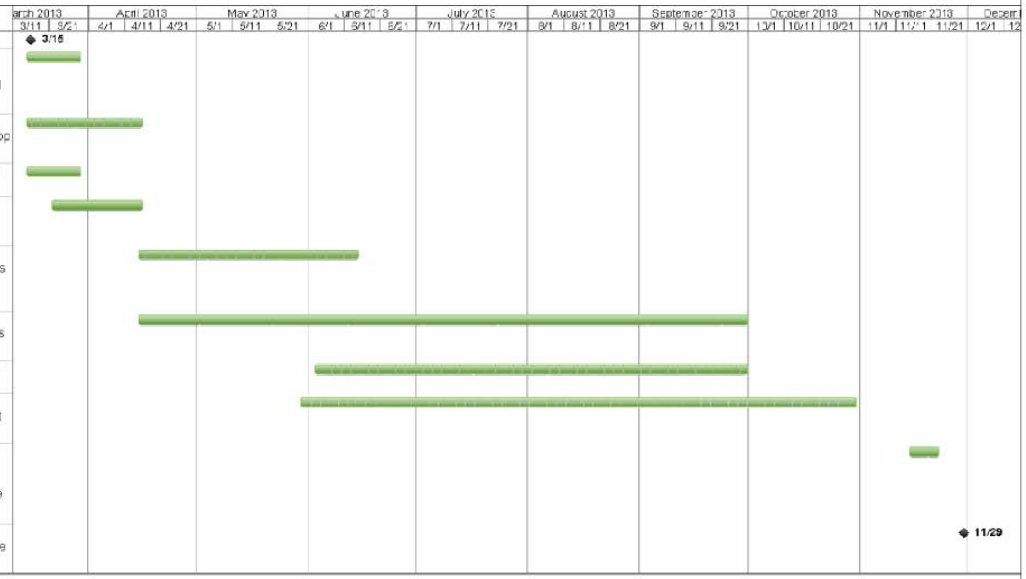
Work Plan (3.1.3)

Timeline (3.1.3.1)

We have included our timeline on the following page to summarize the tasks to be performed and the anticipated completion dates for Medicaid Plan year 2010. The timeline was developed based upon an estimated award date of March 15, 2013 with the delivery of the final report by November 30, 2013. Our plan assumes documentation will be provided very soon after the start date. Any delay in the tasks would likely adversely affect the anticipated completion dates. Our plan anticipates no delay in receiving information from the Bureau. In the event that CMS issues guidance or changes the timelines for submission of the engagements, we will work with the Bureau regarding any necessary changes in order to meet the new CMS requirements.

West Virginia Department of Health and Human Resources, Bureau of Medical Services
Proposed Project Time Line

Task Name	Purpose
Approximate Date Contract Begins	
Conduct Entrance Conference with State representatives	To explain nature of procedures, answer questions, and obtain initial information
Obtain and review DSH Allocation Schedule, MMIS data and any other DSH data from State	To understand nature of payments made and develop audit plan
Finalize work plan with State	To document the approach to the audits
Provide training for hospitals	To explain what and how information needs to be provided
Documentation received from State and hospital	Information on which hospital-specific procedures will be performed
Perform hospital-specific procedures	Ensure the data used to determine DSH allocation is proper
Perform state-level procedures	Ensure DSH payments are proper
Deliver Draft Report	Summarize draft findings and comply with DSH Audit Rule
Exit Conference	Discuss results of procedures with the State representatives and allow adequate time for response
Deliver Final Report	Summarize findings and comply with DSH Audit Rule



DSH Audit Requirements/ DSH Auditing Protocol/ CMS Guidance (3.1.3.2-4)

Having worked on DSH audits with more than 35 states, our project plan is designed to meet CMS's reporting and verification requirements in the most efficient and effective manner possible within the parameters of the applicable auditing standards. Our procedures are designed to be sufficiently flexible should CMS issue further clarifications or guidelines on the type of engagement or standards to be used for the implementation of the Rule.

In order to express an opinion on the verification areas outlined in the DSH Audit Rule, we will perform a mix of analytical procedures and substantive tests at both the state and hospital levels using a risk-based approach. Engagement risk arises from a number of factors including complexity of the program, sensitivity of the work, size of the program, the auditor's access to records, and the adequacy of the audited entity's systems and processes to detect inconsistencies, significant errors or fraud. GAGAS recognizes the existence of engagement risk and allows for auditors to make adjustments to procedures to address these risks. We describe our risk-based approach in greater detail later in this section.

While we are cognizant of the fact that CMS can revise their interpretation of the DSH rule at any time, we can afford the Bureau a high level of assurance of the propriety of our procedures and training material.

Examination Program and Staffing (3.1.3.5)

Examination Program

Myers and Stauffer (previously as PHBV Partners) has been the contractor on this project since the implementation of the DSH audit final rule. Contracting with us, therefore, will provide a fluid transition into the future for both the providers and the state. The providers are familiar with the information to be provided and the professional staff that will be performing the procedures, which provides a great advantage over other contractors. In addition, we have developed an annual process for gathering all of the data needed from the state, which makes the process for the state much more efficient each year.

Many states, including West Virginia, have made DSH payments to hospitals based upon historical data. The data was used to estimate hospital-specific DSH limits, and other data elements necessary to distribute DSH funds under the approved state plan.

Under the final DSH audit rule published December 19, 2008, states must now measure the actual hospital-specific DSH limit for that state plan year and compare that to the DSH payment received. These requirements also specify that Medicare cost reporting principles must be used to calculate the hospital-specific DSH limit, which contains the net unreimbursed cost of providing care to Medicaid and uninsured individuals.

To accomplish this task, it will be necessary to utilize data from several sources. Sources will include existing Medicare cost reports, hospital financial records, and paid claims summaries. In addition, since some data is not readily available or routinely tracked in the provider's accounting records (e.g., charges and payments attributable to the uninsured); we have developed a detailed survey

document for each hospital that received a DSH payment to complete. A sample survey document is included in *Appendix F: Sample Survey.*

A summary of our process is below and details can be found in the next section of our proposal:

- *Begin the project by meeting with the state to discuss the project and all timelines.*
- *Update our DSH survey tool to reflect any changes needed in the future.*
- *Gather necessary data such as MMIS reports, cost reports, state plan, and other data from the state.*
- *Mail surveys to the providers for them to complete and submit to us for audit.*
- *Conduct desk reviews on the surveys.*
- *Using a risk-based approach, we will select providers for expanded procedures.*
- *Complete expanded procedure audits by August 31.*
- *Perform senior management review of desk reviews and audits.*
- *Prepare a draft audit report for submission to the state by October 30.*
- *Meet with the state to discuss the audit report and findings.*
- *Issue the final audit report for submission to CMS by November 30. We will continue to provide you with continuous communication throughout the audit process. In addition to the entrance and exit conferences, we will hold intermittent status meetings to discuss the detailed project plan and our progress towards completion. Further, we will be available to answer any questions and address any concerns during the course of the examination.*

In addition, it is equally important to maintain open lines of communication with the hospitals. The hospitals must be provided with direction on the audit process and the specific information they will be asked to submit. They must also be afforded an avenue to have their questions answered. We have direct hands-on experience in working through many hospital concerns regarding the significant data requests required by the CMS DSH audit rule. Our significant experience in this area will be used to ease the West Virginia hospitals burdens of providing their own specific data.

State Reporting Requirements

Under 42 CFR Section 447.299, states are required to submit to CMS, at the same time as it submits the completed audit required under Section 455.304, the following information for each DSH hospital to which the state made a DSH payment in order to permit verification of the appropriateness of such payments:

1. *Hospital name.* The name of the hospital that received a DSH payment from the state, identifying facilities that are IMDs and facilities that are located out-of-state.

2. *Estimate of hospital-specific DSH limit.* The state's estimate of eligible uncompensated care for the hospital receiving a DSH payment for the year under examination based on the state's methodology for determining such limit.

3. *Medicaid inpatient utilization rate*. The hospital's Medicaid inpatient utilization rate, as defined in Section 1923(b)(2) of the Act, if the state does not use alternative qualification criteria described in Number 5 below.

4. *Low income utilization rate*. The hospital's low income utilization rate, as defined in Section 1923(b)(3) of the Act if the state does not use alternative qualification criteria described in Number 5 below.

5. *State defined DSH qualification*. If the state uses an alternate broader DSH qualification methodology as authorized in Section 1923(b)(4) of the Act, the value of the statistic and the methodology used to determine that statistic.

6. *IP/OP Medicaid fee-for-service (FFS) basic rate payments*. The total annual amount paid to the hospital under the State plan, including Medicaid FFS rate adjustments, but not including DSH payments or supplemental/enhanced Medicaid payments, for inpatient and outpatient services furnished to Medicaid eligible individuals.

7. *IP/OP Medicaid managed care organization payments*. The total annual amount paid to the hospital by Medicaid managed care organizations for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals.

8. *Supplemental/enhanced Medicaid IP/OP payments.* Indicate the total annual amount of supplemental/enhanced Medicaid payments made to the hospital under the State plan. These amounts do not include DSH payments, regular Medicaid FFS rate payments, and Medicaid managed care organization payments.

9. *Total Medicaid IP/OP Payments*. Provide the total sum of items identified in Numbers 6, 7, and 8.

10. *Total Cost of Care for Medicaid IP/OP Services*. The total annual cost incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals.

11. *Total Medicaid Uncompensated Care*. The total amount of uncompensated care attributable to Medicaid inpatient and outpatient services. The amount should be the result of subtracting the amount identified in Number 9 from the amount identified in Number 10. The uncompensated care costs of providing Medicaid physician services cannot be included in this amount.

12. *Uninsured IP/OP revenue.* Total annual payments received by the hospital by or on behalf of individuals with no source of third party coverage for inpatient and outpatient hospital

services they receive. This amount does not include payments made by a state or units of local government, for services furnished to indigent patients.

13. *Total Applicable Section 1011 Payments.* Federal Section 1011 payments for uncompensated inpatient and outpatient hospital services provided to Section 1011 eligible aliens with no source of third party coverage for the inpatient and outpatient hospital services they receive.

14. *Total cost of IP/OP care for the uninsured.* Indicate the total costs incurred for furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for the hospital services they receive.

15. *Total uninsured IP/OP uncompensated care costs.* Total annual amount of uncompensated IP/OP care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive. The amount should be the result of subtracting Numbers 12 and 13 from Number 14.

16. *Total annual uncompensated care costs.* The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental/ enhanced Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services. This should equal the sum of Numbers 9, 12, and 13 subtracted from the sum of Numbers 10 and 14.

17. *Disproportionate share hospital payments.* The total annual payment adjustments made to the hospital under Section 1923 of the Act.

In addition, each state must maintain, in readily reviewable form, documentation that provides a detailed description of each DSH program, the legal basis of each DSH program, and the amount of DSH payments made to each individual public and private provider or facility each quarter.

If a state fails to comply with the reporting requirements contained in this section, future grant awards will be reduced by the amount of Federal Financial Participation (FFP) CMS estimates is attributable to the expenditures made to the disproportionate share hospitals as to which the state has not reported properly, until such time as the state complies with the reporting requirements. Deferrals and/or disallowances of equivalent amounts may also be imposed with respect to quarters for which the state has failed to report properly. Unless otherwise prohibited by law, FFP for those expenditures will be released when the state complies with all reporting requirements.

We will work with the Bureau to compile this information in the proper format so as to ensure it complies with the reporting requirements.

Approach

The examination process will encompass auditing data from approximately 55 hospitals for state fiscal year 2010. To complete the reports, we will gather information for the cost reporting periods that cover the state plan rate year under audit. In cases where the hospital's fiscal year-end may not coincide with the state plan rate year (DSH year), information will be gathered for two or more hospital cost reporting periods. In rare instances when a change of ownership has occurred, it may be necessary to gather data for three cost reporting periods to cover a single state plan rate year.

We will customize the survey tool we have developed to meet the needs of the West Virginia program. This survey tool has successfully been used in other states to collect the data necessary to calculate each of the required data elements in accordance with the guidance provided in the final DSH audit rule. A sample DSH survey is included in *Appendix F: Sample Survey.*

While the methodologies used to calculate the uncompensated care for Medicaid and the uninsured for DSH payment purposes were approved by CMS in the state plan, the final rule requirements specify the cost of caring for Medicaid and the uninsured must be determined using Medicare cost finding techniques. The survey tool will obtain sufficient detail to allow us to calculate the Medicaid and uninsured cost using the routine per diems and ancillary cost-to-charge ratios from the providers' Medicare/Medicaid cost reports.

As part of the audit process, Myers and Stauffer will also perform the following functions as outlined in the final rule.

1. Review State's Methodology

As part of the DSH audit process, we will review the approved Medicaid state plan for DSH payments. This will include reviewing the methodology for estimating each hospital's DSH limit and the state's DSH payment methodologies.

While the main objective of the DSH audit process is to comply with the CMS rule and provide the verifications and reports that are required, there are additional benefits that can accrue for the Bureau through this process. By selecting Myers and Stauffer to perform the audit, the state not only selects a contractor skilled in providing Medicaid audit services, but also a consultant that has a long history of assisting states, including West Virginia, address the complexities of their Medicaid DSH programs.

The audit process established by CMS has allowed states a period of time (until the SFY 2011 DSH audit) to refine their DSH programs before hospital overpayment recoupments are scheduled to occur. It is important that the state select a contractor that is not only able to conduct the audit but is also experienced in designing and implementing DSH payment methodologies. After reviewing the state's methodology for estimating hospitals DSH limits and the state's DSH payment methodologies, our DSH experience will enable us to assist with refining the methodologies to help eliminate the possibility of adverse outcomes when the audit requires recoupment of DSH funds that were paid in excess of the hospital-specific DSH limits.

2. Review of State's DSH Audit Protocol
A review of the state's DSH audit protocol will be performed to ensure consistency with inpatient and outpatient Medicaid reimbursable services in the approved Medicaid State Plan.

3. Compilation of Cost and Revenue
Myers and Stauffer has developed a survey tool to be sent to all in-state hospitals that received a Medicaid DSH payment for the state fiscal years under audit. This document includes sections that will enable providers to cost out their Medicaid and uninsured claims using Medicare cost report mechanics. The survey tool will compile routine per diem costs and ancillary cost-to-charge ratios from the applicable cost reports. The hospitals will then be responsible for grouping their charges and patient days to the appropriate cost centers for costing purposes. As identified in the survey document, there are multiple patient types that must be included in the calculation of the uncompensated care costs, including:

- *In-State Medicaid FFS*
- *In-State Medicaid Managed Care*
- *In-State Medicaid FFS Cross-Over*
- *In-State Other Medicaid-Eligible*
- *Uninsured Services*
- *Out-of-State Medicaid FFS*
- *Out-of-State Medicaid Managed Care*
- *Out-of-State Medicaid FFS Cross-Over*
- *Out-of-State Other Medicaid-Eligible*

The sample DSH survey included in *Appendix F: Sample Survey* provides the hospitals with the appropriate columns to group the days and charges with each of the above patient types to the appropriate per diems or cost-to-charge ratios. The form also provides the appropriate cells to enter the payments received for each of the patient categories. In addition to having the hospitals complete the survey, we will obtain copies of the cost reports for the appropriate cost reporting periods. As part of the examination process, we will verify that the hospitals have entered the appropriate cost-to-charge ratios and per diems on the survey. We will also test the reported days and charges back to the supporting documentation (Medicaid MMIS claims runs, or hospital generated claims detail).

4. Compilation of DSH Payments
We will obtain from West Virginia's Medicaid agency a schedule of DSH payments made for state fiscal year 2010. Upon contract award, we will confirm with the state agency that these are the final DSH payments for each state fiscal year that were claimed as Medicaid DSH payments to CMS.

These payments will be compared to the total calculated uncompensated care costs for each hospital.

5. Compare Hospital-Specific DSH Limits against Hospital-Specific DSH Payments
The audit report will include a schedule that summarizes all in-state hospitals that received a DSH payment in the state fiscal year under audit. The schedule will also include the audited hospital-specific DSH limit (uncompensated care costs) for the period under audit. Hospitals that received DSH funds in excess of their hospital-specific DSH limits will be clearly identified.

The final rule has indicated that the results of the DSH audit, and potential identification of hospitals exceeding their hospital-specific DSH limits, will not be subject to recoupment of the excess funds until the SFY 2011 DSH audit. As mentioned above, it will be important for the state to identify potential overpayment issues and address these issues in its DSH payment methodology prior to making future DSH payments.

In addition to the schedule summarizing each hospital's DSH payment and calculated uncompensated care costs, the reporting requirements in the final rule also require the auditor to identify any data deficiencies or caveats identified during the audit. Throughout the audit process, as data issues or caveats arise, they will be fully documented in the audit work papers. Data issues may include missing or incomplete records due to natural disaster, change of ownership or electronic data retention issues. As issues are identified, alternative procedures will be utilized to verify the data. Any unresolved data issues or caveats will be fully documented and disclosed in the final examination report.

The initial DSH audits have been a learning experience for the Medicaid program and DSH hospitals. Myers and Stauffer works with the hospitals during the audit to address any data gathering or reporting limitations. We keep the state agency apprised of issues encountered.

We will help the Bureau resolve any data limitations encountered during the audits to ensure all issues are addressed by West Virginia hospitals and/or managed care organizations before the audits approach time frames when they may have state/hospital fiscal consequences.

Myers and Stauffer will not only provide the required examination report, we will also take additional steps to help ensure the program is able to correct any current deficiencies to prevent problems in future DSH years.

Verification Requirements
Myers and Stauffer's approach to this examination process begins with thoroughly assessing the risk associated with each of the verifications. We will design testing to mitigate risk. The Myers and Stauffer DSH Desk Review Program is included in *Appendix: G: Audit Program.*

This engagement is unique since the report is to be on a statewide basis, yet the certifications being prepared are at the hospital-specific level. Some level of testing must be completed for each in-state hospital that received a DSH payment. In the final rule, however, CMS acknowledged that a field visit to each hospital receiving a DSH payment is likely not necessary.

Myers and Stauffer anticipates a two-phase examination process with the first phase involving a comprehensive desk review of the data elements necessary for the DSH examination process. Risk thresholds will be established and if exceeded, the hospital will potentially be selected for expanded procedures review, which is the second phase of the examination process.

Desk Review Risk Assessment Process
The initial phase of the process will be to obtain the necessary information from the state agency and the hospitals, organizing each hospital's documents into an electronic work paper. The survey form, central to the entire process, will be checked for mathematical accuracy and completeness. The reported survey elements will be traced to supporting detailed documents, such as Medicaid paid claims summaries, cost report per diems and cost-to-charge ratios traced to the Medicare cost report (2552) and uninsured charges and payments traced to the claims detail provided by the hospital.

The following data sources will be used for the examination: the approved Medicaid state plan for the Medicaid state plan rate year under examination, payment and utilization information from the state's MMIS, the Medicare 2552 hospital cost reports and audited hospital financial statements and accounting records.

The detailed data will be reviewed for consistency with the time periods under examination and to identify any improper claims included in the reported data. Adjustments will be proposed for any identified items and adjusted hospital-specific DSH limits will be calculated.

These adjusted hospital-specific DSH limits will be compared to the DSH payments to initially assess examination risk. The primary examination risk is when a hospital's DSH payment exceeded its hospital-specific DSH limit.

The initial risk assessment will include comparing the preliminary (hospital reported) uncompensated care costs to the DSH payments made for the DSH year. This comparison will allow us to assess the risk of any hospital being paid more than its hospital-specific DSH limit.

We will also analyze all data elements reported and used in the uncompensated care calculation. Myers and Stauffer has many years of experience working with Medicaid DSH data, using this knowledge, we will be able to assess the risk of potential misstatements on the DSH survey, and target these data elements for review.

Based on a review of the data for all hospitals, a risk threshold will be established and hospitals will be selected for detailed desk reviews or expanded procedure reviews. Once the process is complete, we will evaluate the overall coverage of DSH hospitals selected through the risk assessment process. If insufficient numbers of hospitals have been selected, additional ones may be added using selected hospital characteristics or lowering the risk threshold.

Expanded Procedures Examination Process
Hospitals selected for an expanded procedures review will be contacted to discuss the information needed during the expanded procedures review and methods of providing the needed information.

Needed information will include patient financial and medical records, financial statements and supporting general ledgers, as well as charge masters for the period under audit.

The expanded procedures examination process involves testing the accuracy of the data related to the six required verifications. One of the first engagement steps will be to review draft desk review and expanded procedures examination programs that we have developed with state agency officials and use the input to finalize the programs for this project.

Myers and Stauffer's approach to the examination process is to thoroughly assess the risk associated with each of the verifications and design testing to mitigate that risk. Each of the required verifications is identified below along with a discussion of the steps that must be taken to examine this verification.

Verification 1: Each hospital that qualifies for a DSH payment in the state is allowed to retain the payment which is then available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage in order to reflect the total amount of claimed DSH expenditures.

Verification 1 involves obtaining assurance that hospitals are allowed to retain the DSH payment received and are not required to return any of the payment to the state, or are required by the state to use the DSH funds for specific purposes as a condition for receiving the DSH payment. Our preliminary examination procedures will include a review of the approved state plan, DSH calculation and payment process. We will meet with West Virginia Medicaid officials and confirm hospitals are allowed to retain the entire calculated DSH payment. We will question providers to determine if any hospitals were required to return all or a portion of their DSH payment. Additional testing, if needed, will include tracing the DSH payment into the hospital's accounting records and identifying any indications of credits or amounts being returned to the state.

Verification 2: DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited Medicaid State plan rate year, the DSH payments made in the audited Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same audited Medicaid State plan rate year.

To express an opinion on this verification, it is necessary to obtain data to calculate hospital-specific DSH limits. Data sources include the Medicaid agency, the hospital's cost reports for period(s) under review, as well as data obtained from the hospital's internal financial records.

To obtain hospital internal financial records, we propose to survey each in-state hospital that received a DSH payment from the state of West Virginia. A Sample DSH Survey developed to comply with the federal regulations is included in *Appendix F: Sample Survey.*

As indicated in the final rule, it may be necessary to gather data for more than one hospital fiscal year to cover the entire state plan rate year. For this reason, the survey allows the hospital to report multiple years of data.

It is unlikely that all hospitals' fiscal year-ends will coincide with the state plan rate year under examination. CMS indicated in the final rule that it will be acceptable to allocate the calculated hospital-specific DSH limit for each hospital's fiscal year-end to the state plan rate year by the number of months covered. For example, if the state plan rate year under examination ends June 30 and the hospital fiscal year ends December 31, it is acceptable to use six months of the DSH limit calculated for the hospital fiscal year end that covers the start of the state plan rate year, and six months of the DSH limit calculated for the hospital fiscal year end that covers the end of the state plan rate year.

Verification 3: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g)(1)(A) of the Act.

The final rule created a unique issue in the recognition of payments for the uninsured. CMS, in the comments and responses, indicated that payments received on behalf of the uninsured should be recognized on a cash basis. This basically requires hospitals to gather two data sets related to the uninsured for each hospital fiscal year-end under review.

The first data set will be used to generate the days and charges associated with uninsured individuals who received services during the cost report year. The second data set will identify all payments received during the cost report period from individuals who were uninsured.

Since there are two separate data sets required for the uninsured, the testing will be separated by uninsured charges and uninsured payments. While many of the tests will be similar, it is important to test the validity of both data sets.

Uninsured Charges
We will begin testing the hospital's representations of uninsured charges, by reviewing the information system's extraction criteria with hospital representatives. If discrepancies are noted in the definitions utilized in querying the data, we will discuss the best method to eliminate incorrect data or to obtain any additional data needed to meet the federal definitions of uninsured.

Testing will include reviewing the listing to ensure only services provided within the applicable hospital fiscal year were included in the analysis. If needed, detailed testing of the uninsured charges will be accomplished through sampling the individual patients reported uninsured charges.

If expanded testing is needed, the auditors will request access to the patient's financial records for a sample of selected patients. The files will be reviewed to verify the following:

- *Dates of service were within the service period of the cost report under review.*
- *No evidence of available third party coverage (even if no payments were received from the third party).*
- *Charges included on the claim detail were only for inpatient and outpatient hospital services and did not include items such as physician professional fees, provider-based non-hospital units (SNF, NF, HHA, etc.).*
- *Reported charges were the customary charge for that hospital; verified by tracing detailed charges to the hospital's charge master on a sample basis.*
- *Where significant risk for duplicate claims is noted, an electronic match of the data sets may be needed.*
- *Review claims for evidence of large payments that may indicate insurance coverage.*

If exceptions are noted during the testing of uninsured charges, one of two methods will be utilized to eliminate the impact of the exception. It may be possible to eliminate all of the claims that contain the characteristic identified (for example, patients with a billing code of P1, which represent county inmates who should not be included). If so, the specific claims not in compliance with the federal definition of uninsured services will be removed. The second method will utilize statistical extrapolation to adjust known exceptions out of the data. Extrapolation will be used in instances where errors or exceptions were identified but no method of specifically identifying all claims in the claim set that contain that characteristic was available. Myers and Stauffer's extrapolation methodologies have been approved by an expert statistician as required by CMS program integrity guidelines.

After performing the initial testing procedures, risk will again be evaluated and, if it has not been reduced to an acceptable level, additional testing may be required. Additional testing may include expanding the sample of claims, as well as performing additional detailed insurance eligibility reviews of the claims sampled. Once risk has been reduced to an acceptable level, the proposed adjustments will be summarized.

Uninsured Payments

Due to the different recognition criteria (cash basis as opposed to accrual) for the uninsured payments, it is necessary to test the hospital's analysis of received uninsured payments. Many testing steps will be the same as the uninsured charges; however, they will be conducted on a different sample of patients.

The testing will begin by reviewing with the provider the criteria utilized in generating the listing of payments received from the uninsured. If issues are identified in the methodology utilized to query the hospital's financial system, we will identify the most efficient method to acquire the necessary

data, either eliminating unnecessary data from the analysis already provided or obtaining a revised analysis from the hospital.

If necessary, detailed testing of the uninsured payments will involve selecting a sample of claims from the self-pay payment analysis provided with the survey. Unlike the uninsured charge sampling, the payment sampling will include all self-pay payments as opposed to only those received from uninsured patients. This is necessary because a provider may understate its uninsured payments as opposed to overstating them.

We will determine if any payments were received during the cost reporting year under review for the claims sampled in the uninsured charges testing. If payments were received, we will verify the payments are appropriately reflected in the uninsured payments analysis. If needed, the claims sampled from the self-pay payment analysis will be reviewed to determine:

- *Payments were received during the cost reporting period.*
- *All payments received for the patient during the cost reporting period were included on the analysis.*
- *The individual was in fact uninsured during the time services were provided.*
- *Payments for other than inpatient or outpatient hospital services were not included in the analysis. This will include removing the professional portion of any uninsured payments.*
- *Payments shown as "insured" in the self-pay payment analysis were, in fact, insured at the time services were provided.*

Additional testing includes discussing the provider's policy for selling accounts receivable. If the provider sells accounts receivable, additional testing will include reviewing contracts associated with the sales to determine if all payments for the uninsured were properly included in the analysis.

Testing will be performed to determine if the provider has obtained liens against the property of any uninsured individuals. If so, identifying if any payments were received during the cost report year on those liens.

In addition to the self-pay uninsured payments, we will collect illegal alien payments (Section 1011 payments) and compare them to the provider's financials to the extent necessary. Once risk has been reduced to an acceptable level, any proposed adjustments to the hospital's uninsured charges and payments will be summarized and included in the subsequent calculation of the hospital-specific DSH limit.

Verification 4: For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.

In calculating the hospital-specific DSH limit, it is required that all Medicaid payments received by the hospital offset the Medicaid cost of providing inpatient and outpatient hospital services to Medicaid eligible individuals. For testing purposes, we will request paid claims detail from the state agency for both fee-for-service and Medicaid managed care (if applicable) to obtain the payments directly associated with the provided services. In addition, we will request any supplemental or enhanced Medicaid payments (e.g., supplemental payments associated with an upper payment limit program). As part of the survey document sent to providers, we will request information on Medicaid services provided to out of state residents, as well as any DSH payments received from other states.

Uncompensated Medicaid costs will be calculated by first costing out the Medicaid hospital services provided utilizing Medicare cost finding principles. The routine cost centers will be costed utilizing Medicaid days multiplied by cost per diems for each applicable cost center from the Medicare cost report. The ancillary services will be costed utilizing Medicaid charges multiplied by the applicable cost-to-charge ratios from the Medicare cost report. The total cost of providing Medicaid services will be reduced by all payments received for providing inpatient and outpatient hospital services. The resulting amount will be netted against the uncompensated costs of providing services to the uninsured. If the calculation of uncompensated Medicaid costs is negative or a gain, the gain must be used to reduce the uncompensated care services to the uninsured.

Verification 5: Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this section; and any payments made on behalf of the uninsured from payment adjustments under this section has been separately documented and retained by the state.

As part of the examination process, we will gather all necessary documentation to support the claimed expenditures for Medicaid and the uninsured. We maintain our work paper documentation, along with the documents submitted by the provider in an electronic format which enables us to easily and efficiently store the documentation and make it available to others. The documentation will be provided to the state agency upon request at the completion of each year's examination, in a format requested by the state.

Verification 6: The information specified in paragraph (d)(5) of this section includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the state defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient and outpatient hospital services they received.

A detailed description of the methodology used in calculating the hospital-specific DSH limits will be included in the documentation maintained for the state agency. The description will include the definition of incurred inpatient and outpatient hospital costs. Much of this information will be contained in the instructions and survey documents that are developed and distributed on an annual basis to DSH participating hospitals.

Appendix H: Draft Report includes a Sample DSH Examination Report we propose to issue under this contract. The examination report will contain an Independent Accountant's Report in accordance with GAGAS standards. Following the accountants report will be the schedule of hospital-specific data elements specified by CMS in the final rule, including a comparison of each hospital's actual uncompensated care costs for the examination period and the actual DSH payment made.

Included within the data schedule will be any data caveats or exceptions that were noted during the examination process as requested by CMS. These data caveats may include items such as records that were unavailable due to natural disaster or data purging issues within a hospital's electronic records.

Staff Hours

We pride ourselves in performing high-quality, efficient examinations staffed by professionals with the appropriate level of experience and expertise. Below we have outlined our proposed work hours by staff level for the 2010 examinations:

Staff Level	Proposed Hours	Percentage of Engagement
Project Directors	114	5%
Project Manager	354	16%
Supervisor	40	2%
Staff	1,759	77%

Below we have outlined the engagement by examination program section and level of staffing.

Audit Program Section	Staff Level
State Procedures	
General Planning	Project Manager
Statewide Planning	Project Manager, Project Director
Statewide Review	Supervisor, Project Manager
Statewide Wrap-Up	Project Manager
Reporting Procedures	Project Manager, Supervisor, Project Director
Hospital Procedures	
General Procedures	Accountant or Sr. Accountant
Preliminary DSH Survey Review	Accountant or Sr. Accountant. Supervisor, Project Manager, Project Director
Cost Report Review	Accountant or Sr. Accountant
Medicaid Review	Accountant or Sr. Accountant
Other Medicaid Payments	Accountant or Sr. Accountant
Uninsured Review	Accountant or Sr. Accountant
Uninsured Payment Review	Accountant or Sr. Accountant
Charity Care & Subsidies Review	Accountant or Sr. Accountant
Conclusions and Wrap-Up	Accountant or Sr. Accountant, Supervisor, Project Manager

Draft Report Package (3.1.3.6)

We have provided a copy of the examination program in *Appendix G: Examination Program.* This is a preliminary draft program that will be modified prior to implementation to meet the specific needs of the Bureau. We have also provided a sample draft report and opinion letter as *Appendix H: Draft Report.*

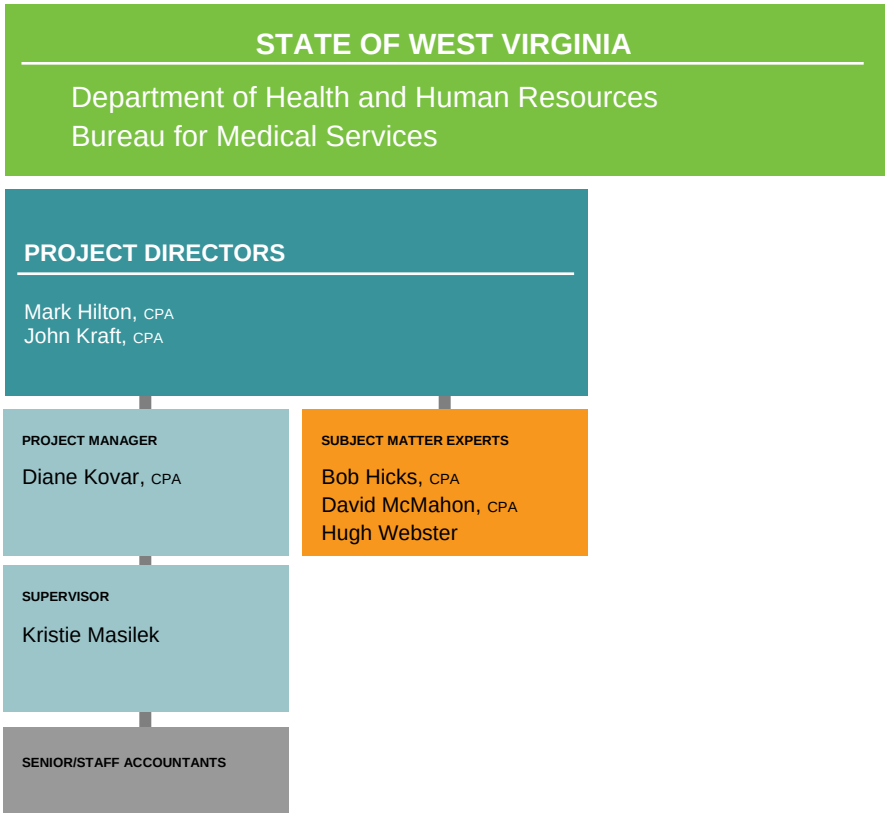
Resumes (3.1.3.7)

Myers and Stauffer staffs each project to exceed our clients' expectations, including meeting all required deadlines. As we demonstrate below, our level of staffing will allow us to seamlessly continue this contract.

As mentioned previously, our professsionals are required to obtain extensive continuing education and are given frequent internal health care specific training to keep up with the ever-changing field of health care. This institutional experience and knowledge is invaluable to the Bureau. We will continue to provide intensive and continuous training for our staff to ensure they understand West Virginia's Medicaid regulations and policies, as well as DSH reimbursement rules. We also cross train our staff, so someone is always available for our clients.

Key Personnel

Our proposed engagement management team has a collective total of over 75 years of health care provider audit experience, including DSH experience. You will see that we have kept the same team as we use in our current engagement thus reducing transition and training time and increasing audit efficiency.



We have designated project directors who have overall responsibility for the engagement, deal with all contract issues, and guarantee top quality service. You will be supplied with all methods of contact information, so that you may contact them at anytime. In addition, we have designated a project manager who will service the engagement on a day-to-day basis. The project manager will also be available to the Bureau at all times. We believe this approach will give each requirement of the contract the high level of attention it deserves. The following descriptions highlight our senior staff members' experience and areas of expertise. In addition, we have included their resumes in *Appendix I: Resumes.*

<u>Key Management</u>

Mark K. Hilton, CPA – Project Director

Mr. Hilton will continue to have overall engagement responsibility and will ensure total client satisfaction and establish the overall client service approach. He has over 29 years of audit

experience relating exclusively to performing health care related services and applying Medicare and Medicaid principles of reimbursement.

In addition to being the current project director for our current hospital audit work in West Virginia, Mr. Hilton also serves as the engagement director for our DSH contracts with the states of South Carolina (since 2005), New Hampshire, Vermont, Oregon, Rhode Island, Colorado, Tennessee, and the District of Columbia. Mr. Hilton has been an active participant in the development of the protocols that have been developed for applying the DSH Audit Rule. He led in the effort to prepare comprehensive and executive summaries of the final rule when it was published by CMS. He has had face-to-face meetings with the CMS primary author of the DSH rule as well as the CMS personnel responsible for implementing the DSH Final Rule. He has also presented specific DSH training to hospitals in South Carolina, West Virginia, and Mississippi, various state representatives, the National Association of Human Services Finance Officers, as well as internal personnel.

He also has experience performing cost report audits for the state of Maryland Department of Health and Mental Hygiene for more than 20 years. Since 1998, Mr. Hilton has directed Myers and Stauffer's health care fraud investigation services provided to various agencies of the Department of Justice including the Criminal and Civil divisions of the United States Department of Justice Commercial Litigation Branch, the Federal Bureau of Investigation, and various Assistant United States Attorneys. These services include investigation of cost report fraud and various other false claims asserted by the government. The types of providers investigated include hospitals, home health agencies, psychiatric hospitals, rehabilitation hospitals, skilled nursing homes, and include involvement in national high profile cases investigating large hospital chains and management companies. Mr. Hilton is also a former Medicare Fiscal Intermediary Audit Supervisor, familiar with reimbursement issues impacting Acute Care Hospitals, Psychiatric and Rehabilitation Hospitals, State-operated Hospitals, Chronic Hospitals, Federally Qualified Health Centers, Rural Health Clinics, Comprehensive Outpatient Rehabilitation Facilities, Outpatient Physical Therapy Facilities, Home Health Agencies, Skilled Nursing Facilities, End Stage Renal Dialysis Facilities, and Home Offices.

Mr. Hilton is a licensed CPA and a member of the Maryland Association of CPAs, the American Institute of CPAs, the Healthcare Financial Management Association, and the American Health Lawyers Association.

John D. Kraft, CPA, CHFP - Project Director
Mr. Kraft will also serve as a project director and ensure total client satisfaction and establish the overall client service approach. For over 27 years, he has performed Medicare and Medicaid audit, desk review and rate calculation services for a number of provider types, including hospitals. These engagements require in-depth knowledge of Medicare cost reporting principles and regulations. He also directs or has directed our DSH audit contracts with West Virginia, South Carolina, New Hampshire, Connecticut, Vermont, Rhode Island, Oregon, Tennessee, Massachusetts and the District of Columbia, In addition, he has provided litigation support for our Medicaid clients' cost report appeals. He also has performed various cost report audit services for Carefirst of Maryland, the former Medicare fiscal intermediary. Most recently, he has been a key participant in the health care litigation support practice area.

Mr. Kraft is a licensed CPA and Certified Health Care Financial Professional. He is a member of the Maryland Association of Certified Public Accountants, the American Institute of Certified Public Accountants, the Healthcare Financial Management Association, and the American Health Lawyers Association.

Diane Kovar, CPA – Project Manager
Ms. Kovar will serve as the project manager for the engagement. She will be your point of contact accountable for scheduling of audits, training and assigning staff, responding to questions (from the Bureau, providers, and staff), and performing the first level management workpaper and report review. She will be available for coordination with the Bureau by telephone and email on a daily basis and for status and issue resolution meetings as needed.

Ms. Kovar has over 14 years of experience with Myers and Stauffer working on health care-related audits, fraud investigations, and litigation support services. In addition to being the Project Manager for West Virginia, she has managed DSH audits in South Carolina and Connecticut. She has also worked on the DSH engagements in Rhode Island, Oregon, and New Hampshire. Outside of DSH, she has worked on health care engagements with the Maryland Department of Health and Mental Hygiene and CMS. Ms. Kovar is a CPA.

Technical Advisors

Robert Hicks, CPA - Subject Matter Expert
Mr. Hicks will be available to assist the Bureau as a subject matter expert on the technical requirements of the DSH rule.

Mr. Hicks has extensive experience with hospital cost report auditing, DSH payments, intergovernmental transfers, and creation of analytical reports and models. He has nearly 17years audit experience in the health care field performing Medicaid/Medicare audits.

Mr. Hicks has performed cost report audits for Medicare and Medicaid in several states. Mr. Hicks has also assisted in provider tax calculations and cost report refinements for the state of Louisiana. Mr. Hicks has also been the lead manager on the firm's DSH audit contracts. He has consulted with several states on their DSH audits and has trained hospitals and state personnel in Missouri, Louisiana, Kentucky, and North Dakota on DSH audits.

Mr. Hicks has been the project lead for the Kansas DSH calculations. In addition, Mr. Hicks oversees the annual Louisiana non-rural community hospital DSH calculations. His duties on both projects include supervising staff in the collection of cost report data, claims data, and uninsured data for use in the calculation of DSH payments. He also develops the actual calculations based on the state plan and produces final payment notifications to all eligible hospitals. He a is licensed CPA.

David McMahon, CPA - Subject Matter Expert
Mr. McMahon will be available to assist the Bureau as a subject matter expert on the technical requirements of the DSH rule. For the past four years, Mr. McMahon has managed multiple hospital and DSH audits for state agencies including Colorado, Texas, Nevada, South Carolina, and Mississippi.

Throughout his 14 years of experience, he has also performed other regulatory health care audit and consulting work for the state agencies of Mississippi, North Carolina, Alabama, Nevada, and Texas. Also, David has a wealth of experience pertaining to hospital reporting and operations including federal and state regulations and policies governing the auditing of Medicaid Programs. In addition to his work on behalf of the government sector, he was previously employed by one of the nation's larger hospitals, where his responsibilities included generating the Medicare cost report each year.

In addition, Mr. McMahon is recognized for his expertise in the area of Medicare and Medicaid hospital reimbursement. He has presented at numerous external and internal health care conferences including DSH presentations for Alabama, Michigan, Nevada, Oklahoma, Pennsylvania, Texas, and Washington. Furthermore, he presented Cost Report Audit Training for CMS Medicare Part A staff. He a is licensed CPA and is a member of both the North Carolina and South Carolina Association of CPAs and the American Institute of CPAs.

Hugh Webster- Subject Matter Expert
Mr. Webster will be available to assist the Bureau as a subject matter expert on the technical requirements of the DSH rule and also as a liaison with CMS as necessary. The former CMS Atlanta Region Branch Manager of Financial and Programmatic Operations of Medicaid and State Children's Health Insurance Program (SCHIP), Mr. Webster possesses over 31 years of audit, management, analysis and consulting experience in the health care industry and government sector. He has extensive knowledge of a broad spectrum of complex Medicaid issues in various states that are critical to the ongoing success of state operations.

Previously responsible for the oversight of long-term care expenditures in eight of the largest Medicaid programs in the nation, Mr. Webster focused on complex hospital reimbursement programs and the state plans, audits, and regulations affecting them. He is highly qualified in areas related to Medicaid and SCHIP agency performance, state Medicaid/SCHIP quarterly budget and expenditure reports, complex funding mechanisms (CPE, IGT, taxes, and donations), and the DSH program. In his professional capacity, Mr. Webster was charged with not only understanding the myriad of complexities associated with institutional reimbursement, but also possessing the ability to articulate these complexities in a manner that was understood by all stakeholders, including CMS leadership, state officials, provider associations, and the Office of Inspector General. Further, Mr. Webster maintains excellent personal and professional relationships with federal regulators and state leaders across the nation.

Staff

Kristie Masilek, Manager
Ms. Masilek will work directly with the project manager in completing the audits of the data provided by the hospitals and the state. She has more than 16 years of experience working on health care-related audits including DSH audits in South Carolina, New Hampshire, Massachuetts, Rhode Island, Vermont, and Connecticut Her other clients have included the Maryland Department of Health and Mental Hygiene, Maryland Health Care Commission, DOJ and CMS.

Additional Staff
We will assign senior associates and associates from our Baltimore, Maryland and Richmond, Virginia offices as needed. We assure the Bureau that the quality of staff will be maintained over the term of the contract agreement due to the depth of our experience with Medicaid agencies.

Training Program (3.1.4)

Experience Providing Training (3.1.4.1)

The success of our internal training programs and our hands-on training, is evidenced through the opportunities that our professionals routinely have to present to national associations, provider groups, state employees, and other stakeholders. In addition, they provide Continuing Professional Education (CPE) compliant training at internal conferences. In addition to the specific West Virginia DSH training presented in 2010, below is a select sample of our most recent training and presentations.

DSH Related Training			
Training	**Date**	**Audience**	**Outcome**
DSH Audit SFY 2010	2/2013	Louisiana Hospitals	Our DSH training benefits both the state and the hospitals. We have received repeated positive feedback from the states that the training has increased efficiency in the audit process by reducing individual questions and issues. The hospital staff have expressed that the training allowed them to understand the process and has facilitated the gathering of information. The training has also resulted in more hospitals completing their initial reports correctly and a reduction in reports that must be resubmitted.
DSH Audit SFY 2010 Update	2/2013	Missouri Hospitals	
DSH Auditing	5/2012	Washington Hospitals	
DSH Auditing	2/2012	Michigan Hospitals	
DSH Auditing	9/2011	Massachusetts Hospitals	
DSH Auditing and CMS Reviews	8/2011	National Association of State Human Services Finance Officers	
DSH Audit Training	8/2011	State of Pennsylvania Bureau of Audits	
DSH Audit Training	8/2011	Connecticut Hospitals	
DSH Audit Training	5/2011	Tennessee Hospitals	
DSH Audit Training	4/2011	New Hampshire Hospitals	
DSH Audit Training	4/2011	South Carolina Hospitals	

Other Regulatory Health Care Training		
Training	**Date**	**Audience**
Certified Public Expenditures Training	12/2012	Tennessee State Representatives
Health Care Fraud: The Government's Response	5/2012	VSCPA Health Care Industry Symposium

Other Regulatory Health Care Training		
Training	**Date**	**Audience**
Auditing 101	4/2012	CMS Regional Offices
Why Audit MCOs?	2/2012	Medicaid Program Institute
Introduction to the Part C and D Payment Process	12/2011	CMS- Center for Program Integrity
Introduction to the Part C and Part D Payment Process	9/2011	National Benefit Integrity Medicare Drug Integrity Contractor
Health Insurance Exchanges	8/2011	National Association of State Human Services Finance Officers
Health Care Reform	8/2011	Virginia Society of Certified Public Accountants,
Medicaid Managed Care Auditing and Accountability	8/2011	National Association for Medicaid Program Integrity Annual Conference
Parts C & D Information Exchange	5/2011	CMS PI Field Offices/ Law Enforcement
Developing Risk Assessments and Work Plans	2/2011	NHCAA Institute for Health Care Fraud Prevention, Health Care Policy & Reform Update
Medicaid Reimbursement for Special Education Services	2/2011	Virginia Association of School Business Officials

Ensuring Training Objectives (3.1.4.2)

We have developed a comprehensive training program based on our knowledge and experience providing DSH audits to over 35 states. In addition, we are constantly revising our program based on feedback, questions and issues raised by our state and hospital audiences. Presenting the training is only a first step to ensuring the understanding of the DSH audit. We provide a copy of the training for states and hospitals to reference as needed, are available to answer further questions and work with providers as the begin their part of the audit.

Sample Training Materials (3.1.4.3)

We have provided sample training materials in *Appendix J:Sample Training Materials.* These materials have been used in our presentations to Missouri, Louisiana, and Texas.

Training Schedule (3.1.4.4)

We will provide training at least two months prior to the beginning of field work and also within six weeks of any new regulations issued by CMS.

Training Location (3.1.4.5)

We will provide initial training onsite with subsequent years and training related to CMS updates by webinar.

Externally Driven Changes (3.1.5)

CMS Procedures (3.1.5.1)

We agree to make all adjustments to audit procedures and reporting that impact the scope of the engagement upon future issuance of guidance by CMS, regardless of the timing of such guidance.

Administrative/Expert Witness Services (3.1.5.2)

Should the need arise for any administrative, expert witness, or other services, we will represent the Bureau. This includes providing services in the event of an audit, provider appeals, or receipt of questions related to our work. We will provide these services until all litigation, claims and/or audit findings are resolved with the federal government regardless of whether our contract period has expired.

Additional Services (3.1.5.3)

We will also provide additional services to comply with externally driven changes to Bureau programs and requirements, including any state or federal laws, rules, and regulations. We understand that additional services should be bid as an all-inclusive hourly rate and shall require Bureau approval of a Statement of Work (SOW) and submission of a related cost estimate.

Cost

REQUEST FOR QUOTATION
[MED13004] [Audit Services – Disproportionate Share Hospital Program]

Exhibit A:

All inclusive, firm fixed price for each audit period:

SFY 2010 (July 1, 2009 – June 30, 2010)

				Total Cost for Audit Period SFY10
Total Cost SFY10 Audit				(A_1) $304,690.00

Additional Services	Hourly Rate	Hours	Total Cost for Audit Period SFY10 (Hourly Rate * 100)
Additional Services	$218.33	100	(A_2) $ 21,833.00

Estimated Grand Total Not to Exceed Cost (A_1+A_2)	(A) $326,523.00

Optional Renewal Periods:

SFY 2011 (July 1, 2010 – June 30, 2011)

				Total Cost for Audit Period SFY11
Total Cost SFY11 Audit				(B_1) $313,830.70

Additional Services	Hourly Rate	Hours	Total Cost for Audit Period SFY11 (Hourly Rate * 100)
Additional Services	$224.88	100	(B_2) 22,488.00

Estimated Grand Total Not to Exceed Cost (B_1+B_2)	(B) $336,318.70

SFY 2012 (July 1, 2011 – June 30, 2012)

				Total Cost for Audit Period SFY12
Total Cost SFY12 Audit				(C_1) $323,245.62

Additional Services	Hourly Rate	Hours	Total Cost for Audit Period SFY12 (Hourly Rate * 100)
Additional Services	$231.63	100	(C_2) $23,163.00

Estimated Grand Total Not to Exceed Cost (C_1+C_2)	(C) $346,408.62

Estimated Grand Total for Three (3) Year Contract Period (A+B+C) $ $1,009,250.32

REQUEST FOR QUOTATION
[MED13004] [Audit Services – Disproportionate Share Hospital Program]

Notes

1. The Vendors Estimated Grand Total Not to Exceed Cost will include all general and administrative staffing (secretarial, clerical, etc.), travel, supplies and other resource costs necessary to perform all services within the scope of this procurement.
2. The hours for Additional Services are estimated and are to be used for cost bid evaluation purposes only.
3. The cost bid proposal will be evaluated based on the Estimated Grand Total for the Three (3) year contract period.
4. The Vendor will invoice in arrears monthly. Payment will be issued in equal monthly increments during the contract period for each audit year, with the last payment withheld until a final audit report is delivered and accepted by the Bureau.
5. Additional services will be reimbursed based on an approved Statement of Work at the hourly rate bid.

Myers and Stauffer LC
(Company)

Mark Hilton, Member
(Representative Name, Title)

410-453-5540
(Contact Phone/Fax Number)

February 18, 2013
(Date)

If applicable, sign and submit the attached Resident Vendor Preference Certificate with the quotation.

While not applicable, we have included the signed form in Appendix: Required Forms.

Appendices

A: Hospital Schedule

Please note that this proposal includes data that shall not be disclosed outside the State Government and shall not be duplicated, used, or disclosed - in whole or in part - for any purpose other than to evaluate this proposal. All data marked CONFIDENTIAL herein are subject to this restriction.

Below is the rationale for those items marked as confidential

- *Hospital Schedule:* The information contained in this Appendix contains proprietary information and/or trade secrets*;* therefore *Appendix A: Hospital Schedule* is marked "Confidential – Not for Public Disclosure"

If you have any questions regarding the above, please contact Mark Hilton at 410-308-8184 or MHilton@mslc.com.

B: Quality Control Manual

CHAPTER 2 Ethical Requirements

[QC §10.21-10.26; 10.A7-10.A10]

It is the policy of the firm that all personnel be familiar with and adhere to relevant ethical requirements of the AICPA in its *Code of Professional Conduct* and pertinent regulatory agencies, and when applicable to the engagement, Generally Accepted Government Auditing Standards.

Certified Public Accountants (CPAs) must be familiar with and adhere to all relevant *AICPA Professional Standards* and requirements of state boards of accountancy and CPA societies for states germane to one's practice area.

The following is offered to clarify this policy:

1. The firm endeavors to avoid situations that present conflicts of interest. It does not accept providers of health care services as clients. It is the policy of the firm not only to maintain independence in fact and appearance, but also in mental attitude. Although not all-inclusive, the following are considered prohibited transactions:

    a. Investments by the firm or its personnel in a client's or health care provider's business, except indirectly as a passive investor through a mutual fund or retirement plan.

    b. Partnership, joint venture, or joint investment by the firm or its personnel with a client or health care provider, or their personnel.

    c. The firm or its personnel borrowing from or making loans to a client or health care provider, or their personnel.

    d. The firm's personnel accepting cash or gifts from or offering cash or gifts to a client or health care provider, or their personnel (with the exception of non-cash token gifts of nominal value).

    e. Certain close family relationships between the firm's personnel and client or health care provider personnel – consult the Quality Control Committee for a ruling and relevant mitigation steps.

f. The firm or its personnel engaging in any activity or undertaking any transaction that may give the appearance that the firm is not independent of a client or a health care provider, or their personnel.

g. The firm or its personnel engaging in any transaction, event, circumstance, or action that would impair independence or violate the firm's ethical policies.

2. When facing situations that raise potential independence threats not specifically addressed by independence rules, one should report the matter to the Quality Control Committee. Such threats will be evaluated by reference to *Conceptual Framework for AICPA Independence Standards* contained in the *AICPA Professional Standards*, Volume 2 ET §100, through professional judgment to determine whether an independence breach exists. When necessary, appropriate authorities from AICPA or state CPA societies are consulted. The firm will take appropriate action to mitigate the threat.

3. Notwithstanding the preceding guidance and list of prohibited transactions, at the Quality Control Committee's discretion, prohibitions can be waived if deemed in the best interest of the firm and if allowed by professional standards.

The firm implements this policy through the following procedures:

Requiring all personnel to sign an Independence, Integrity, and Objectivity Representation when hired, and annually thereafter, that acknowledges familiarity with the firm's relevant ethical requirements policies and procedures, including independence.

Requiring all personnel to promptly notify the Quality Control Committee of any circumstances or relationships that may create a potential threat to independence or an independence breach, so that appropriate action can be taken. To acknowledge these responsibilities, personnel are required when hired, and annually thereafter, to sign the Representation and list known circumstances and relationships that may create a potential threat to independence or violate the firm's ethical requirements policy. The *Code of Professional Conduct* is contained in the *AICPA Professional Standards*, Volume 2 ET and is available in each office. Authoritative resources and advice of the Quality Control Committee should be consulted when one is not sure if a transaction, event, or circumstance may be a violation or should be reported.

Requiring all personnel to determine annually whether their situation (personal and business) involves a prohibited transaction with a state agency or a health care provider or their personnel. If one determines that a prohibited transaction may exist, one is required to review the firm's client list and related health care provider lists. The time sheet program includes a listing of all state agency contracts and is updated regularly. The engagement partner in charge of each

state agency contract maintains a current listing of all health care providers covered under that contract. When hired, and annually thereafter, all personnel are required to sign a representation that confirms this responsibility.

Assigning responsibility for obtaining a signed Independence, Integrity, and Objectivity Representation from all personnel each year to the Quality Control Committee. It is reviewed for completeness and information relating to identified threats to ethical requirements. If a potential threat is identified, the Quality Control Committee communicates relevant information to management so it can take appropriate action to address identified threats. In determining a resolution, refer to paragraph 2 in the clarification above. Documentation of resolution is filed in the employee's personnel folder.

Requiring independence representations from other CPA firms when necessary. During the course of performing an accounting and auditing engagement, the ET may utilize a report prepared by another independent accountant to corroborate the ET's independent findings. Under these circumstances, no independence representation is required from the other auditors. On the other hand, if another auditor performs a segment of our accounting and auditing engagement, a separate independence representation is required from such auditor.

Assigning to the Executive Committee the primary responsibility for determining whether there are unpaid fees by clients that would impair the firm's independence and determine its impact.

Assigning to the Executive Committee the primary responsibility for determining whether actual or threatened litigation has an effect on the firm's independence with respect to a client.

Assigning to the engagement partner the responsibility for promptly notifying the Quality Control Committee when personnel may have violated the firm's independence or other ethics policies or procedures. The engagement partner, in consultation with the Quality Control Committee, may initiate other reasonable steps to mitigate the firm's risk exposure.

Requiring notification of breach. If a breach of independence or other ethics issue is identified, all parties that know of a possible breach in Ethical Requirements should promptly notify the Quality Control Committee. The committee should determine the facts and circumstances and promptly notify the Executive Committee of the incident and recommended action. Recommended action for each incident is determined by facts and circumstances and may include eliminating a personal impairment, requiring additional training, drafting a reprimand letter, or even termination.

Assigning to the Executive Committee resolution of breaches in ethical requirements. The committee confirms its resolution to the Quality Control Committee and notifies other affected parties.

Table of Selected Rules in the AICPA Code of Professional Conduct
(These rules apply to all personnel.)

Description of Rule	Location in Professional Standards*
Article I Responsibilities	ET §52
Article II The Public Interest	ET §53
Article III Integrity	ET §54
Article IV Objectivity, Independence	ET §55
Article V Due Care	ET §56
Article VI Scope, Nature of Services	ET §57
Rule 101 Independence	ET §101.01
Rule 101 Interpretations	ET §101.02-.19
Rule 102 Integrity and Objectivity	ET §102.01
Rule 102 Interpretations	ET §102.02-.07
Ethics Rulings	ET §191.001-.229

* From *AICPA Professional Standards*, Volume 2

C: Supporting Documentation for References – Virginia

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

February 18, 2013

Mr. Robert Price
Buyer
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100
Charleston, West Virginia 25301

Re: *MED 13004 – Documentation of Audit Deadlines*

Dear Mr. Price:

Please accept this notarized letter as documentation that Myers and Stauffer completed the following tasks as part of our Disproportionate Share Hospital (DSH) Audits for the Virginia Department of Medical Assistance Services (DMAS):

- The audit engagement was conducted in accordance with CMS DSH regulations
- The audit engagement was completed by September 30 of the applicable year
- The audit reports were delivered to the State prior to December 30 of the applicable year for filing to CMS in order to satisfy DSH- related regulation requirements
- To our knowledge, the audit reports were accepted by CMS

For additional details, feel free to contact Bill Lessard at DMAS (804-225-4593 or William.Lessard@dmas.virginia.gov).

Sincerely,

Mark K. Hilt
Mark Hilton, CPA, Member

State of MD

County of BALTO to-wit:

Taken, subscribed, and sworn to me before this 18 day of FEB, 2013

My Commission expires MAR. 10, 2016

Linda P. Kromm

LINDA P. KROMM NOTARY PUBLIC BALTIMORE COUNTY, MD

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

9515 Deereco Rd, Ste 500 | Timonium, MD 21093
p: 410.308.8884 | fx 410.453.0904
www.mslc.com

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PROVIDER REIMBURSEMENT DIVISION
Richmond, Virginia

DISPROPORTIONATE SHARE PROGRAM
AGREED UPON PROCEDURES
Medicaid State Plan Rate Year June 30, 2009

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PHBV Partners LLP
www.phbvpartners.com

INDEPENDENT ACCOUNTANT'S REPORT
ON APPLYING AGREED-UPON PROCEDURES

Provider Reimbursement Division
Department of Medical Assistance Services
Richmond, Virginia 23219

We have performed the procedures enumerated in Exhibits I, II and III, of this report, which were agreed to by the Commonwealth of Virginia, Department of Medical Assistance Services (DMAS), solely to assist specified parties in evaluating DMAS's compliance with the Social Security Act as it relates to Medicaid Disproportionate Share Hospital (DSH) payments during the period July 1, 2008 through June 30, 2009, in accordance with 42 CFR 455.304(d) (1). DMAS management is responsible for DMAS's compliance with those requirements. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and the *Government Auditing Standards*, issued by the Comptroller General of the United States. The sufficiency of these procedures is solely the responsibility of the DMAS. Consequently, we make no representation regarding the sufficiency of the procedures either for the purpose for which this report has been requested or for any other purpose.

An overview of the disproportionate share program is included at Exhibit IV of this report. Findings noted as a result of the procedures are presented in Exhibits V.

We were not engaged to, and did not conduct an examination of the matters addressed herein, the objective of which would be the expression of an opinion on such information. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the DMAS and the Centers for Medicare & Medicaid Services and is not intended to be, and should not be, used by anyone other than these specified parties.

PHBV Partners LLP

Richmond, Virginia
December 18, 2012

EXHIBIT I
Page 1 of 2

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PROVIDER REIMBURSEMENT DIVISION
OVERVIEW OF AGREED UPON PROCEDURES

The agreed upon procedures enumerated in **Exhibits II and III,** were performed to assist the Virginia Department of Medical Assistance Services in evaluating its compliance with the Social Security Act (the Act) as it relates to Medicaid Disproportionate Share Hospital (DSH) payments. The objective of these procedures was to verify that:

- Each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the MSP rate year to Medicaid-eligible individuals and individuals with no source of third-party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

- DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited MSP rate year, the DSH payments made in that audited MSP rate year are measured against the actual uncompensated care cost in that same audited MSP rate year.

- Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no third-party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g) (1) (A) of the Social Security Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g) (1) (A) of the Social Security Act.

- For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals, which are in excess of the Medicaid-incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third-party coverage for such services.
- Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and any payments made on behalf of the uninsured from payment adjustments have been separately documented and retained by the State.

EXHIBIT I
Page 2 of 2

- The information specified in the preceding verification (Verification 5) includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g) (1) of the Social Security Act. Included in the description of the methodology, the State has specified how it defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the inpatient hospital and outpatient hospital services they received.

The agreed upon procedures were performed in two phases. In the first phase, DSH hospitals were subjected to desk procedures. The specific procedures are enumerated in **Exhibit II**. In the second phase, the procedures enumerated in **Exhibit III** were applied at the state-wide level to DMAS.

An overview of the Virginia Disproportionate Share Program is included at **Exhibit IV**.

Our findings resulting from these procedures are described in **Exhibit V.**

EXHIBIT II
Page 1 of 10

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PROVIDER REIMBURSEMENT DIVISION
DISPROPORTIONATE SHARE HOSPITAL PROCEDURES

Exhibit A – General Procedures

Purpose: To determine whether the hospital is eligible for DSH.

1. Determine if the provider meets **both** of the following overall DSH qualifications:
    a. Medicaid Day Utilization (MDU) of at least 1%.
    b. Obtain the names of 2 Obstetricians with staff privileges. Obtain the physician's UPIN number from the hospital and determine that the physician was licensed as an Obstetrician thru review of the E-care website at Upin.ecare.com (Rural hospitals may use physicians with any specialty as long as they have staff privileges to perform non-emergency obstetric procedures). Determine that the physician participates in "State" Medicaid by reviewing the State's Medicaid Agency's website. This step does not apply to hospitals that did not offer non-emergency obstetric services to the general population as of December 22, 1987or for hospitals predominantly serving individuals under 18 years of age.
2. Ensure the hospital has met the federal DSH criteria and the State defined DSH qualification criteria.

Exhibit B – Scoping and Planning Procedures

Purpose: To plan and prepare for the Agreed Upon Procedures to determine information needed to satisfy the requirements of the 42 CFR §455.204 in reviewing the Commonwealth of Virginia's Disproportionate Share Hospital program. To review the timing and nature of the engagement with provider personnel and to make preliminary inquiries.

1. Maintain an adjustment summary, on an ongoing basis, to accumulate all proposed adjustments, by period. All adjustments which will not be made must be included on the Passed Adjustment Summary.
2. If this provider has been selected for an onsite visit based upon the State procedures, arrange a date to begin the on site verification procedures that is mutually agreeable with provider personnel by telephone. Instruct the personnel what records will be needed to complete the procedures on-site. If feasible, inform the provider personnel of the duration of the onsite visit and how many staff members are assigned to the engagement.
3. Maintain documentation of written communications with provider of arrangements made in Step #2.
4. Review all pertinent provider files, including cost report package for the provider fiscal year(s) under review, most recently issued Medicare Notice of Program Reimbursement (NPR), prior years' work papers, correspondence files, permanent

files, etc. Make note of any items which will require special attention and cross-reference to the appropriate work papers.

5. Maintain throughout the engagement procedures, a "Notes to Subsequent Reviewers" for use in following cost reporting periods. These notes should include any adjustments or items which may effect the subsequent year(s).
6. Review the following from the prior year work paper binder for possible material impact on the current year cost report:
    a. Notes to subsequent reviewers
    b. Audit Results Summary
7. Prepare the Engagement Planning Guide. Conduct a planning meeting with the engagement Manager, Senior Manager, and/or Partner. Prepare budget worksheet.
8. For on-site reviews, upon arrival at the Provider's office, conduct an entrance conference with the appropriate Provider personnel to include the following:
    a. Determination of provider personnel who will be contacted during the course of the onsite for information, explanations, documents, etc.
    b. Discuss the guidelines that ill govern the conduct of onsite procedures. This includes the need to have records available in a reasonable time, availability of provider personnel who can answer questions and problems encountered during the verification procedure will be discussed with appropriate personnel for resolutions.
    c. Discuss the nature of the procedures being conducted
    d. Document the entrance conference and the provider's responses.

Exhibit C – Working Trial Balance (WTB) and Financial Statement Reconciliation

***Purpose:** To determine that the cost report was prepared from documents generated from the provider's accounting system. To resolve any material differences between the WTB, Cost Report and/or the Financial Statements.*

Important Note to Auditors: The CMS Audit Protocol states that the Medicare cost allocation process will be used to determine facility costs for inclusion in determining DSH eligible hospital costs. In order to provide complete financial information for the Medicaid State plan (MSP) rate year under audit, hospitals must use two or more Medicare costs reports if the cost reporting period does not correspond with the MSP rate year under audit. Once costs are allocated according to the Medicare cost allocation process, those costs should be allocated to the MSP rate year on a pro-rata basis to develop 12 full months of cost. Bear this in mind when requesting WTB and other cost report information from the hospitals.

1. Determine if the State Medicaid agency has performed a review of the cost report(s) covering the MSP rate year. If no review performed, proceed to step #2, otherwise continue to step #4.
2. Determine if Medicare has issued a Notice of Provider Reimbursement (NPR) for cost report(s) during the MSP rate year. Obtain copy of the NPR. If the provider gave a paper copy of the NPR and NOT an electronic Medicare audited MCA file, then review the paper adjustment report from Medicare and determine if any adjustments

were made to worksheet A, worksheet C, the S-3 and apply those adjustments in the HFS software using the Medicare auditor tool. Place a PDF copy of your applied adjustments from HFS into the FX binder for review purposes.

3. Obtain the provider's expense and revenue mapping schedules.
4. Review the audited financial statements along with the notes for any significant items with potential uncompensated care impact. Follow-up on noted items as needed.
5. Determine if provider is a transplant facility. If so, obtain Medicaid and uninsured transplants by organ and uninsured by organ. Use CMS 2552 w/s D-6, Part III to calculate cost of transplants.

Exhibit D-Medicaid Fee for Service Settlement Data

Purpose: To determine that the Medicaid fee for service settlement data is presented in accordance with 42 CFR 447.299(c).

1. Obtain the Virginia Medicaid Management Information Systems (VAMMIS) summary report of charges, payments and days for the facility service dates during the corresponding cost reporting period from the State Medicaid Agency (or fiscal intermediary if applicable) that applies to the MSP rate year under review.
2. Review the VAMMIS summary report and ensure that in addition to regular Medicaid fee for service payments, the data also includes the following:
    a. No Pay or zero paid claims (Other third party payer pays more than the entire Medicaid payment amount)
    b. Medicare Crossover payments
    c. Third Party Payments (actual payments, not Medicaid liability)
    d. Coinsurance and deductible information
3. Prepare work paper which calculates the variances and adjustments between the amounts reported by the provider and those reflected on the VAMMIS summary report. Utilize the provider prepared mapping of revenue codes by cost center to the extent it is applicable, reasonable and necessary.
4. Utilizing the VAMMIS summary report, propose adjustments to the following cost report worksheets as necessary:
    a. Medicaid Inpatient ancillary charges on DRG-796, Exhibit D, Part 1, and Medicaid days on Exhibit D-1, Part I.
    b. Medicaid Outpatient ancillary charges on Exhibit C.
    c. Medicaid payments on Exhibit S.
5. Using the most recent Medicaid settled cost report, determine cost settlement payments made to provider for inpatient and outpatient hospital services. DO NOT include settlement payments related to DSH, GME, IME, or other supplemental payments.
6. If dual eligible accounts and Medicaid unbilled accounts are not included in the VAMMIS report, obtain detail from provider. Review to determine if amounts reported by the provider are 1) within the correct date range; 2) not duplicated; and 3) have appropriate payer and insurance codes. Propose adjustments if necessary.
7. Prepare a work paper which utilizes the provider prepared mapping of revenue codes by cost center to the extent it is applicable and apply the mapping the data from #6

above in order to determine the cost center specific days and charges. If a crosswalk was not provided, allocate charges based on the settled Medicaid cost report charges and days.

8. Apply cost center specific per diems and cost to charge ratios to cross walked (or allocated) days and charges to calculate additional Medicaid FFS cost.
9. Determine if the hospital receives GME payments from the State. If so, obtain GME cost calculation work paper form the settlement file. If it was not completed during settlement, compute GME costs using the GME cost calculation template.
10. Summarize data from Medicaid FFS analysis above for inclusion of IP/OP Medicaid fee-for-service (FFS) basic rate payments and Total cost of Care for Medicaid IP/OP Services on the Provider Data Summary Schedule (PDSS).

Exhibit E – Medicaid Managed Care and Out of State Settlement Data

Purpose: To determine that the Medicaid Managed Care and Out of State settlement data is presented in accordance with 42 CFR 447.299(c).

1. Identify Medicaid Managed Care Organizations that had members served by the provider during the portion of the cost reporting period that is within the MSP rate year. Ensure that all documentation has been obtained for these claims. Review to determine if amounts reported by the provider are 1) within the correct date range; 2) not duplicated; and 3) have appropriate payer and insurance codes. Propose adjustments if necessary.
2. Identify payments from other states for Medicaid eligible patients and for uninsured patients to whom the hospital provided services during the portion of cost reporting period that is within the MSP rate year. Review to determine if amounts reported by the provider are 1) within the correct date range; 2) not duplicated; and 3) have appropriate payer and insurance codes. Propose adjustments if necessary.
3. For the Medicaid out of state claims, review the MMIS summary report or other available documentation and ensure that in addition to regular Medicaid fee for service payments, the data also includes the following:
    a. No Pay or zero paid claims (Other third party payer pays more than the entire Medicaid payment amount)
    b. Medicare Cross Over payments
    c. Third Party Payments (actual payments, not Medicaid liability)
    d. Deductibles and coinsurance amounts
4. Calculate the ratio of MCO and/or OOS charges (to be analyzed separately) to the sum of all Medicaid plus Uninsured charges. Determine if this ratio is greater than the state average ratio for MCO; or 10% for OOS.
    a. Yes – proceed to procedure #5
    b. No – proceed to procedure #7
5. For medium and high risk DSH hospitals, select a random sample of 81 inpatient accounts (10 for replacements) and 81 outpatient accounts (10 for replacements). The random sample is based upon attribute testing with a 90% confidence level and 10% margin of error, with four attributes. For low DSH hospitals, select the largest ten accounts for testing to verify reasonableness of amounts included. Upload the sample listing(s) to secured website. Communicate with provider concerning the upload of

the samples, documentation needed for the samples and deadline date for documentation to ready for review. Document conversation with provider in correspondence file. Summarize data for inclusion of IP/OP Medicaid managed care organization payments and Total cost of Care for Medicaid IP/OP Services on the PDSS.

6. Review each sample for the following:
   a. Evidence that the service was performed and is a covered service as defined by Medicaid State Plan.
   b. That amounts in provider MCO/OOS charges detail are accurate.
   c. Verify that the patient was covered by MCO/OOS.
   d. That no professional fees are included in uninsured charges (including CRNA's).
7. Prepare a work paper which utilizes the provider prepared mapping of revenue codes by cost center to the extent it is applicable and apply the mapping to the MCO and OOS charges and determine the cost center specific MCO and OOS days and charges. If a crosswalk was not provided, allocate charges based on the settled Medicaid charges.
8. Apply cost center specific per diems and cost to charge ratios to cross walked (or allocated) days and charges to calculate the MCO and OOS cost.
9. Summarize data for inclusion of IP/OP Medicaid MCO and OOS fee-for-service (FFS) basic rate payments and Total cost of Care for Medicaid MCO and OOS IP/OP Services on the PDSS.

Exhibit F – Review of Uninsured Charges

Purpose: Determine that hospital reported accounts meet uninsured criteria as defined in Social Security Act §1923(g) (1) (A). Verify amount for hospital reported based on 42 CFR §447.299(c) (14).

1. From the DRG-796, Exhibit H-1, if Total DSH Payments exceed Total Medicaid Unreimbursed Costs, proceed to Step 3. If Total Medicaid Unreimbursed Costs exceed Total DSH Payments proceed to Step 2.
2. Obtain signed letter from the hospital that states the hospital Medicaid losses exceeded its DSH payment and that, in addition, it did have uninsured losses. Retain the list of uninsured detail, and review payer types and date range for reasonableness. Then, proceed to Step 20.
3. Identify and remove from the uninsured detail accounts that are not inpatient and/or outpatient hospital services (excl. Skilled nursing, home health, outpatient dialysis, outpatient prescription pharmacy, dental services, etc). Separate list by inpatient and outpatient hospital services.
4. Identify and remove from the uninsured detail any duplicate entries.
5. Identify and remove from the uninsured detail accounts that have discharge dates outside the MSP Rate Year for inpatient services or dates of services outside the Rate Year for outpatient services.
6. Identify and remove from the uninsured detail any accounts with an identified primary payer. (Anything other than Self-Pay.)

EXHIBIT II
Page 6 of 10

7. Review Medicaid Report detail to remove patients included as uninsured and also included on the Medicaid claims data.
8. Identify and remove professional charges from the uninsured inpatient and outpatient hospital services.
9. Identify any inpatient and outpatient listing for accounts that were not flagged during procedures #3-8 (Clean Listing). Review the provider data to determine if the listing contains charges and days by UB 92/04 revenue code. If the listing does not contain the revenue codes, contact provider concerning listings and determine if the provider wants to provide the listing of charges with the UB 92/04 revenue code. If not, then we can allocate it based on Medicaid charges and days. If the provider does want to provide the revenue codes, place clean listings on secured website and request summarized listing of charges and days by UB 92/04 revenue code for accounts reported on each listing (IP/OP). Provide deadline date for submission of charge documentation. Document conversation with provider and place in correspondence file
10. Identify any inpatient and outpatient listing for accounts that were flagged during procedures #3-8 (Reject Listing). Place reject listings on secured website and contact provider about the listing being placed on the website. Any documented rejected account should include listing of charges and days by UB 92/04 Revenue Code. Communicate deadline date for provider's response. Document conversation in correspondence file.
11. Identify provider's classification as agreed upon with the State.
    a. Low DSH – Proceed to procedure #18
    b. Moderate DSH – Proceed to procedure #12
    c. High DSH – Proceed to procedure #13
12. Based on Clean Listing generated, select a random sample of 81 inpatient accounts (71 for review and 10 for replacements) and 81 outpatient accounts (71 for review and 10 as replacements). The random sample is based upon attribute testing with a 90% confidence level and 10% margin of error, with four attributes. Upload sample listings to secured website. Communicate with provider concerning the upload of the samples, documentation needed for the samples and deadline date for documentation to be ready for review. Document conversation with provider in correspondence file. Proceed to procedure #14.
13. Based on Clean Listing generated, select highest dollar accounts that cover a minimum of 10% of the Clean Listing for both inpatient and outpatient accounts. In addition, select a random sample of 81 inpatient accounts (71 for review and 10 for replacements) and 81 outpatient accounts (71 for review and 10 as replacements) from the remaining population. The random sample is based upon attribute testing with a 90% confidence level and 10% margin of error, with four attributes. Upload sample listings to secured website. Communicate with provider concerning the upload of the samples, documentation needed for the samples and deadline date for documentation to ready for review. Document conversation with provider in correspondence file.
14. Review each sample for the following:
    a. Evidence that the service was performed and is a covered service as defined by Medicaid State Plan.

   b. That amounts in provider uninsured charges detail are properly reported.
   c. That the patient did not have insurance.
   d. That no professional fees are included in uninsured charges (including CRNA's).
15. If professional fees are identified during the review of sample, request listing of professional fees for all accounts reported on Clean Listings.
16. Submit through secured website sample accounts rejected during review (sample errors) to provider for provider response. Communicate deadline date for response to claims removed during review of sample. Document communication in correspondence
17. Review documentation concerning sample errors and determine any modification of results as needed.
18. Review documentation supplied by provider concerning accounts listed on sample error listing. Incorporate any accounts that are determined to be uninsured on clean listings and adjust charges by revenue code accordingly.
19. Determine error rate of sample reviews and extrapolate error rate to Clean Listing population.
20. Once the final charges and days are determined, prepare a work paper which utilizes the provider prepared mapping of revenue codes by cost center to the extent it is applicable and apply the mapping to the uninsured charges and determine the cost center specific uninsured days and charges. If a crosswalk was not provided, allocate charges based on the settled Medicaid charges.
21. Apply cost center specific per diems and cost to charge ratios to cross walked (or allocated) days and charges to calculate the uninsured cost.
22. Summarize data for inclusion of uninsured costs on the PDSS.

Exhibit G – Review of Non-Governmental and Non-Third Party Payer Payments

Purpose: Verify payments at hospital level as required under 42 CFR §447.299(c) (12) and 42 CFR §447.299(c) (13).

1. Obtain Federal Section 1011 payments from provider or third party source documenting payments received during the MSP rate year under review. Documentation should be detailed by patient with account numbers or other identification indicator included.
2. Review detailed Federal Section 1011 list to determine which payments should be included as payments on uninsured. If no detail listing was provided all Federal Section 1011 payments are considered uninsured. (As criteria for excluding Section 1011 payments, see page 77916 of the Federal Register publishing 42 CFR Parts 447 and 455 for a discussion of Section 1011 payments and why they are excluded).
3. Review working trial balance and audited financial statements for any payments received from non-third party payers or State and Local Government indigent programs. Examples of such payments include but not limited to:
   a. The Ryan White HIV/AIDS Program
   b. Trauma Assistance Funds Not Specifically Tied To Indigent Patients
   c. Victim's Assistance Funds

   d. Provider Created Foundations
   e. Tobacco Settlement Fund Not Specifically Tied To Indigent Patients
4. Request from provider a detail of payments received for funds identified in Step #3 by patient. Review detail to determine which payments should be treated as Uninsured IP/OP Revenue. If no detail is provided, all revenue should be treated as Uninsured IP/OP Revenue.
5. Review detailed self pay payment listing obtained from provider to determine the payments that should be treated as Uninsured IP/OP Revenue. If provider did not furnish self pay payment listing then treat all self pay payments provider received during the MSP rate year as Uninsured IP/OP Revenue.
6. Review working trial balance and audited financial statements and provider reports of collection efforts for all uninsured patient payments and collection effort recoveries received during the Medicaid State Plan Year. (The statutory definition of uncompensated care includes the costs of furnishing hospital services to uninsured patients, minus the payments actually received from those patients. See page 77910 of the Federal Register publishing 42 CFR Parts 447 and 455 for a discussion. The statute defining this is Section 1923 (j) (2) (A) of the SSA). Review detailed self pay payment listing obtained from provider with historical listing to determine the payments that should be treated as Uninsured IP/OP Revenue. If provider did not furnish self pay payment listing then treat all self pay payments provider received during the MSP rate year as Uninsured IP/OP Revenue. (Note: Auditors should be aware that they need to determine if the provider reports collection efforts back to the patient account. If so, the detail listing received for self-pay patients would include all collection efforts. If not, we need to obtain collection efforts and apply them to patient accounts).
7. Summarize Federal Applicable Section 1011 Payments and Uninsured IP/OP Revenue and adjust the Provider Data Summary Schedule (PDSS).

Exhibit H – Review of Miscellaneous Hospital Reporting Provisions

Purpose: Verify information at hospital level as required under 42 CFR §447.299(c) (3) through §447.299(c) (5), §447.299(c) (7), and §447.299(c) (8).

1. Determine Medicaid Inpatient Utilization Rate based on updated Medicaid eligible days determined under review of FFS Medicaid and Non-FFS Medicaid. Divide Medicaid eligible days by total days to determine utilization rate. Total days should include both acute and sub-provider days but exclude observation days. Adjust PDSS for updated Medicaid Inpatient Utilization Rate.
2. If Low Income Utilization Rate is reported by provider, obtain provider's documentation for charity care patients. Determine if information is reasonable and re-calculate as necessary. Adjust PDSS for updated Low Income Utilization Rate.
3. Obtain documentation from Provider and State regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following:
   a. Upper Payment Limit Payments for inpatient and outpatient services
   b. Cost report settlements (tentative and/or final)

   c. Additional payments for graduate medical education
   d. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(6)

   For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust Supplemental/Enhanced Medicaid IP/OP Payments on the Provider Data Summary Schedule.

4. Obtain documentation from Provider and Medicaid Managed Care Organizations regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following:
   a. Upper Payment Limit Payments for inpatient and outpatient services
   b. Additional payments for graduate medical education
   c. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(7)

   For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust IP/OP Medicaid Managed Care Organization Payments on the Provider Data Summary Schedule.
5. Obtain documentation from Provider and Out of State Medicaid agencies regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following:
   a. Upper Payment Limit Payments for inpatient and outpatient services
   b. Additional payments for graduate medical education
   c. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(7)

   For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust IP/OP Out of State Medicaid Payments on the Provider Data Summary Schedule.
6. Summarize Disproportionate Share Hospital Payments and supplemental/enhanced Medicaid payments the provider has received from Supplemental/Enhanced payments, Medicaid Managed Care Organizations and Out of State Medicaid Agencies.
7. Verify that DSH funds received by the providers reconcile with the amount reported as paid by the state.
8. Verify that the state has not required providers to inter-governmentally transfer (IGT) DSH funds back to the state after disbursement.
9. Verify with provider if any redistribution or recovery has been made based on identification of DSH payments made in excess of hospital specific limits. If so, obtain documentation from the provider that the redistribution or recovery was made based on the results of the hospital verification procedures.

EXHIBIT II
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Exhibit I – Final Report on Hospital/Completion of Procedures

Purpose: To summarize procedures completed and prepare information for the provider's cost settlement and for inclusion in review of Disproportionate Share Hospital program at the State level in accordance with 42 CFR 447.299(c).

1. Complete provider reporting and management comment steps to determine items impacting PDSS and limitations of data being used.
2. Prepare audit summary report to send to provider. Do not send until the report has been issued to the state.
3. Complete the provider DSH comparison summary, which compares amounts on DRG-796 settled cost report Exh. H-1 to what was determined by the DSH audit. Investigate any variances.
4. Obtain a general representation letter signed by an appropriate provider official and dated the day procedures are completed.
5. Complete Provider Data Summary Schedule (PDSS) for incorporation into review of the State Medicaid Disproportionate Share Program.
6. Conduct detailed level review of work papers and PDSS.

EXHIBIT III
Page 1 of 4

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PROVIDER REIMBURSEMENT DIVISION
DISPROPORTIONATE SHARE STATE LEVEL PROCEDURES

Exhibit A – General Planning Procedures

Purpose: To document general planning and administrative procedures for conducting verifications required under the DSH audit rule as specified in 42 CFR 455.304(d)(1).

1. Obtain State agreement for the agreed upon procedures that will be conducted.
2. Maintain throughout the engagement a "Notes to Subsequent Auditors" for use in following cost reporting periods. A copy of this point sheet should be included in the work papers.
3. Obtain State's estimate of hospital specific DSH limit that was determined when the DSH payments for the Medicaid State Plan (MSP) rate year were calculated.
4. Accumulate Provider Data Summary Schedule (PDSS) and note any differences from State's DSH Reporting Schedule (DRS).

Exhibit B – Verification One

Purpose: To conduct steps to report on Verification One of the DSH Audit Rule that each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures as specified in 42 CFR 455.304(d)(1).

1. Review state documentation to determine if each hospital that received a DSH payment has met the federal DSH criteria or the State defined DSH qualification criteria for the MSP rate year under review.
2. Through inquiry at the state and the providers, determine if the state has required providers to IGT DSH funds back to the state after disbursement. Identify the different funding mechanisms used and follow the procedures identified below to verify that the state is not reducing providers' DSH payments by the amount of any IGT, provider tax, or other funding mechanism, and that the DSH payment equals the CPE.
3. If the State uses Certified Public Expenditures (CPE), reconcile the DSH payment to CPE filed by the State for claiming of Federal funds.
4. If the State uses Intergovernmental Transfers (IGT), review documentation to confirm that the State receives an IGT from the providers. Obtain documentation that confirms that the provider received the full DSH payment in a separate transaction.

5. If state funds (or other tax receipts) finance the DSH program, validate through review of DSH payments and funding, and inquiry of the providers and state, that the entire state and federal components are retained by the provider.
6. Through discussion with State personnel, determine if any redistribution or recovery has been made based on identification of DSH payments made in excess of hospital specific limits. If so, obtain documentation from the State that the redistribution or recovery was made based on the results of the hospital verification procedures.
7. Review the DRS to determine if the state has updated DRS to include DSH Payments made by Out of State Medicaid State Agencies. Inquire of state personnel as to procedures followed to include Out of State Medicaid DSH payments.
8. Generate verification assessment language for Verification One based on results of procedures.

Exhibit C – Verification Two

Purpose: To ensure DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit as specified in 42 CFR 455.304(d) (2).

1. Prepare summary schedule detailing the State's procedures performed to determine whether or not the State made DSH payments that exceeded any provider's specific DSH limit during the Medicaid State plan rate year.
2. Utilizing the individual Provider Data Summary Schedules, summarize the hospital-specific uncompensated care costs incurred during the Medicaid State plan year under examination. Compare hospital-specific DSH payments to the uncompensated care costs and note any providers where the DSH payments exceeded the hospital-specific uncompensated care costs.
3. Prepare verification assessment language for Verification #2 to note whether the State's procedures satisfy the Federal regulation at Section 1923(g) (1) (A) of the Act and that identify any providers that exceeded their hospital-specific DSH payment limit.

Exhibit D – Verification Three

Purpose: To ensure that only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and uninsured individuals as described in Section 1923(g)(1)(A) of the Act are included in the calculation of the hospital-specific limits as specified in 42 CFR 455.304(d)(3).

1. Prepare summary schedule detailing the State's procedures performed to determine that only the uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and uninsured individuals are included in the calculation of the hospital-specific limits.
2. Assess whether the state's procedures only use uncompensated care costs of I/P and O/P hospital services in calculation of hospital specific limits.
3. Prepare verification assessment language for Verification #3 to note whether the State's procedures satisfy the Federal regulation at Section 1923(g) (1) (A) of the Act.

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Exhibit E – Verification Four

Purpose: To ensure that all Medicaid payments, including supplemental/enhanced Medicaid payments, are in the calculation of the hospital-specific DSH limit as specified in 42 CFR 455.304(d)(4).

1. Prepare summary schedule detailing the State's procedures performed to determine that all payments (Medicaid FFS, Medicaid managed care, and supplemental/enhanced Medicaid payments) have been included in the calculation of the hospital-specific DHS limits.
2. Assess whether the state's procedures take into account all payments (Medicaid FFS, Medicaid managed care, and supplemental/enhanced Medicaid payments) in the calculation of hospital specific limits.
3. Prepare verification assessment language for Verification #4 to note whether the State's procedures satisfy the Federal regulation at Section 1923 of the Act.

Exhibit F – Verification Five

Purpose: To ensure that the State has separately documented and retained a record of: all its costs under the Medicaid program; uninsured costs in the determining of payment adjustments under Section 1923 of the Act; and any payments made on behalf of the uninsured from payment adjustments under Section 1923 of the Act, as specified in 42 CFR 455.304(d)(5).

1. Obtain copies of the State's policies and procedures regarding documentation retention related to information and records of all inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and, any payments made on behalf of the uninsured from payment adjustments under Section 1923 of the Act.
2. Prepare summary schedule detailing the State's documentation procedures including the specific data elements retained by the State.
3. Assess whether the state has documented and retained information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section has been separately documented and retained by the State.
4. Obtain CMS-64 forms for quarters falling in SFY 2009. Reconcile to column 16 of the PDSS. Obtain back up schedules if necessary. Inquire of any variances greater than 1% with the State Agency.
5. Prepare verification assessment language for Verification #5 to note whether the State's procedures satisfy the Federal regulation at Section 1923 of the Act.

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Exhibit G – Verification Six

Purpose: To ensure that the information specified in Verification #5 includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act, including how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individual and individuals with no source of third party coverage for the inpatient and outpatient services they receive as specified in 42 CFR 455.304(d)(6).

1. Obtain documentation from the State outlining the methodology used to calculate the hospital-specific DSH limit and methodology used to calculate the various DSH payments. Review for compliance with applicable regulations.
2. Review state's DSH procedures to determine that the definitions used for IP/OP Medicaid reimbursable services are in agreement with that in the Medicaid State Plan.
3. Review DSH procedures to determine that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.
4. Review State Plan section covering DSH payments to determine if it complies with applicable Federal regulations.
5. Assess and document how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they received.
6. Prepare verification assessment language for Verification Six to note whether the State's procedures satisfy the Federal regulation at Section 1923 of the Act.

EXHIBIT IV
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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PROVIDER REIMBURSEMENT DIVISION
OVERVIEW OF VIRGINIA DISPROPORTIONATE SHARE PROGRAM

The disproportionate share hospital (DSH) program originated with the Omnibus Budget Reconciliation Act (OBRA) of 1981, which required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. States had considerable flexibility to define DSH under sections 1923(a) and (b) of the Social Security Act (the Act).

Section 13261 of OBRA 1993 amended section 1923 of the Act to limit DSH payments to the amount of a hospital's incurred uncompensated care costs (UCC). The UCC was limited to the costs of medical services provided to Medicaid and uninsured patients less payments received for those patients, excluding Medicaid DSH payments.

According to Virginia's State Medicaid Plan, hospitals satisfying one of the following criteria qualify for the Virginia DSH program:

a. General acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, with a Medicaid Inpatient Utilization Rate (MIUR) in excess of 15% or a low-income utilization percentage of at least 25%, as determined in the base year; or

b. Long stay hospitals and state-owned rehabilitation hospitals with a MIUR in excess of 8% or a low-income utilization percentage of at least 25%, as determined for the provider's cost reporting period.

The MIUR is calculated for both acute and rehab units. A hospital may qualify for acute DSH payments or rehab DSH payments, or both.

Additionally, hospitals must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. 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. This criteria does not apply to a hospital at which the inpatients are predominately individuals under 18 years of age, or which does not offer nonemergency obstetric services as of December 21, 1987.

According to Virginia's State Plan, DSH payments to qualifying hospitals are calculated as follows:

General acute care hospitals, rehabilitation hospitals, and freestanding psychiatric hospitals are divided into two types, Type One hospitals being state-owned teaching hospitals, and Type Two hospitals consisting of all other hospitals. The formulas in place

EXHIBIT IV
Page 2 of 2

reimburse state-owned teaching hospitals at a higher rate. For general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, payments are prospectively determined in advance of the state fiscal year to which they apply. Payments are determined through a formula that considers the hospital's MIUR or LIUR, and the hospital's Medicaid operating reimbursement. The payments are not subject to settlement except when necessary due to the hospital specific limit. Each hospital's eligibility for DSH payment and the amount of the DSH payment is calculated at the time of rebasing using the most recent data available. In years when DSH payments are not rebased, the previous year's amounts are adjusted for inflation.

For long stay hospitals and state-owned rehabilitation hospitals, the disproportionate share adjustment is determined by multiplying the hospital's Medicaid utilization in excess of 8% by the lower of the prospective operating cost rate or ceiling. Payments are made through the cost report and settlement process, based on the rate from the current year or previous years' operating cost rate or ceiling.

The State Plan states that no DSH payment shall exceed any applicable limitations upon such payments established by federal laws and regulations. The State uses schedules within the Medicaid cost report to determine the hospital-specific DSH limit for each hospital, and to determine if they met eligibility criteria. Cost to charge ratios from the CMS 2552 are used to determine costs.

Hospitals that received DSH payments in excess of the calculated hospital-specific DSH limit are required to pay back the excess DSH payments as part of the cost report settlement. Funds recouped are not redistributed.

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PROVIDER REIMBURSEMENT DIVISION
VIRGINIA DISPROPORTIONATE SHARE PROGRAM VERIFICATIONS

The agreed upon procedures enumerated in **Exhibits II and III,** were performed to assist the Virginia Department of Medical Assistance Services in evaluating its compliance with the Social Security Act (the Act) as it relates to Medicaid Disproportionate Share Hospital (DSH) payments. The procedures were also performed to assess the Department's compliance with the six Verifications required under 42 CFR §455.304(d). Our findings relating to the Verifications are shown below.

1. Twenty-seven in-state hospitals originally received DSH payments in SFY 2009. Of the twenty-seven, three hospitals that originally received DSH payments did not qualify based on the obstetrician requirement. DMAS had already recouped the DSH payments made to these three hospitals. Twenty-four of twenty-four in-state hospitals that qualify for a DSH payment under the State Plan are allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient and outpatient hospital services during the Medicaid State Plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for services in order to reflect the total amount of claimed DSH expenditures. Two of the twenty-four in-state hospitals and three of ten out-of-state hospitals would not qualify for a DSH payment using FY 6/30/2009 data to determine eligibility.

2. Twenty-two of twenty-four in-state DSH hospitals received DSH payments that comply with the hospital-specific DSH payment limit. Two of twenty-four in-state hospitals received DSH payments that do not comply with the hospital-specific DSH payment limit. For each audited Medicaid State Plan rate year, the DSH payments made in that audited Medicaid State Plan rate year were measured against the actual uncompensated care cost in that same audited Medicaid State Plan rate year.

3. Twenty-four of twenty-four in-state DSH hospitals included only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g) (1) (A) of the Act in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g) (1) (A) of the Act.

4. Twenty-four of twenty-four in-state DSH hospitals included all Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to the disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid

EXHIBIT V-2
Page 2 of 2

eligible individuals for purposes of the hospital-specific limit calculation. Medicaid payments that were in excess of the Medicaid incurred costs of such services were applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.

5. The State has separately documented and retained any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section.

6. The information specified in the preceding verification (Verification 5) includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g) (1) of the Social Security Act. Included in the description of the methodology, the State has specified how it determines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the inpatient hospital and outpatient hospital services they received.

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EXHIBIT VI

December 18, 2012

Ms. Cynthia Jones, Director
Commonwealth of Virginia
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Ms. Jones:

We are submitting this letter in connection with our Independent Accountant's Report on Applying Agreed-Upon Procedures submitted to the Virginia Department of Medical Assistance Services on the Disproportionate Share Hospital (DSH) Program for Medicaid State Plan Rate (MSP) Year 2009.

These agreed upon procedures applied to the DSH program were conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA) and the standards applicable to attestation engagements contained in *Generally Accepted Government Auditing Standards* (GAGAS), issued by the Comptroller General of the United States.

In the Disproportionate Share Hospital Payments Final Rule (Rule), the Centers for Medicare & Medicaid Services (CMS) defined an "independent audit" to mean an audit conducted according to the standards specified in GAGAS. In addition, CMS indicated in the discussion accompanying the Rule that an independent auditor must operate independently from the Medicaid agency and the subject hospitals. Furthermore, CMS has issued guidance that the DSH auditor must submit a signed statement declaring independence of the respective Medicaid agency and hospitals for MSP years 2007 and later. This statement is to be included with the audit report submitted to CMS on an annual basis. In order for you to comply with this CMS guidance, we are furnishing you this letter to accompany the report that you will be submitting to CMS.

GAGAS requires that "(I)n all matters related to the audit work, the audit organization and the individual auditor, whether government or public, should be free both in fact and appearance from personal, external, and organizational impairments to independence, and must avoid the appearance of such impairments of independence."

PHBV Partners LLP is independent of the Virginia Department of Medical Assistance Services and the Virginia DSH hospitals as defined by GAGAS. In addition, I, Mark Hilton, acting as the engagement partner-in-charge of the engagement to perform procedures on the Virginia DSH program under the Rule, am independent of the Virginia Department of Medical Assistance Services and Policy and the DSH hospitals.

Sincerely,

PHBV Partners LLP

Mark K. Hilton

Mark K. Hilton, CPA
Partner

D: Supporting Documentation for References – Nevada

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

February 18, 2013

Mr. Robert Price
Buyer
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100
Charleston, West Virginia 25301

Re: *MED 13004 – Documentation of Audit Deadlines*

Dear Mr. Price:

Please accept this notarized letter as documentation that Myers and Stauffer completed the following tasks as part of our Disproportionate Share Hospital (DSH) Audits for the Nevada Department of Health and Human Services (the Department)

- The audit engagement was conducted in accordance with CMS DSH regulations
- The audit engagement was completed by September 30 of the applicable year
- The audit reports were delivered to the State prior to December 30 of the applicable year for filing to CMS in order to satisfy DSH- related regulation requirements
- To our knowledge, the audit reports were accepted by CMS

For additional details, feel free to contact Janice Prentice at the Department (775-684-3791 or Jprentice@dhcfp.nv.gov).

Sincerely,

Mark K. Hilton

Mark Hilton, CPA, Member

State of MD

County of BALTO to-wit:

Taken, subscribed, and sworn to me before this 18 day of FEB., 2013

My Commission expires MAR. 10, 2016

Linda P. Kromm

LINDA P. KROMM NOTARY PUBLIC BALTIMORE COUNTY, MD

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STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING & POLICY
Carson City, Nevada

DISPROPORTIONATE SHARE PROGRAM
AGREED UPON PROCEDURES
Medicaid State Plan Rate Year JUNE 30, 2009

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INDEPENDENT ACCOUNTANT'S REPORT
ON APPLYING AGREED-UPON PROCEDURES

Department of Health and Human Services
Division of Health Care Financing and Policy
Carson City, Nevada 89701

We have performed the procedures enumerated in Exhibits II and III, of this report, which were agreed to by the State of Nevada, Division of Health Care Financing and Policy (DHCFP), solely to assist specified parties in evaluating DHCFP's compliance with the Social Security Act as it relates to Medicaid Disproportionate Share Hospital (DSH) payments during the period July 1, 2008 through June 30, 2009. Management is responsible for DHCFP's compliance with those requirements. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and the *Government Auditing Standards*, issued by the Comptroller General of the United States. The sufficiency of these procedures is solely the responsibility of those parties specified in this report. Consequently, we make no representation regarding the sufficiency of the procedures either for the purpose for which this report has been requested or for any other purpose.

Findings noted as a result of the procedures are presented in Exhibit V of this report.

We were not engaged to, and did not conduct an audit of the matters addressed herein, the objective of which would be the expression of an opinion on such information. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the DHCFP and is not intended to be, and should not be, used by anyone other than these specified parties.

PHBV Partners LLP

Richmond, Virginia
September 17, 2012

EXHIBIT I
Page 1 of 2

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING & POLICY
OVERVIEW OF AGREED UPON PROCEDURES

The agreed upon procedures enumerated in **Exhibits II and III,** were performed to assist the Nevada Department of Health and Human Services in evaluating its compliance with the Social Security Act (the Act) as it relates to Medicaid Disproportionate Share Hospital (DSH) payments. The objective of these procedures was to verify:

- Each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State Plan (MSP) rate year to Medicaid-eligible individuals and individuals with no source of third-party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

- DSH payments to each qualifying hospital comply with the hospital-specific DSH payment limit as defined under Section 1923 of the Act. For each audited MSP rate year, the DSH payments made in that audited MSP rate year are measured against the actual uncompensated care cost in that same audited MSP rate year.

- Only uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid-eligible and individuals with no third-party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g) (1) (A) of the Social Security Act are included in the calculation of the hospital-specific DSH payment limit.

- Any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organizations payments) in excess of Medicaid incurred costs are applied against the uncompensated care costs of furnishing inpatient and outpatient hospital services to individuals with no source of third party coverage.

- Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustment; and any payments made on behalf of the uninsured from payment adjustment have been separately documented and retained by the State.

- The State has separately documented and retained a record of all its costs and claimed expenditures under the Medicaid program, as well as uninsured costs and payments used in determining the DSH payment adjustments.

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The agreed upon procedures were performed in three phases. In the first phase, two DSH hospitals were subjected to on-site procedures. In the second phase, the remaining DSH hospitals were subjected to the desk procedures. These desk procedures were performed without an on-site review of the hospitals' records. The specific procedures are enumerated in **Exhibit II**. Lastly, the procedures enumerated in **Exhibit III** were applied at the state-wide level to the DHCFP.

An overview of the Nevada Disproportionate Share Program is included at **Exhibit IV**.

Our findings resulting from these procedures are described in **Exhibit V**.

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STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING & POLICY
DISPROPORTIONATE SHARE HOSPITAL PROCEDURES

General Procedures

Purpose: To determine the acceptability of the information filed by the provider and the extent of the review to be performed on the information.

1. If the Medicare Electronic Cost Report (ECR) will be used for cost finding, perform the conversion of the finalized ECR file if received from the Medicare fiscal intermediary or the as-filed ECR if the cost report has not been finalized into the Health Financial Systems (HFS) software. The following steps must be completed:
    a. Ensure there are no variances between the cost report and the ECR file.
    b. Ensure the payment system type for Medicaid on Worksheet S-2 is ***O***.
    c. Ensure all Level I errors are corrected.
    d. Ensure that Worksheet S-2 Line 25.01 is answered Yes and Line 25.02 is answered No if provider has reported residency cost.
    e. Ensure that Worksheet S-2 Lines 38.01 and 38.02 are answered Yes.
2. Determine if the provider meets **both** of the following overall DSH qualifications:
    a. Medicaid Day Utilization (MDU) of at least 1%.
    b. Obtain the names of 2 Obstetricians with staff privileges. Obtain the physician's UPIN number from the hospital and determine that the physician was licensed as an Obstetrician thru review of the Ecare website at Upin.ecare.com (Rural hospitals may use physicians with any specialty as long as they have staff privileges to perform non-emergency obstetric procedures). Determine that the physician participates in Nevada Medicaid by reviewing the State's Medicaid Agency's website. This step does not apply to hospitals that did not offer non-emergency obstetric services to the general population as of December 22, 1987.
3. Ensure the hospital has met the federal DSH criteria or the State defined DSH qualification criteria. If provider does not meet criteria, contact appropriate State personnel.

Scoping and Planning Procedures

Purpose: To plan and prepare for the Agreed Upon Procedures to determine information needed to satisfy the requirements of the 42 CFR §455.204 in reviewing the State of Nevada's Disproportionate Share Hospital program. To review the timing and nature of the engagement with provider personnel and to make preliminary inquiries.

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1. Maintain an adjustment summary, on an ongoing basis, to accumulate all proposed adjustments, by period. All adjustments which will not be made must be included on the Passed Adjustment Summary.
2. If this provider has been selected for an onsite visit based upon the State procedures, arrange a date to begin the on site verification procedures that is mutually agreeable with provider personnel by telephone. Instruct the personnel what records will be needed to complete the procedures on-site. If feasible, inform the provider personnel of the duration of the onsite visit and how many staff members are assigned to the engagement.
3. Maintain documentation of written communications with provider of arrangements made in Step #2.
4. Review all pertinent provider files, including cost report package for the provider fiscal year(s) under review, most recently issued Medicare Notice of Program Reimbursement (NPR), prior years' work papers, correspondence files, permanent files, etc. Make note of any items which will require special attention and cross-reference to the appropriate work papers.
5. Maintain throughout the engagement procedures, a "Notes to Subsequent Reviewers" for use in following cost reporting periods. These notes should include any adjustments or items which may effect the subsequent year(s).
6. Review the following from the prior year work paper binder for possible material impact on the current year cost report:
    a. Notes to subsequent reviewers
    b. Historical clean listing from permanent file.
7. Prepare the Engagement Planning Guide. Conduct a planning meeting with the engagement Manager, Senior Manager, and/or Partner. Prepare budget worksheet.

Working Trial Balance (WTB) and Financial Statement Reconciliation

Purpose: To determine that the cost report was prepared from documents generated from the provider's accounting system. To identify any differences between the WTB, Cost Report and/or the Financial Statements.

Important Note to Auditors: The CMS Audit Protocol states that the Medicare cost allocation process will be used to determine facility costs for inclusion in determining DSH eligible hospital costs. In order to provide complete financial information for the Medicaid State plan (MSP) rate year under audit, hospitals must use two or more Medicare costs reports if the cost reporting period does not correspond with the MSP rate year under audit. Once costs are allocated according to the Medicare cost allocation process, those costs should be allocated to the MSP rate year on a pro-rata basis to develop 12 full months of cost. Bear this in mind when requesting WTB and other cost report information from the hospitals.

1. Determine if the State Medicaid agency has performed a review of the cost report(s) during the MSP rate year. If no review performed, proceed to step #2, otherwise procedures are complete.

2. Determine if Medicare has issued a NPR for cost report(s) during the MSP rate year. Obtain copy of the NPR. If no NPR, proceed to step #3, otherwise procedures are complete.
3. Obtain the provider's expense mapping schedule.
4. Obtain the provider's revenue mapping schedule.
5. Review the audited financial statements along with the notes for any items with potential uncompensated care impact. Follow-up on noted items as needed.
6. Determine if provider is a transplant facility. If so, obtain Medicaid transplants by organ and uninsured by organ. Remove revenue from Wkst D-6, Part III. Also, determine if transplants were reimbursed through FFS, Medicaid Managed Care, or Out-of-State.

Medicaid Fee for Service Settlement Data

Purpose: To determine that the Medicaid fee for service settlement data is presented in accordance with 42 CFR 447.299(c).

1. Obtain the Medicaid Management Information Systems (MMIS) summary report of charges, payments and days for the facility service dates during the corresponding cost reporting period from the State Medicaid Agency (or fiscal intermediary if applicable) that applies to the MSP rate year under review.
2. Review the MMIS summary report and ensure that in addition to regular Medicaid fee for service payments, the data also includes the following:
    a. No Pay or zero paid claims (Other third party payer pays more than the entire Medicaid payment amount)
    b. Medicare Crossover payments
    c. Third Party Payments (actual payments, not Medicaid liability)
    d. Coinsurance and deductible information
3. Identify any other charges and payments associated with Medicaid eligible patients to whom the hospital provided services during the portion of the cost reporting period that is within the MSP rate year, but for whom they did not bill Medicaid. Review to determine if amounts reported by the provider are:
    a. Within the correct date range
    b. Not duplicated
    c. Have appropriate payer and insurance codes
4. Prepare a work paper which utilizes the provider prepared mapping of revenue codes by cost center to the extent it is applicable and apply the mapping to the MMIS charges and determine the cost center specific MMIS days and charges. If a crosswalk was not provided, allocate charges based on the reported D-4 (Title XIX) and D part V (Title XIX) cost report as filed charges. (If Title XIX worksheets are not available, do NOT use the Title XVIII worksheets to allocate charges, instead use worksheet C to allocate charges).
5. Apply cost center specific per diems and cost to charge ratios to cross walked (or allocated) days and charges to calculate the Medicaid cost.

6. Summarize data for inclusion of Inpatient (IP) and Outpatient (OP) Medicaid fee-for-service (FFS) basic rate payments and Total Cost of Care for Medicaid IP/OP Services on the Provider Data Summary Schedule (PDSS).

Medicaid Managed Care and Out of State Settlement Data

Purpose: To determine that the Medicaid Managed Care and Out of State settlement data is presented in accordance with 42 CFR 447.299(c).

1. Identify Medicaid Managed Care Organizations that had members served by the provider during the portion of the cost reporting period that is within the MSP rate year. Ensure that all documentation has been obtained for these claims. Review to determine if amounts reported by the provider are:
    a. Within the correct date range
    b. Not duplicated
    c. Have appropriate payer and insurance codes
2. Identify payments from other states for Medicaid eligible patients and for uninsured patients to whom the hospital provided services during the portion of cost reporting period that is within the MSP rate year. Ensure that documentation has been obtained for all other States. Review to determine if amounts reported by the provider are:
    a. Within the correct date range
    b. Not duplicated
    c. Have appropriate payer and insurance codes
3. For the Medicaid out of state claims, review the MMIS summary report or other available documentation and ensure that in addition to regular Medicaid fee for service payments, the data also includes the following:
    a. No Pay or zero paid claims (Other third party payer pays more than the entire Medicaid payment amount
    b. Medicare Cross Over payments
    c. Third Party Payments (actual payments, not Medicaid liability)
    d. Deductibles and coinsurance amounts
4. Identify if the MCO and/or OOS charges (to be analyzed separately) are greater than 10% of the sum of all Medicaid plus Uninsured charges.
    a. Yes – proceed to procedure #5
    b. No – proceed to procedure #7
5. Split sample size of 81 patient accounts (71 for review and 10 for replacements) between IP and OP based on percent to total population size (based on number of accounts). The random sample is based upon attribute testing with a 90% confidence level and 10% margin of error, with four attributes. Select a random sample and upload sample listings to secured website. Communicate with provider concerning the upload of the samples, documentation needed for the samples, and deadline date for documentation to ready for review. Document communication with provider in correspondence file.
6. Review each sample for the following:
    a. Evidence that the service was performed and is a covered service as defined by the Medicaid State Plan.
    b. That amounts in provider MCO/OOS charges detail are accurate.

   c. Verify that the patient was covered by MCO/OOS.
   d. That no professional fees are included in charges (including CRNA's).
7. Prepare a work paper which utilizes the provider prepared mapping of revenue codes by cost center to the extent it is applicable and apply the mapping to the MCO and OOS charges and determine the cost center specific MCO and OOS days and charges. If a crosswalk was not provided, allocate charges based on the reported D-4 (Title XIX) and D part V (Title XIX) cost report as filed charges. (If Title XIX worksheets are not available, do NOT use the Title XVIII worksheets to allocate charges, instead use worksheet C to allocate charges).
8. Apply cost center specific per diems and cost to charge ratios to cross walked (or allocated) days and charges to calculate the MCO and OOS cost.
9. Summarize data for inclusion of IP/OP Medicaid managed care organization payments and Total Cost of Care for Medicaid IP/OP Services on the PDSS.

Review of Uninsured Charges

Purpose: Determine that hospital reported accounts meet uninsured criteria as defined in Social Security Act §1923(g) (1) (A). Determine allowability and proper reporting of charges included in the uninsured amount for hospital based on 42 CFR §447.299(c) (14).

1. Identify and remove from the uninsured detail accounts that are not inpatient and/or outpatient hospital services (excl. skilled nursing, home health, outpatient dialysis, outpatient prescription pharmacy, dental services, etc). Separate list by inpatient and outpatient hospital services.
2. Identify and remove from the uninsured detail any duplicate entries.
3. Identify and remove from the uninsured detail accounts that have discharge dates outside the MSP Rate Year for inpatient services or dates of services outside the MSP rate year for outpatient services.
4. Identify and remove from the uninsured detail any accounts with an identified primary payer. (Anything other than Self-Pay.)
5. Review MMIS Report detail to remove patients included as uninsured and also included on the Medicaid claims data.
6. Identify and remove professional charges from the uninsured inpatient and outpatient hospital services.
7. Identify any inpatient and outpatient listing for accounts that were not flagged during procedures #3-8 (Clean Listing). Place clean listings on secured website. Contact provider concerning listings placed on secured website and request summarized listing of charges and days by UB 92/04 revenue code for accounts reported on each listing. Provide deadline date for submission of charge documentation. Document conversation with provider and place in correspondence file.
8. Identify any inpatient and outpatient listing for accounts that were flagged during procedures #3-8 (Reject Listing). Place reject listings on secured website and contact provider about the listing being placed on the website. Any documented rejected account should include listing of charges and days by UB 92/04 Revenue Code.

Communicate deadline date for provider's response. Document conversation in correspondence file.

9. Identify provider's classification as agreed upon with the State.
    a. Low DSH – Proceed to procedure #16
    b. Moderate DSH – Proceed to procedure #10
    c. High DSH – Proceed to procedure #11
10. Based on Clean Listing generated, select a random sample of 81 inpatient accounts (71 for review and 10 for replacements) and 81 outpatient accounts (71 for review and 10 as replacements). The random sample is based upon attribute testing with a 90% confidence level and 10% margin of error, with four attributes. Upload sample listings to secured website. Communicate with provider concerning the upload of the samples, documentation needed for the samples and deadline date for documentation to be ready for review. Document conversation with provider in correspondence file. Proceed to procedure #12.
11. Based on Clean Listing generated, select highest dollar accounts that cover a minimum of 10% of the Clean Listing for both inpatient and outpatient accounts. In addition, select a random sample of 81 inpatient accounts (71 for review and 10 for replacements) and 81 outpatient accounts (71 for review and 10 as replacements) from the remaining population. The random sample is based upon attribute testing with a 90% confidence level and 10% margin of error, with four attributes. Upload sample listings to secured website. Communicate with provider concerning the upload of the samples, documentation needed for the samples and deadline date for documentation to ready for review. Document conversation with provider in correspondence file.
12. Review each sample for the following:
    a. Evidence that the service was performed and is a covered service as defined by Medicaid State Plan.
    b. That amounts in provider uninsured charges detail are properly reported.
    c. That the patient did not have insurance.
    d. That no professional fees are included in uninsured charges (including CRNA's).
13. If professional fees are identified during the review of sample, request listing of professional fees for all accounts reported on Clean Listings.
14. Submit through secured website sample accounts rejected during review (sample errors) to provider for provider response. Communicate deadline date for response to claims removed during review of sample. Document communication in correspondence file.
15. Review documentation concerning sample errors and determine any modification of results as needed.
16. Review documentation supplied by provider concerning accounts listed on sample error listing. Incorporate any accounts that are determined to be uninsured on clean listings and adjust charges by revenue code accordingly.
17. Determine error rate of sample reviews and extrapolate error rate to Clean Listing population.
18. Update historical listing of uninsured accounts of provider for accounts included on finalized clean listings.

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Review of Non-Governmental and Non-Third Party Payer Payments

Purpose: Verify payments at hospital level as required under 42 CFR §447.299(c) (12) and 42 CFR §447.299(c) (13).

1. Obtain Federal Section 1011 payments from provider or third party source documenting payments received during the MSP rate year under review. Documentation should be detailed by patient with account numbers or other identification indicator included.
2. Compare detailed Federal Section 1011 payments to historical clean listings for provider to determine which payments should be included as payments on uninsured. If no detail listing was provided all Federal Section 1011 payments are considered uninsured. (As criteria for excluding Section 1011 payments, see page 77916 of the Federal Register publishing 42 CFR Parts 447 and 455 for a discussion of Section 1011 payments and why they are excluded).
3. Review working trial balance and audited financial statements for any payments received from non-third party payers or State and Local Government indigent programs. Examples of such payments include but not limited to:
    a. The Ryan White HIV/AIDS Program
    b. Trauma Assistance Funds Not Specifically Tied To Indigent Patients
    c. Victim's Assistance Funds
    d. Provider Created Foundations
    e. Tobacco Settlement Fund Not Specifically Tied To Indigent Patients
4. Request from provider a detail of payments received for funds identified in Step #3 by patient. Compare detail to historical clean listings to determine revenue that should be treated as Uninsured IP/OP Revenue. If no detail is provided, all revenue should be treated as Uninsured IP/OP Revenue.
5. Review working trial balance and audited financial statements and provider reports of collection efforts for all uninsured patient payments and collection effort recoveries received during the Medicaid State Plan Year. (The statutory definition of uncompensated care includes the costs of furnishing hospital services to uninsured patients, minus the payments actually received from those patients. See page 77910 of the Federal Register publishing 42 CFR Parts 447 and 455 for a discussion. The statute defining this is Section 1923 (j) (2) (A) of the SSA). Review detailed self pay payment listing obtained from provider with historical listing to determine the payments that should be treated as Uninsured IP/OP Revenue. If provider did not furnish self pay payment listing then treat all self pay payments provider received during the MSP rate year as Uninsured IP/OP Revenue. (Note: Auditors should be aware that they need to determine if the provider reports collection efforts back to the patient account. If so, the detail listing received for self-pay patients would include all collection efforts. If not, we need to obtain collection efforts and apply them to patient accounts).
6. Summarize Federal Applicable Section 1011 Payments and Uninsured IP/OP Revenue and adjust the Provider Data Summary Schedule (PDSS).

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Review of Miscellaneous Hospital Reporting Provisions

Purpose: Verify information at hospital level as required under 42 CFR §447.299(c) (3) through §447.299(c) (5), §447.299(c) (7), and §447.299(c) (8).

1. If hospital qualified under State Defined DSH Qualification Criteria, then proceed to Step #4' otherwise complete Step #2 or Step #3 based on PDSS.
2. Determine Medicaid Inpatient Utilization Rate based on updated Medicaid eligible days determined under review of FFS Medicaid and Non-FFS Medicaid. Divide Medicaid eligible days by total days to determine utilization rate. Total days should include both acute and sub-provider days but exclude observation days. Adjust PDSS for updated Medicaid Inpatient Utilization Rate.
3. If Low Income Utilization Rate is reported by provider, obtain provider's documentation for charity care patients. Determine if information is reasonable and re-calculate as necessary. Adjust PDSS for updated Low Income Utilization Rate.
4. Obtain documentation from Provider and State regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following:
    a. Upper Payment Limit Payments for inpatient and outpatient services
    b. Cost report settlements (tentative and/or final)
    c. Additional payments for graduate medical education
    d. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(6)

    For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust Supplemental/Enhanced Medicaid IP/OP Payments on the Provider Data Summary Schedule.
5. Obtain documentation from Provider and Medicaid Managed Care Organizations regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following:
    a. Upper Payment Limit Payments for inpatient and outpatient services
    b. Additional payments for graduate medical education
    c. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(7)

    For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust IP/OP Medicaid Managed Care Organization Payments on the Provider Data Summary Schedule.
6. Obtain documentation from Provider and Out of State Medicaid agencies regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following:
    a. Upper Payment Limit Payments for inpatient and outpatient services
    b. Cost report settlements (tentative and/or final)
    c. Additional payments for graduate medical education
    d. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(6)

For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust IP/OP Out of State Medicaid Payments on the Provider Data Summary Schedule.

7. Summarize Disproportionate Share Hospital Payments and supplemental/enhanced Medicaid payments the provider has received from the Medicaid state agency, Medicaid Managed Care Organizations and Out of State Medicaid Agencies.
8. Review documentation to determine that DSH funds received by the providers reconcile with the amount reported as paid by the state.
9. Inquire of the provider to determine if the state has required providers to inter-governmentally transfer (IGT) DSH funds back to the state after disbursement.
10. Inquire of provider to determine if any redistribution or recovery has been made based on identification of DSH payments made in excess of hospital specific limits. If so, obtain documentation from the provider that the redistribution or recovery was made based on the results of the hospital verification procedures.
11. Ensure that Net Patient Revenues per the cost report traces within reason to the trial balance and audited financial statements and that it includes bad debts.

Final Report on Hospital/Completion of Procedures

Purpose: To summarize procedures completed and prepare information for the provider's cost settlement and for inclusion in review of Disproportionate Share Hospital program at the State level in accordance with 42 CFR 447.299(c).

1. Send the provider a copy of the audit results. File a copy of the audit results given to the provider in the work papers.
2. If using the ECR file to determine costs, incorporate adjustments into the CMS Form 2552 software utilizing the Medicare Auditor function and produce a Level I error free cost report. Maintain a CMS 2552 for out of State Medicaid and Medicaid MCO as one report, Medicaid FFS as a second report, and Medicaid Uninsured as a third report.
3. Obtain a general representation letter signed by an appropriate provider official and dated the day procedures are completed.
4. Conduct detailed level review of adjustments.
5. Mail a copy of the audit results and findings to the provider representative with a copy to the State.
6. Complete Provider Data Summary Schedule (PDSS) for incorporation into review of the State Medicaid Disproportionate Share Program.

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STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING & POLICY
DISPROPORTIONATE SHARE STATE LEVEL PROCEDURES

General Planning Procedures

Purpose: To document general planning and administrative procedures for conducting verifications required under the DSH audit rule as specified in 42 CFR 455.304(d)(1).

1. Obtain State agreement for the agreed upon procedures that will be conducted.
2. Maintain throughout the engagement a "Notes to Subsequent Auditors" for use in following cost reporting periods. A copy of this point sheet should be included in the work papers.
3. Obtain State's estimate of hospital specific DSH limit that was determined when the DSH payments for the Medicaid State Plan (MSP) rate year were calculated.
4. Accumulate Provider Data Summary Schedule (PDSS) and note any differences from State's DSH Reporting Schedule (DRS).

Verification One

Purpose: To conduct steps to report on Verification One of the DSH Audit Rule that each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures as specified in 42 CFR 455.304(d)(1).

1. Review state documentation to determine if each hospital that received a DSH payment has met the federal DSH criteria or the State defined DSH qualification criteria for the MSP rate year under review.
2. Through inquiry at the state and the providers, determine if the state has required providers to IGT DSH funds back to the state after disbursement. Identify the different funding mechanisms used and follow the procedures identified below to verify that the state is not reducing providers' DSH payments by the amount of any IGT, provider tax, or other funding mechanism, and that the DSH payment equals the CPE.
3. If the State uses Certified Public Expenditures (CPE), reconcile the DSH payment to CPE filed by the State for claiming of Federal funds.
4. If the State uses Intergovernmental Transfers (IGT), review documentation to confirm that the State receives an IGT from the providers. Obtain documentation that confirms that the provider received the full DSH payment in a separate transaction.

5. If state funds (or other tax receipts) finance the DSH program, validate through review of DSH payments and funding, and inquiry of the providers and state, that the entire state and federal components are retained by the provider.
6. Through discussion with State personnel, determine if any redistribution or recovery has been made based on identification of DSH payments made in excess of hospital specific limits. If so, obtain documentation from the State that the redistribution or recovery was made based on the results of the hospital verification procedures.
7. Review the DRS to determine if the state has updated DRS to include DSH Payments made by Out of State Medicaid State Agencies. Inquire of state personnel as to procedures followed to include Out of State Medicaid DSH payments.
8. Generate verification assessment language for Verification One based on results of procedures.

Verification Two

Purpose: To ensure DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit as specified in 42 CFR 455.304(d) (2).

1. Prepare summary schedule detailing the State's procedures performed to determine whether or not the State made DSH payments that exceeded any provider's specific DSH limit during the Medicaid State plan rate year.
2. Utilizing the individual Provider Data Summary Schedules, summarize the hospital-specific uncompensated care costs incurred during the Medicaid State plan year under examination. Compare hospital-specific DSH payments to the uncompensated care costs and note any providers where the DSH payments exceeded the hospital-specific uncompensated care costs.
3. Prepare verification assessment language for Verification #2 to note whether the State's procedures satisfy the Federal regulation at Section 1923(g) (1) (A) of the Act and that identify any providers that exceeded their hospital-specific DSH payment limit.

Verification Three

Purpose: To ensure that only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and uninsured individuals as described in Section 1923(g)(1)(A) of the Act are included in the calculation of the hospital-specific limits as specified in 42 CFR 455.304(d)(3).

1. Prepare summary schedule detailing the State's procedures performed to determine that only the uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and uninsured individuals are included in the calculation of the hospital-specific limits.
2. Assess whether the state's procedures only use uncompensated care costs of I/P and O/P hospital services in calculation of hospital specific limits.
3. Prepare verification assessment language for Verification #3 to note whether the State's procedures satisfy the Federal regulation at Section 1923(g) (1) (A) of the Act.

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Verification Four

Purpose: To ensure that all Medicaid payments, including supplemental/enhanced Medicaid payments, are in the calculation of the hospital-specific DSH limit as specified in 42 CFR 455.304(d)(4).

1. Prepare summary schedule detailing the State's procedures performed to determine that all payments (Medicaid FFS, Medicaid managed care, and supplemental/enhanced Medicaid payments) have been included in the calculation of the hospital-specific DHS limits.
2. Assess whether the state's procedures take into account all payments (Medicaid FFS, Medicaid managed care, and supplemental/enhanced Medicaid payments) in the calculation of hospital specific limits.
3. Prepare verification assessment language for Verification #4 to note whether the State's procedures satisfy the Federal regulation at Section 1923 of the Act.

Verification Five

Purpose: To ensure that the State has separately documented and retained a record of: all its costs under the Medicaid program; uninsured costs in the determining of payment adjustments under Section 1923 of the Act; and any payments made on behalf of the uninsured from payment adjustments under Section 1923 of the Act, as specified in 42 CFR 455.304(d)(5).

1. Obtain copies of the State's policies and procedures regarding documentation retention related to information and records of all inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and, any payments made on behalf of the uninsured from payment adjustments under Section 1923 of the Act.
2. Prepare summary schedule detailing the State's documentation procedures including the specific data elements retained by the State.
3. Assess whether the state has documented and retained information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section has been separately documented and retained by the State.
4. Prepare verification assessment language for Verification #5 to note whether the State's procedures satisfy the Federal regulation at Section 1923 of the Act.

Verification Six

Purpose: To ensure that the information specified in Verification #5 includes a description of the methodology for calculating each hospital's payment limit under

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Section 1923(g)(1) of the Act, including how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individual and individuals with no source of third party coverage for the inpatient and outpatient services they receive as specified in 42 CFR 455.304(d)(6).

1. Obtain documentation from the State outlining the methodology used to calculate the hospital-specific DSH limit and methodology used to calculate the various DSH payments. Review for compliance with applicable regulations.
2. Review state's DSH procedures to determine that the definitions used for IP/OP Medicaid reimbursable services are in agreement with that in the Medicaid State Plan.
3. Review DSH procedures to determine that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.
4. Review State Plan section covering DSH payments to determine if it complies with applicable Federal regulations.
5. Assess and document how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they received.
6. Prepare verification assessment language for Verification Six to note whether the State's procedures satisfy the Federal regulation at Section 1923 of the Act.

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STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING & POLICY
OVERVIEW OF NEVADA DISPROPORTIONATE SHARE PROGRAM

The disproportionate share hospital (DSH) program originated with the Omnibus Budget Reconciliation Act (OBRA) of 1981, which required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. States had considerable flexibility to define DSH under sections 1923(a) and (b) of the Social Security Act (the Act).

Section 13261 of OBRA 1993 amended section 1923 of the Act to limit DSH payments to the amount of a hospital's incurred uncompensated care costs (UCC). The UCC was limited to the costs of medical services provided to Medicaid and uninsured patients less payments received for those patients, excluding Medicaid DSH payments.

According to Nevada's State Medicaid Plan, hospitals satisfying one of the following criteria qualify for the Nevada DSH program:

a. Hospitals with a Medicaid Inpatient Utilization Rate (MIUR) at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payment in the state.

b. Hospitals with a low-income utilization percentage of at least 25%.

c. For public hospitals, a MIUR of at least one percent.

d. For counties which do not have a public hospital, the hospital in the county which provided the greatest number of Medicaid inpatient days in the previous year.

e. A private hospital, located in a county with a public hospital, which provided the greatest number of Medicaid inpatient days in the previous year.

Additionally, hospitals must satisfy the following three criteria in order to qualify for the Nevada DSH program:

a. Hospitals must have a MIUR percentage of at least one percent.

b. Hospitals must have at least two (2) obstetricians with staff privileges who have agreed to provide obstetrical services to Medicaid patients. For rural hospitals, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. (This federal rule does not apply to a hospital in which the inpatients are predominately individuals under 18 years of age or that did not offer non-emergency obstetric services to the general population as of December 22, 1987).

EXHIBIT IV
Page 2 of 2

c. Hospitals must not be an institution for mental disease or other mental health facility subject to the limitation on DSH expenditures under Section 4721 of the Balanced Budget Act of 1997.

According to Nevada's State Plan, DSH payments to qualifying hospitals are calculated as follows:

Hospitals are grouped into five different distribution pools, based on public vs. private hospitals and the size of the county in which they are located. DSH payments are prescribed by the State Plan for each pool, as a set dollar amount plus a percentage of remaining DSH funds. The State Plan also specifies minimum DSH payments for specific hospitals in each pool. The remaining DSH funds are allocated to other qualifying hospitals in each pool based on the remaining funds for that pool.

In the event that the total individual hospital DSH amounts exceed the total federal allotment, hospital DSH payments will be decreased to ensure payments are within the allotment amount.

The State Plan states that the total amount of distributions per pool cannot exceed the total uncompensated costs for those facilities.

The State Plan does not have any provisions to compare the hospitals' individual DSH payments to the hospitals' uncompensated care costs as described in Section 1923 of the Act. In 2009, the State did compare the DSH payments of each individual hospital to uncompensated care costs (from 2007, as reported by the hospitals), and limited payments to the uncompensated care cost. However, this is not prescribed in the State Plan.

EXHIBIT V-1
Page 1 of 1

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING & POLICY
SUMMARY OF FINDINGS

1. One hospital was not eligible for DSH as it did not meet any of the State defined eligibility criteria.
2. One hospital had DSH payments that exceeded their uncompensated care costs.
3. One hospital did not sign and submit a General Representation Letter.
4. One hospital did not fill out Worksheet D, Part V of the CMS 2552 for Title XIX, and one hospital did not fill out Worksheet D-4 of the CMS 2552 for Title XIX.
5. One hospital did not report Medicaid Fee for Service (FFS) charges by cost center.
6. Two hospitals did not report Medicaid Managed Care Organization (MCO) and/or Medicaid Out of State (OOS) charges by revenue code or cost center.
7. Two hospitals did not report uninsured charges by revenue code or cost center.
8. One hospital included a number of accounts in their uncompensated care charge detail that should not have been included. All accounts described below were removed:
    - Underinsured patients
    - Patients with Medicaid (and no Medicaid payments), insurance (and no insurance payments), veterans, and worker's compensation
    - Accounts for their Outpatient Pharmacy, which is not a covered service
9. One hospital included accounts with a flat rate payment agreement in their uncompensated care charge detail. For these accounts it was impossible to determine whether or not the patients were insured or not. This hospital was able to provide a list of all such accounts, which were removed.
10. One hospital included accounts with insurance provided through related party insurance companies. These accounts were removed.

EXHIBIT V-2
Page 1 of 2

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING POLICY
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM

	1	2	3	4	5	6		7	8
Hospital Name	State Estimated Hospital-Specific DSH Limit	Medicaid IP Utilization Rate	Low-Income Utilization Rate	State-Defined DSH Qualification Criteria	Regular IP/OP Medicaid FFS Basic Rate Payments	IP/OP Medicaid MCO Payments	IP/OP Medicaid OOS Payments	Supplemental/ Enhanced IP/OP Medicaid Payments	Total Medicaid IP/OP Payments
UMC	$ 159,939,483	38.69%	45.78%	NOTE 1	$ 65,340,346	$ 11,646,587	$ 3,326,409	$ 28,791,747	$ 109,105,089
North Vista	$ 17,955,303	33.62%	19.36%	NOTE 2	$ 16,953,237	$ 2,872,102	$ 1,260,964	$ -	$ 21,086,303
St Rose De Lima	$ 17,209,213	14.94%	8.43%	NOTE 2	$ 7,349,030	$ 1,402,930	$ 196,457	$ -	$ 8,948,417
Renown	$ 70,677,770	20.46%	15.00%	NOTE 2	$ 34,843,763	$ 4,867,861	$ 4,084,407	$ -	$ 43,796,031
Humboldt	$ 759,312	12.06%	2.79%	NOTE 1	$ 842,937	$ 2,128	$ 13,962	$ 359,531	$ 1,218,558
Wm Bee Ririe	$ 873,314	16.38%	4.30%	NOTE 1	$ 946,163	$ -	$ 259	$ 302,991	$ 1,249,413
Mt. Grant	$ 1,686,464	12.09%	7.74%	NOTE 1	$ 453,842	$ 7,695	$ 8,725	$ 14,036	$ 484,298
South Lyon	$ 1,019,974	12.68%	4.98%	NOTE 1	$ 316,928	$ -	$ -	$ 12,332	$ 329,260
Carson-Tahoe	$ 11,840,416	12.55%	10.91%	NOTE 3	$ 8,524,375	$ 21,406	$ 385,130	$ -	$ 8,930,911
Northeastern NV	$ 3,514,627	15.97%	5.91%	NOTE 3	$ 2,838,875	$ 3,477	$ 53,358	$ -	$ 2,895,710
Churchill Community	$ 5,860,329	19.36%	11.00%	NOTE 3	$ 2,847,313	$ -	$ 23,020	$ -	$ 2,870,333
Desert View	$ 4,639,816	10.61%	7.14%	NOTE 3	$ 1,436,187	$ -	$ 93,179	$ 91,810	$ 1,621,176
Nye Regional	$ 614,300	8.51%	3.30%	NOTE 4	$ 280,566	$ -	$ -	$ -	$ 280,566
Institute for Mental Disease									
None									
Out-of-State DSH Hospitals									
None									

NOTE 1 - Public Hospital with MIUR of at least one percent
NOTE 2 - Private Hospital with MIUR above State average
NOTE 3 - Private Hospital with highest Medicaid days in county with no Public Hospital
NOTE 4 - This Hospital is not eligible for DSH

MEDICAID STATE PLAN RATE YEAR 2009

EXHIBIT V-2
Page 2 of 2

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING POLICY
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM

	9	10	11	12	13	14	15	16
Hospital Name	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care	Uninsured IP/OP Revenue	Total Applicable Section 1011 Payments	Total Cost of IP/OP Care for the Uninsured	Total Uninsured IP/OP Uncompensated Care Cost	Total Annual Uncompensated Care Costs	Disproportionate Share Hospital Payments
UMC	$ 150,015,927	$ 40,910,838	$ 3,257,563	$ 161,347	$ 134,497,721	$ 131,078,811	$ 171,989,649	$ 79,563,211
North Vista	$ 25,482,743	$ 4,396,440	$ 344,971	$ 11,695	$ 7,236,592	$ 6,879,926	$ 11,276,366	$ 750,892
St Rose De Lima	$ 15,093,313	$ 6,144,896	$ 330,738	$ 41,946	$ 10,680,577	$ 10,307,893	$ 16,452,789	$ 807,807
Renown	$ 66,976,795	$ 23,180,764	$ 374,580	$ -	$ 40,752,124	$ 40,377,544	$ 63,558,308	$ 5,158,700
Humboldt	$ 1,396,849	$ 178,291	$ 90,156	$ -	$ 2,811,647	$ 2,721,491	$ 2,899,782	$ 215,109
Wm Bee Ririe	$ 2,249,496	$ 1,000,083	$ 113,258	$ -	$ 1,620,024	$ 1,506,766	$ 2,506,849	$ 204,001
Mt. Grant	$ 575,188	$ 90,890	$ 54,477	$ -	$ 416,898	$ 362,421	$ 453,311	$ 665,173
South Lyon	$ 509,931	$ 180,671	$ 44,621	$ -	$ 278,030	$ 233,409	$ 414,080	$ 174,417
Carson-Tahoe	$ 14,969,189	$ 6,038,278	$ 1,341,750	$ -	$ 10,991,180	$ 9,649,430	$ 15,687,708	$ 1,000,000
Northeastern NV	$ 4,868,220	$ 1,972,510	$ 500,867	$ -	$ 2,502,960	$ 2,002,093	$ 3,974,603	$ 500,000
Churchill Community	$ 5,132,712	$ 2,262,379	$ 236,041	$ -	$ 3,178,189	$ 2,942,148	$ 5,204,527	$ 500,000
Desert View	$ 2,583,021	$ 961,845	$ 122,097	$ -	$ 1,921,696	$ 1,799,599	$ 2,761,444	$ 693,701
Nye Regional	$ 310,427	$ 29,861	$ 43,482	$ -	$ 413,974	$ 370,492	$ 400,353	$ 115,000
Institute for Mental Disease								
None								
Out-of-State DSH Hospitals								
None								

MEDICAID STATE PLAN RATE YEAR 2009

EXHIBIT V-3
Page 1 of 1

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING & POLICY
NEVADA DISPROPORTIONATE SHARE PROGRAM VERIFICATIONS

The agreed upon procedures enumerated in **Exhibits II and III** were performed to assist the Nevada Department of Health Care Financing & Policy in evaluating its compliance with the Social Security Act (the Act) as it relates to Medicaid Disproportionate Share Hospital (DSH) payments. The procedures were also performed to assess the Department's compliance with the six Verifications required under 42 CFR 455.304(d). Our findings relating to each Verification are shown below.

1. Twelve of thirteen hospitals that received a DSH payment qualify for DSH payments under Federal and State defined criteria. All twelve qualifying DSH hospitals in the State are allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient and outpatient hospital services during the Medicaid State Plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for services in order to reflect the total amount of claimed DSH expenditures.
2. Disproportionate Share Hospital payments made to eleven of twelve qualifying hospitals comply with the hospital-specific DSH payment limit. DSH payments made to one of twelve qualifying hospitals do not comply with the hospital-specific DSH payment limit. The DSH payments made in the audited Medicaid State Plan rate year were measured against the actual uncompensated care cost in that same audited Medicaid State Plan rate year.
3. For thirteen of thirteen hospitals, only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage (for the inpatient and outpatient hospital services they received) as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g)(1)(A) of the Act.
4. For purposes of determining hospital-specific limit calculations, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.
5. Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section has been separately documented and retained by the State.
6. The information specified in (5) above includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act.

PHBV partners

EXHIBIT VI
Page 1 of 2

June 8, 2012

Mr. Charles Duarte, Administrator
State of Nevada
Division of Health Care Financing and Policy

Dear Mr. Duarte,

We are submitting this letter in connection with our Independent Accountant's Report on Applying Agreed-Upon Procedures submitted to the Nevada Division of Health Care Financing and Policy on the Disproportionate Share Hospital (DSH) Program for Medicaid State Plan Rate (MSP) Year 2009.

These agreed upon procedures applied to the DSH program were conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA) and the standards applicable to attestation engagements contained in *Generally Accepted Government Auditing Standards* (GAGAS), issued by the Comptroller General of the United States.

In the Disproportionate Share Hospital Payments Final Rule (Rule), the Centers for Medicare & Medicaid Services (CMS) defined an "independent audit" to mean an audit conducted according to the standards specified in GAGAS. In addition, CMS indicated in the discussion accompanying the Rule that an independent auditor must operate independently from the Medicaid agency and the subject hospitals. Furthermore, CMS has issued guidance that the DSH auditor must submit a signed statement declaring independence of the respective Medicaid agency and hospitals for MSP years 2007 and later. This statement is to be included with the audit report submitted to CMS on an annual basis. In order for you to comply with this CMS guidance, we are furnishing you this letter to accompany the report that you will be submitting to CMS.

GAGAS requires that "(I)n all matters related to the audit work, the audit organization and the individual auditor, whether government or public, should be free both in fact and appearance from personal, external, and organizational impairments to independence, and must avoid the appearance of such impairments of independence."

EXHIBIT VI
Page 2 of 2

PHBV Partners is independent of the Nevada Division of Health Care Financing and Policy and the Nevada DSH hospitals as defined by GAGAS. In addition, I, Mark Hilton, acting as the engagement partner-in-charge of the engagement to perform procedures on the Nevada DSH program under the Rule, am independent of the Nevada Division of Health Care Financing and Policy and the DSH hospitals.

Sincerely,

Mark K. Hilton

Mark K. Hilton, CPA
Partner

E: Supporting Documentation for References - Missouri

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

February 18, 2013

Mr. Robert Price, Buyer
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100
Charleston, West Virginia25301

Re: *MED 13004 – Documentation of Audit Deadlines*

Dear Mr. Price:

Please accept this notarized letter as documentation that Myers and Stauffer completed the following tasks as part of our Disproportionate Share Hospital (DSH) Audits for the Missouri Department of Social Services (the Department)

- The audit engagement was conducted in accordance with CMS DSH regulations
- The audit engagement was completed by September 30 of the applicable year
- The audit reports were delivered to the State prior to December 30 of the applicable year for filing to CMS in order to satisfy DSH- related regulation requirements
- To our knowledge, the audit reports were accepted by CMS

For additional details, feel free to contact Rebecca L. Rucker at the Department (573-751-3737 or Rebecca.L.Rucker@dss.mo.gov).

Sincerely,

Robert J. Hicks

Robert Hicks, CPA
Member

Notary Public - State of Kansas
SHEILA LAUGHLIN
My Commission Expires 10-10-15

State of Kansas

County of Johnson, to-wit:

Taken, subscribed, and sworn to me before this 18th day of Feb., 2013

My Commission expires Oct. 10, 2015

DEDICATED TO GOVERNMENT HEALTH PROGRAMS 11440 Tomahawk Creek Pkwy | Leawood, KS 66211
PH 913.234.1166 | PH 800.374.6858 | FX 913.234.1104
www.mslc.com

Report on Disproportionate Share Hospital Verifications
(With Independent Accountant's Report Thereon)

State of Missouri
Missouri Department of Social Services
Jefferson City, Missouri

DSH Year Ended June 30, 2009

Prepared by:

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

Independent Accountant's Report
and
Report on DSH Verifications

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Missouri Department of Social Services
Jefferson City, Missouri

Independent Accountant's Report

We have examined the state of Missouri's compliance with Disproportionate Share Hospitals (DSH) payment requirements listed in the Report on DSH Verifications as required by 42 CFR §455.301 and §455.304(d) for the year ending June 30, 2009. The state of Missouri is responsible for compliance with federal Medicaid DSH program requirements. Our responsibility is to express an opinion on the state of Missouri's compliance with federal Medicaid DSH program requirements based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants, and General DSH Audit and Report Protocol as required by 42 CFR §455.301 and §455.304(d), except as discussed in the Notes to the Report on DSH Verifications. Based on these standards, our examination included examining, on a test basis, evidence about the state of Missouri's compliance with those requirements and performing such other procedures we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination of the state of Missouri's compliance with federal Medicaid DSH requirements.

Our examination was conducted for the purpose of forming an opinion on the state of Missouri's compliance with federal Medicaid DSH program requirements included in the Report on DSH Verifications. The Schedule of Annual Reporting Requirements provided in accordance with 42 CFR §447.299 is presented for purposes of additional analysis and is not a required part of the Report on DSH Verifications. Such information has not been subjected to the procedures applied in the examination of the Report on DSH Verifications, and, accordingly, we express no opinion on it.

In our opinion, except for the effect of the items addressed in the Notes to the Report on DSH Verifications, the Report on DSH Verifications presents fairly the state of Missouri's compliance with federal Medicaid DSH program requirements addressed by the DSH verifications for the year ending June 30, 2009.

Myers and Stauffer LC

Myers and Stauffer LC

October 19, 2012

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State of Missouri Disproportionate Share Hospital (DSH)

Report on DSH Verifications

For the Year Ended June 30, 2009

As required by 42 CFR §455.304(d) the state of Missouri must provide an annual independent certified examination report verifying the following items with respect to its disproportionate share hospital (DSH) program.

Verification 1: Each hospital that qualifies for a DSH payment in the State was allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

Findings: The results of testing performed related to this verification are summarized in the Report on DSH Verifications table included with this report.

Verification 2: The DSH payments made in the Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same Medicaid State plan rate year. The actual uncompensated care costs for the Medicaid State plan rate year have been calculated and compared to the DSH payments made. Uncompensated care costs for the Medicaid State plan rate year were calculated in accordance with Federal Register/Vol. 73, No. 245, December 19, 2008.

Findings: The results of testing performed related to this verification are summarized in the Report on DSH Verifications table included with this report.

Verification 3: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923 (g)(1)(A) of the Act.

Findings: The total uncompensated care costs reflected in the Report on DSH Verifications reflects the uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage.

Verification 4: For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.

Findings: In calculating the hospital-specific DSH limit represented in the Report on DSH Verifications, if a hospital had total Medicaid payments in excess of the calculated Medicaid cost, the excess was used to reduce the total uncompensated care costs.

State of Missouri Disproportionate Share Hospital (DSH)

Report on DSH Verifications

For the Year Ended June 30, 2009

Verification 5: Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section have been separately documented and retained by the State.

Findings: The state of Missouri has retained documentation of costs and payments associated with calculating the hospital-specific DSH limits contained in this report. The state retains cost data through the collection of cost reports; Medicaid expenditure data through the MMIS and other documentation; and uninsured data through the DSH payment calculations and DSH examination.

Verification 6: The information specified in verification 5 above includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient services they received.

Findings: The documentation retained related to the calculation of the hospital-specific DSH limits contained in this report includes a description of the methodology used to calculate each hospital's DSH limit under Section 1923(g)(1) of the Act. For DSH payment purposes, the state defines the hospitals' payment limits in accordance with its state plan. For purposes of this examination, the state defines the hospitals' payment limits in accordance with 42 CFR §455.304.

State of Missouri
Report on DSH Verifications (table)
For the Medicaid State Plan Rate Year Ended June 30, 2009

Hospital	Verification #1	Verification #2			Verification #3	Verification #4	Verification #5	Verification #6
	Was Hospital Allowed to Retain DSH Payment?	DSH Payment for Medicaid State Plan Rate Year (In-State and Out-of-State)	Total Uncompensated Care Costs for Medicaid State Plan Rate Year	DSH Payment Under or <Over> Total Uncompensated Care Costs (UCC)	Were only I/P and O/P Hospital Costs to Medicaid eligible and Uninsured Included in UCC?	If Medicaid Payments were in excess of Medicaid cost was the Total UCC reduced by this amount?	Have all claimed expenditures and payments for Medicaid and Uninsured been documented and retained?	Does the retained documentation include a description of the methodology used to calculate the UCC?
Advanced Healthcare Medical Center (Reynolds County)	Yes	119,432	39,605	(79,827)	Yes	Yes	Yes	Yes
Audrain Medical Center	Yes	1,603,497	(406,133)	(1,603,497)	Yes	Yes	Yes	Yes
Aurora Community Hospita	Yes	1,237,624	(221,047)	(1,237,624)	Yes	Yes	Yes	Yes
Barnes-Jewish Hospital - St. Louis	Yes	30,437,809	14,226,939	(16,210,870)	Yes	Yes	Yes	Yes
Barnes-Jewish St. Peters Hospital	Yes	2,097,412	1,709,353	(388,059)	Yes	Yes	Yes	Yes
Barnes-Jewish West County Hospital	Yes	393,025	1,018,651	625,626	Yes	Yes	Yes	Yes
Barton County Memorial Hospital	Yes	891,881	231,566	(660,315)	Yes	Yes	Yes	Yes
Bates County Memorial Hospital	Yes	1,862,613	218,787	(1,643,826)	Yes	Yes	Yes	Yes
Boone Hospital Center	Yes	3,483,564	1,097,859	(2,385,705)	Yes	Yes	Yes	Yes
Bothwell Regional Health Center	Yes	3,361,414	808,032	(2,553,382)	Yes	Yes	Yes	Yes
Callaway Community Hospital	Yes	617,794	(986,467)	(617,794)	Yes	Yes	Yes	Yes
Cameron Community Hospita	Yes	1,179,672	845,254	(334,418)	Yes	Yes	Yes	Yes
Capital Region Medical Center	Yes	2,023,726	(2,662,479)	(2,023,726)	Yes	Yes	Yes	Yes
Cardinal Glennon Children's Hospital	Yes	9,695,926	(36,792,711)	(9,695,926)	Yes	Yes	Yes	Yes
Carroll County Memorial Hospital	Yes	243,896	166,051	(77,845)	Yes	Yes	Yes	Yes
Cass Medical Center	Yes	1,046,628	1,334,338	287,710	Yes	Yes	Yes	Yes
Cedar County Memorial Hospital	Yes	343,529	195,045	(148,484)	Yes	Yes	Yes	Yes
Centerpoint Medical Center	Yes	6,281,661	3,003,042	(3,278,619)	Yes	Yes	Yes	Yes
Centerpointe Hospital (Spirit of St. Louis)	Yes	485,169	(3,167,276)	(485,169)	Yes	Yes	Yes	Yes
Childrens Mercy Hospital	Yes	15,176,161	744,019	(14,432,142)	Yes	Yes	Yes	Yes
Christian Hospital Northeast	Yes	7,654,227	9,755,970	2,101,743	Yes	Yes	Yes	Yes
Citizens Memorial Hospital	Yes	1,488,297	(290,442)	(1,488,297)	Yes	Yes	Yes	Yes
Columbia Regional Hospital	Yes	1,059,496	(3,094,930)	(1,059,496)	Yes	Yes	Yes	Yes
Community Hospital Assn - Fairfie	Yes	282,789	28,755	(254,034)	Yes	Yes	Yes	Yes
Cooper County Memorial Hospital	Yes	622,371	528,102	(94,269)	Yes	Yes	Yes	Yes
Cox (Lester E.) Medical Center	Yes	22,402,293	(1,634,600)	(22,402,293)	Yes	Yes	Yes	Yes
Cox-Monett Hospital	Yes	1,600,664	345,946	(1,254,718)	Yes	Yes	Yes	Yes
Crittenton Center	Yes	182,292	(436,615)	(182,292)	Yes	Yes	Yes	Yes
Depaul Health Center	Yes	11,999,975	4,214,836	(7,785,139)	Yes	Yes	Yes	Yes
Des Peres Hospital	Yes	1,711,593	(2,755,279)	(1,711,593)	Yes	Yes	Yes	Yes
Doctor's Hospital of Springfield	Yes	1,633,194	(2,952,022)	(1,633,194)	Yes	Yes	Yes	Yes
Dubuis Hospital of St. Louis (All Saints)	Yes	6,790	111,806	105,016	Yes	Yes	Yes	Yes
Ellett Memorial Hospital	Yes	121,704	186,511	64,807	Yes	Yes	Yes	Yes
Excelsior Springs Medical Center	Yes	545,087	561,318	16,231	Yes	Yes	Yes	Yes
Forest Park Hospital	Yes	5,560,836	(16,761,640)	(5,560,836)	Yes	Yes	Yes	Yes
Freeman-Neosho Hospital	Yes	1,307,687	898,860	(408,827)	Yes	Yes	Yes	Yes
Freeman-Oak Hill Health System	Yes	7,906,475	(4,401,825)	(7,906,475)	Yes	Yes	Yes	Yes
Fulton State Hospital	Yes	69,982,014	59,491,201	(10,490,813)	Yes	Yes	Yes	Yes
Golden Valley Memorial Hospital	Yes	1,467,090	(136,912)	(1,467,090)	Yes	Yes	Yes	Yes
Hannibal Regional Hospital	Yes	2,060,331	(289,661)	(2,060,331)	Yes	Yes	Yes	Yes

See Independent Accountant's Report

State of Missouri
Report on DSH Verifications (table)
For the Medicaid State Plan Rate Year Ended June 30, 2009

Hospital	Verification #1	Verification #2			Verification #3	Verification #4	Verification #5	Verification #5
	Was Hospital Allowed to Retain DSH Payment?	DSH Payment for Medicaid State Plan Rate Year (In-State and Out-of-State)	Total Uncompensated Care Costs for Medicaid State Plan Rate Year	DSH Payment Under or <Over> Total Uncompensated Care Costs (UCC)	Were only I/P and O/P Hospital Costs to Medicaid eligible and Uninsured Included in UCC?	If Medicaid Payments were in excess of Medicaid cost was the Total UCC reduced by this amount?	Have all claimed expenditures and payments for Medicaid and Uninsured been documented and retained?	Does the retained documentation include a description of the methodology used to calculate the UCC?
Harrison County Community Hospita	Yes	245,100	246,811	1,711	Yes	Yes	Yes	Yes
Hawthorn Children's Psychiatric Hospital	Yes	2,090,315	(560,842)	(2,090,315)	Yes	Yes	Yes	Yes
Heartland Behavioral Health Svcs (HSA)	Yes	53,300	(5,319,422)	(53,300)	Yes	Yes	Yes	Yes
Heartland LTAC	Yes	162,869	419,149	256,280	Yes	Yes	Yes	Yes
Heartland Regional Medical Center	Yes	10,211,274	(2,632,054)	(10,211,274)	Yes	Yes	Yes	Yes
Hedrick Medical Center	Yes	792,306	1,832,444	1,040,138	Yes	Yes	Yes	Yes
Hermann Area District Hospital	Yes	383,057	123,305	(259,752)	Yes	Yes	Yes	Yes
I-70 Medical Center	Yes	220,309	(9,120)	(220,309)	Yes	Yes	Yes	Yes
Iron County Hospital	Yes	217,410	571,906	354,496	Yes	Yes	Yes	Yes
Jefferson Memorial Hospital	Yes	3,267,647	(282,975)	(3,267,647)	Yes	Yes	Yes	Yes
John Fitzgibbon Memorial Hospital	Yes	851,116	563,124	(287,992)	Yes	Yes	Yes	Yes
Kindred Healthcare (Vencor) - Kansas City	Yes	301,468	1,565,699	1,264,231	Yes	Yes	Yes	Yes
Kindred Healthcare (Vencor Hospital) St. Louis	Yes	115,160	(2,504,928)	(115,160)	Yes	Yes	Yes	Yes
Lafayette Regional Health Center	Yes	988,164	881,047	(107,117)	Yes	Yes	Yes	Yes
Lake Regional Health System	Yes	6,473,141	1,602,169	(4,870,972)	Yes	Yes	Yes	Yes
Lakeland Regional Hospital	Yes	28,448	(1,594,140)	(28,448)	Yes	Yes	Yes	Yes
Landmark Hospital	Yes	432,895	(966,605)	(432,895)	Yes	Yes	Yes	Yes
Landmark Hospital of Columbia	Yes	22,218	-	(22,218)	Yes	Yes	Yes	Yes
Landmark Hospital of Joplin	Yes	434,820	(200,317)	(434,820)	Yes	Yes	Yes	Yes
Lee's Summit Hospital	Yes	1,551,446	3,042,306	1,490,860	Yes	Yes	Yes	Yes
Liberty Hospital	Yes	4,885,655	5,359,004	473,349	Yes	Yes	Yes	Yes
Lincoln County Memorial Hospita	Yes	1,108,155	1,363,452	255,297	Yes	Yes	Yes	Yes
Macon County Samaritan Memorial Hospital	Yes	431,742	137,941	(293,801)	Yes	Yes	Yes	Yes
Madison Medical Center	Yes	515,486	120,524	(394,962)	Yes	Yes	Yes	Yes
McCune-Brooks Hospital	Yes	1,879,288	1,685,648	(193,640)	Yes	Yes	Yes	Yes
Metropolitan St. Louis Psychiatric Center	Yes	18,769,085	11,931,322	(6,837,763)	Yes	Yes	Yes	Yes
Mid-Missouri Mental Health Center	Yes	5,458,146	7,348,798	(2,109,348)	Yes	Yes	Yes	Yes
Mineral Area Regional Medical Center	Yes	1,773,364	(1,041,342)	(1,773,364)	Yes	Yes	Yes	Yes
Missouri Baptist Hospital of Sullivan	Yes	1,378,460	2,478,516	1,100,056	Yes	Yes	Yes	Yes
Missouri Baptist Medical Center	Yes	2,625,371	3,279,878	654,507	Yes	Yes	Yes	Yes
Missouri Delta Medical Center	Yes	2,869,696	(1,119,130)	(2,869,696)	Yes	Yes	Yes	Yes
Missouri Rehabilitation Center	Yes	413,614	(2,310,118)	(413,614)	Yes	Yes	Yes	Yes
Missouri Southern Healthcare (Dexter)	Yes	457,429	140,297	(317,132)	Yes	Yes	Yes	Yes
Moberly Regional Medical Center	Yes	1,093,421	(3,867,091)	(1,093,421)	Yes	Yes	Yes	Yes
Nevada Regional Medical Center	Yes	1,657,008	875,137	(781,871)	Yes	Yes	Yes	Yes
North Kansas City Hospital	Yes	10,130,921	10,600,800	469,879	Yes	Yes	Yes	Yes
Northeast Regional Medical Center	Yes	1,284,655	(1,116,954)	(1,284,655)	Yes	Yes	Yes	Yes
Northland LTACE Hospital	Yes	507,290	51,464	(455,826)	Yes	Yes	Yes	Yes
Northwest Medical Center (Gentry)	Yes	231,644	617,942	386,298	Yes	Yes	Yes	Yes
Northwest Missouri Psychiatric Rehabilitation Center	Yes	20,591,307	15,482,829	(5,108,478)	Yes	Yes	Yes	Yes

See Independent Accountant's Report

State of Missouri
Report on DSH Verifications (table)
For the Medicaid State Plan Rate Year Ended June 30, 2009

Hospital	Verification #1	Verification #2			Verification #3	Verification #4	Verification #5	Verification #6
	Was Hospital Allowed to Retain DSH Payment?	DSH Payment for Medicaid State Plan Rate Year (In-State and Out-of-State)	Total Uncompensated Care Costs for Medicaid State Plan Rate Year	DSH Payment Under or <Over> Total Uncompensated Care Costs (UCC)	Were only I/P and O/P Hospital Costs to Medicaid Eligible and Uninsured Included in UCC?	If Medicaid Payments were in excess of Medicaid cost was the Total UCC reduced by this amount?	Have all claimed expenditures and payments for Medicaid and Uninsured been documented and retained?	Does the retained documentation include a description of the methodology used to calculate the UCC?
Ozarks Medical Center	Yes	3,181,490	1,172,115	(2,009,375)	Yes	Yes	Yes	Yes
ParklandHealth Center - Farmington	Yes	1,492,055	1,113,818	(378,237)	Yes	Yes	Yes	Yes
Pemiscot Memorial Hospital	Yes	1,218,285	(1,317,496)	(1,218,285)	Yes	Yes	Yes	Yes
Perry County Memorial Hospital	Yes	657,319	18,219	(639,100)	Yes	Yes	Yes	Yes
Pershing Memorial Hospital	Yes	337,732	400,416	62,684	Yes	Yes	Yes	Yes
Phelps County Regional Medical Center	Yes	5,644,877	3,789,801	(1,855,076)	Yes	Yes	Yes	Yes
Pike County Memorial Hospital	Yes	737,021	300,968	(436,053)	Yes	Yes	Yes	Yes
Poplar Bluff Regional Medical Center	Yes	4,004,240	(975,513)	(4,004,240)	Yes	Yes	Yes	Yes
Progress West Healthcare Center	Yes	1,238,544	3,034,209	1,795,665	Yes	Yes	Yes	Yes
Putnam County Memorial Hospita	Yes	140,740	431,720	290,980	Yes	Yes	Yes	Yes
Ray County Memorial Hospital	Yes	572,455	414,411	(158,044)	Yes	Yes	Yes	Yes
Rehab Institute of St. Louis	Yes	392,714	(468,602)	(392,714)	Yes	Yes	Yes	Yes
Research Belton Hospital	Yes	1,919,879	(1,277,455)	(1,919,879)	Yes	Yes	Yes	Yes
Research Medical Center	Yes	12,964,452	(2,242,062)	(12,964,452)	Yes	Yes	Yes	Yes
Research Psychiatric Center	Yes	1,325,935	(332,906)	(1,325,935)	Yes	Yes	Yes	Yes
Ripley County Memorial Hospital	Yes	352,548	(523,754)	(352,548)	Yes	Yes	Yes	Yes
Royal Oaks Hospital	Yes	1,193,839	(2,058,693)	(1,193,839)	Yes	Yes	Yes	Yes
Rusk Rehabilitation Center	Yes	338,113	(863,236)	(338,113)	Yes	Yes	Yes	Yes
Sac-Osage Hospital	Yes	353,044	(260,363)	(353,044)	Yes	Yes	Yes	Yes
Salem Memorial District Hospital	Yes	785,348	449,408	(335,940)	Yes	Yes	Yes	Yes
Scotland County Memorial Hospital	Yes	313,233	(81,690)	(313,233)	Yes	Yes	Yes	Yes
Select Specialty Hospital - Springfield	Yes	631,358	214,933	(416,425)	Yes	Yes	Yes	Yes
Select Specialty Hospital - St. Louis	Yes	147,878	487,391	339,513	Yes	Yes	Yes	Yes
Select Specialty Hospital - Western Mo	Yes	241,472	(511,858)	(241,472)	Yes	Yes	Yes	Yes
Skaggs Community Hospital	Yes	6,992,515	3,589,627	(3,402,889)	Yes	Yes	Yes	Yes
South Barry County Memorial Hospital	Yes	913,313	(143,471)	(913,313)	Yes	Yes	Yes	Yes
Southeast Missouri Hospital	Yes	7,498,799	10,642,911	3,144,112	Yes	Yes	Yes	Yes
Southeast Missouri Mental Health	Yes	25,744,085	14,792,692	(10,951,393)	Yes	Yes	Yes	Yes
St. Alexius Hospital	Yes	6,514,637	(1,036,532)	(6,514,637)	Yes	Yes	Yes	Yes
St. Anthony's Medical Center	Yes	9,840,214	6,012,426	(3,827,788)	Yes	Yes	Yes	Yes
St. Francis Hospital - Maryville	Yes	1,538,921	1,623,391	84,470	Yes	Yes	Yes	Yes
St. Francis Hospital - Mountain View	Yes	429,908	540,533	110,625	Yes	Yes	Yes	Yes
St. Francis Medical Center - Cape Girardeau	Yes	6,987,924	10,662,055	3,674,131	Yes	Yes	Yes	Yes
St. John's Hospital - Lebanon (Breech)	Yes	2,424,181	3,393,420	969,239	Yes	Yes	Yes	Yes
St. John's Mercy Hospital - Washington	Yes	4,279,953	10,083,273	5,803,320	Yes	Yes	Yes	Yes
St. John's Mercy Medical Center - Creve Coeur	Yes	18,385,767	(181,619)	(18,385,767)	Yes	Yes	Yes	Yes
St. John's Mercy Rehabilitation Hospital	Yes	860,100	604,296	(255,804)	Yes	Yes	Yes	Yes
St. John's Regional Health Center	Yes	24,903,950	22,296,457	(2,697,493)	Yes	Yes	Yes	Yes
St. John's Regional Medical Center - Joplin	Yes	11,077,887	15,172,308	4,094,421	Yes	Yes	Yes	Yes
St. Joseph Health Center - Kansas City	Yes	4,932,403	1,945,834	(2,986,569)	Yes	Yes	Yes	Yes

See Independent Accountant's Report

State of Missouri
Report on DSH Verifications (table)
For the Medicaid State Plan Rate Year Ended June 30, 2009

Hospital	Verification #1	Verification #2			Verification #3	Verification #4	Verification #5	Verification #6
	Was Hospital Allowed to Retain DSH Payment?	DSH Payment for Medicaid State Plan Rate Year (In-State and Out-of-State)	Total Uncompensated Care Costs for Medicaid State Plan Rate Year	DSH Payment Under or <Over> Total Uncompensated Care Costs (UCC)	Were only I/P and O/P Hospital Costs to Medicaid eligible and Uninsured Included in UCC?	If Medicaid Payments were in excess of Medicaid cost was the Total UCC reduced by this amount?	Have all claimed expenditures and payments for Medicaid and Uninsured been documented and retained?	Does the retained documentation include a description of the methodology used to calculate the UCC?
St. Joseph Health Center - St. Charles	Yes	7,752,531	3,872,714	(3,879,817)	Yes	Yes	Yes	Yes
St. Joseph Hospital - Kirkwood	Yes	2,325,348	3,011,523	686,175	Yes	Yes	Yes	Yes
St. Joseph Hospital West	Yes	2,680,402	(67,248)	(2,680,402)	Yes	Yes	Yes	Yes
St. Louis Childrens Hospital	Yes	2,471,656	(18,837,157)	(2,471,656)	Yes	Yes	Yes	Yes
St. Louis Psychiatric Rehabilitation Center	Yes	36,213,353	21,893,475	(14,319,877)	Yes	Yes	Yes	Yes
St. Louis University Medical Center	Yes	18,165,663	(5,823,872)	(18,165,663)	Yes	Yes	Yes	Yes
St. Luke's Cancer Institute	Yes	975,153	(2,164,681)	(975,153)	Yes	Yes	Yes	Yes
St. Luke's East - Lee's Summit	Yes	940,807	(304,274)	(940,807)	Yes	Yes	Yes	Yes
St. Luke's Hospital of Kansas City	Yes	14,702,712	3,363,542	(11,339,170)	Yes	Yes	Yes	Yes
St. Luke's Hospital West	Yes	3,360,856	(1,078,903)	(3,360,856)	Yes	Yes	Yes	Yes
St. Luke's Northland Hospital	Yes	4,824,368	2,095,324	(2,729,044)	Yes	Yes	Yes	Yes
St. Luke's Rehabilitation Hospital	Yes	310,441	(80,777)	(310,441)	Yes	Yes	Yes	Yes
St. Mary's Health Center - Jefferson City	Yes	3,877,303	1,927,540	(1,949,763)	Yes	Yes	Yes	Yes
St. Mary's Hospital - Blue Springs	Yes	2,467,810	1,734,205	(733,605)	Yes	Yes	Yes	Yes
Ste. Genevieve County Memorial	Yes	367,808	(34,499)	(367,808)	Yes	Yes	Yes	Yes
Sullivan County Memorial Hospital	Yes	249,736	265,874	16,138	Yes	Yes	Yes	Yes
Texas County Memorial Hospital	Yes	1,181,407	207,311	(974,096)	Yes	Yes	Yes	Yes
Truman Medical Center Lakewood	Yes	28,541,921	14,598,085	(13,943,836)	Yes	Yes	Yes	Yes
Truman Medical Center Hospital Hill	Yes	81,651,807	52,849,642	(28,802,165)	Yes	Yes	Yes	Yes
Twin Rivers Regional Medical Center	Yes	1,695,243	(11,192,147)	(1,695,243)	Yes	Yes	Yes	Yes
Two Rivers Psychiatric Hospital	Yes	515,272	(306,276)	(515,272)	Yes	Yes	Yes	Yes
University of Missouri Hospital and Clinics	Yes	16,506,916	(25,857,831)	(16,506,916)	Yes	Yes	Yes	Yes
Washington County Memorial	Yes	1,102,356	369,248	(733,108)	Yes	Yes	Yes	Yes
Western Missouri Medical Center	Yes	1,786,201	151,993	(1,634,208)	Yes	Yes	Yes	Yes
Western Missouri Mental Health	Yes	18,468,043	12,615,575	(5,852,468)	Yes	Yes	Yes	Yes
Wright Memorial Hospital	Yes	488,659	766,693	278,034	Yes	Yes	Yes	Yes

See Independent Accountant's Report

State of Missouri Disproportionate Share Hospital (DSH)

Notes to the Report on DSH Verifications

For the Year Ended June 30, 2009

Notes to the Report on DSH Verifications

During the course of the engagement, the following data issues or other caveats were identified and are being reported in accordance with the requirements of 42 CFR 455.301.

(1) **Uncompensated Care Cost Definitions**
Uncompensated care costs for patients with no third party coverage were calculated based on the definitions from the Federal Register / Vol. 77, No. 11, Wednesday, January 18, 2012 / Proposed Rules.

(2) **Uninsured Patient Payments**
The following hospitals were unable to satisfactorily document uninsured patient payments received during the DSH year. In many cases the hospitals could not provide the date of collection and/or reported the payments on an accrual basis instead of the required cash basis. Other hospitals were unable to provide any payments or only provided a partial year of payments. These payment issues may result in a misstated uncompensated care cost calculation. These difficulties were most often related to the time period between the patient service dates and/or cash receipt dates (DSH year 2009) and the timing of the DSH examination (calendar year 2012) and not necessarily due to inaction or lack of cooperation by the hospitals listed.

Boone Hospital Center
Centerpointe Hospital (Spirit of St. Louis)
Hannibal Regional Hospital
Heartland Behavioral Health Services (HSA)
Jefferson Memorial Hospital
Lakeland Regional Hospital
Lincoln County Memorial Hospital
McCune-Brooks Hospital
Missouri Southern Healthcare (Dexter)
Ozarks Medical Center
Pemiscot Memorial Hospital
Perry County Memorial Hospital
Rehab Institute of St. Louis
Rusk Rehabilitation Center
Sac-Osage Hospital
St. Alexius Hospital
St. John's Hospital - Lebanon (Breech)
St. John's Regional Medical Center - Joplin

State of Missouri Disproportionate Share Hospital (DSH)

Notes to the Report on DSH Verifications

For the Year Ended June 30, 2009

(3) **Undocumented Uninsured Uncompensated Care Cost**

The following hospitals were unable to satisfactorily document all of the services they provided to uninsured patients and, in most cases, the uninsured payments received during the DSH year. These undocumented services were excluded resulting in a potentially understated uncompensated care calculation. These difficulties were most often related to the time period between the patient service dates and/or cash receipt dates (DSH year 2009) and the timing of the DSH examination (calendar year 2012) and not necessarily due to inaction or lack of cooperation by the hospitals listed.

I-70 Medical Center
Kindred Healthcare (Vencor) - St. Louis
Landmark Hospital
Landmark Hospital of Joplin
Northland LTACH Hospital
Select Specialty Hospital - Springfield
Select Specialty Hospital - Western Missouri
St. Luke's Rehabilitation Hospital

(4) **Partially Documented Uninsured Uncompensated Care Cost**

The following hospitals were unable to satisfactorily document the services they provided to uninsured patients and, in most cases, the uninsured payments received during the DSH year. However, these hospitals were able to estimate the uninsured services provided and payments received using hospital records. Due to the lack of documentation, we were unable to fully test the reasonableness of the hospitals' estimates and the impact of any potential misstatement on their uncompensated care cost calculations. These difficulties were most often related to the time period between the patient service dates and/or cash receipt dates (DSH year 2009) and the timing of the DSH examination (calendar year 2012) and not necessarily due to inaction or lack of cooperation by the hospitals listed.

Cedar County Memorial Hospital
Centerpointe Hospital (Spirit of St. Louis)
Citizens Memorial Hospital
Lake Regional Health System
Lincoln County Memorial Hospital
Madison Medical Center
Ripley County Memorial Hospital
Wright Memorial Hospital

(5) **Dual Eligible (patients with both Medicare and Medicaid)**

We were unable to satisfactorily document the dual-eligible (patients with both Medicare and Medicaid) services provided and payments received. Dual-eligible paid claims summaries from the state's Medicaid Management Information Systems (MMIS) were incomplete due to missing charge data on specific claims. Dual-eligible patient services are included in the uncompensated care cost calculations based on the hospitals' internal data or a combination of hospital and state data. In some cases hospital internal data was not available and estimates were made to complete the missing charges in the state's MMIS data.

State of Missouri Disproportionate Share Hospital (DSH)

Notes to the Report on DSH Verifications

For the Year Ended June 30, 2009

(6) **Missouri Medicaid Managed Care and State Children's Health Insurance Program**
We were unable to obtain Missouri Medicaid managed care paid claims summaries from the Medicaid managed care organizations to satisfactorily document the Missouri Medicaid managed care services provided and payments received. The state of Missouri also experienced difficulties accumulating the claims data we requested for the Medicaid managed care services provided by the DSH hospitals. Missouri Medicaid managed care services are included in the uncompensated care cost calculations for hospitals that were able to provide their own internal data. However, the hospitals' internal data may include individuals paid by the State Children's Health Insurance Program (SCHIP). Hospitals are not able to separate SCHIP individuals from other Medicaid individuals. The state's Medicaid fee-for-service data may also include SCHIP data but since most of the children are covered under managed care it is believed this amount is less significant. We are currently working with the state to obtain eligibility files and other data to begin the process of removing the SCHIP and other non-Title XIX services in future DSH examination years.

(7) **Out-of-State (non-Missouri) Medicaid**
The majority of hospitals were unable to obtain Medicaid out-of-state paid claims reports to satisfactorily document the out-of-state services provided and payments received. Out-of-state (non-Missouri) Medicaid services are included in the uncompensated care cost calculation for hospitals that were able to provide their own internal data. Several hospitals did not report any out-of-state Medicaid services. These difficulties were predominately due to hospital requests to out-of-state Medicaid agencies not being responded to timely, and are not due to inaction or a lack of cooperation by the hospitals.

(8) **State-Owned and Operated Psychiatric Hospital Uncompensated Care Cost Calculations**
The following state-owned and operated psychiatric hospitals were unable to satisfactorily document the services they provided and payments received for uninsured services. They were also unable to satisfactorily document their Medicaid-eligible services and payments received other than those included on the state Medicaid paid claims report. We were able to estimate the uncompensated care cost using facility collection records, Medicaid-eligibility assumptions, and cost report census documents maintained by the hospitals. We were not able to obtain an uninsured patient listing with charge level detail to calculate uncompensated care cost using Medicare cost report methods, or to test that only uninsured and Medicaid-eligible patients were included in the uncompensated care cost calculations. The state hospitals' difficulties fulfilling our data request appeared to be influenced by the length of time between when the DSH examination was performed (calendar year 2012) and the DSH year (state fiscal year 2009).

Fulton State Hospital
Hawthorn Children's Psychiatric Hospital
Metropolitan St. Louis Psychiatric Center
Mid-Missouri Mental Health Center
Northwest Missouri Psychiatric Rehabilitation
Southeast Missouri Mental Health
St. Louis Psychiatric Rehabilitation Center
Western Missouri Mental Health

State of Missouri Disproportionate Share Hospital (DSH)

Notes to the Report on DSH Verifications

For the Year Ended June 30, 2009

(9) **Court-Ordered Patients**

In accordance with CMS guidance, prisoners were excluded from the uncompensated care cost as presented in this report. However, the following state-owned and operated psychiatric hospitals included court-ordered patients in the uncompensated care cost calculation. Federal guidance with respect to a patient's insurance status is unclear when patients have been involuntarily hospitalized under a 72-hour hold; found not-guilty by reason of insanity; admitted to determine their mental competency to stand trial; or previously served a court-ordered sentence but have not been discharged. These individuals were left in the uncompensated care cost calculations presented in this report.

Fulton State Hospital
Hawthorn Children's Psychiatric Hospital
Metropolitan St. Louis Psychiatric Center
Mid-Missouri Mental Health Center
Northwest Missouri Psychiatric Rehabilitation
Southeast Missouri Mental Health
St. Louis Psychiatric Rehabilitation Center
Western Missouri Mental Health

(10) **State-Owned and Operated Psychiatric Hospital Cost Report Days**

The Department of Mental Health (DMH) indicated their total patient days reported on the following psychiatric hospital cost reports are incorrect. They have stated they will amend the cost reports to reflect the revised patient day totals. The revised patient day totals agree to the detailed patient day support provided for the DSH examination. The cost per diems used in the uncompensated care cost (UCC) calculations reflect the amended patient day totals for all of the following hospitals.

Fulton State Hospital
Hawthorn Children's Psychiatric Hospital
Metropolitan St. Louis Psychiatric Center
Mid-Missouri Mental Health Center
Northwest Missouri Psychiatric Rehabilitation
Southeast Missouri Mental Health
St. Louis Psychiatric Rehabilitation Center
Western Missouri Mental Health

(11) **Missouri DSH State Plan**

Missouri hospitals were not required to report uncompensated care cost (UCC) for DSH payment purposes in 2009 under the same requirements as required by the DSH examination in accordance with the Federal Register/Vol. 73, No. 245, December 19, 2008. The hospitals were paid DSH under a Centers for Medicare and Medicaid Services (CMS) approved state plan that did not include the same calculations for UCC as required under the DSH examination. The State of Missouri and several DSH hospitals believe their UCC

State of Missouri Disproportionate Share Hospital (DSH)

Notes to the Report on DSH Verifications

For the Year Ended June 30, 2009

would have been significantly higher had they been allowed to report them in accordance with the CMS approved Missouri state plan for the 2009 DSH year.

(12) **Attestation Statements**

Hospitals were requested to sign attestation statements related to the data they provided to us during our examination. The following hospitals did not sign the requested attestation statements.

Dubuis Hospital of St. Louis (All Saints)
St. John's Regional Health Center

(13) **Medicaid Cost Report Settlements**

Missouri Medicaid calculates cost report settlements related to outpatient payments for new and nominal charge hospitals. As of the date of this report, the final outpatient cost report settlements overlapping the 2009 DSH year had not been fully completed for the following hospitals. The state was able to provide preliminary settlement amounts based on estimates or other as-filed data. These estimated settlements have been included in the uncompensated care calculations. When completed in future years, the final cost report settlements may result in additional Medicaid payments or recoupments.

I-70 Medical Center
Iron County Hospital
Progress West Healthcare Center
St. John's Mercy Rehabilitation Hospital
Truman Medical Center Hospital Hill
Truman Medical Center Lakewood

Schedule of Annual Reporting Requirements

State of Missouri
Schedule of Annual Reporting Requirements
For the Medicaid State Plan Rate Year Ended June 30, 2009

Definition of Uncompensated Care. The definition of uncompensated care was based on guidance published by CMS in the final rule (73 Fed. Reg. 77904, December 19, 2008) and the proposed rule (77 Fed. Reg. 3500, January 18, 2012). The calculated uncompensated care costs (UCC) represent the net uncompensate d costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage. The UCC for these patient groups was calculated using Medicare cost reporting methods, and utilized the Medicare cost report, Medicaid Paid Claims Summarized, and Hospital-Provided Data. Total uncompensated care costs represent the net uncompensated care costs of providing inpatient and outpatient hospital services to patients that fall into one of the following Medicaid-in-State and out-of-State payment categories: Fee-for-Service Medicaid primary, Fee-for-Service Crossovers, Managed Care Medicaid primary, Managed Care Medicaid Crossovers, and Uninsured individuals with no source of third party coverage. The cost of services for each of these payment categories was calculated using the appropriate per diems or cost-to-charge ratios from each hospital's Medicare Cost Report. These costs were then reduced by the total payments received for the services provided, including any supplemental Medicaid payments and Section 1011 payments where applicable.

A	B	C	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Hospital Name	State Estimated Hospital-Specific DSH Limit	Medicaid I/P Utilization Rate	Low-Income Utilization Rate	State-Defined Eligibility Statute	Regular IP/OP Medicaid FFS Rate Payments	IP/OP Medicaid MCO Payments	Supplemental / Enhanced IP/OP Medicaid Payments	Total Medicaid IP/OP Medicaid Payments (F+G+H)	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care Costs (J-I)	Total IP/OP Indigent Care/Shift Pay Revenues	Total Applicable Section 1011 Payments	Total IP/OP Uninsured Cost of Care	Total Uninsured Uncompensated Care Costs (M-M-L)	Total Eligible Uncompensated Care Costs (K+O)	Total In-State DSH Payments Received	Total Out-of-State DSH Payments Received
Advanced Healthcare Medical Center (Reynolds County)	251,601	45.26%	34.49%	1% MHR	3,394,783	-	256,644	3,651,427	3,259,483	(391,944)	1,969	-	408,538	39,549	39,606	119,432	-
Audrain Medical Center	4,345,873	29.07%	13.34%	1% MHR	6,360,574	1,909,304	3,140,663	11,410,541	9,294,995	(2,115,546)	295,466	-	2,006,909	1,709,413	1,603,497	-	-
Aurora Community Hospital	3,632,723	57.01%	32.70%	1% MHR	6,913,908	-	213,637	7,127,545	6,089,069	(1,038,476)	144,243	-	1,121,672	877,429	(221,047)	1,237,624	-
Barnes-Jewish Hospital - St. Louis	90,207,939	30.02%	19.21%	1% MHR	190,525,620	24,437,487	115,478,457	330,441,564	306,497,791	(23,963,693)	2,206,114	-	40,595,746	38,196,632	14,226,939	30,295,926	41,873
Barnes-Jewish St. Peters Hospital	6,198,021	12.81%	6.41%	1% MHR	3,608,963	1,921,873	2,206,783	10,361,621	9,142,946	(598,677)	127,453	-	2,933,531	2,668,028	1,709,351	2,897,412	-
Barnes-Jewish West County Hospital	1,144,687	9.05%	3.49%	1% MHR	2,747,764	414,387	965,534	4,131,705	4,314,984	183,199	292,754	-	1,129,186	836,432	1,019,651	393,025	-
Barton County Memorial Hospital	2,455,169	25.04%	17.36%	1% MHR	3,658,503	-	163,179	3,815,682	3,515,138	(299,944)	97,717	-	627,227	531,510	231,566	591,881	-
Bates County Memorial Hospital	5,316,886	18.35%	20.55%	1% MHR	2,911,183	1,013,148	1,654,352	5,578,683	4,556,307	(1,022,376)	85,803	-	1,328,966	1,243,163	218,787	1,862,613	-
Bates Hospital Center	10,255,789	17.42%	8.92%	1% MHR	10,997,412	2,840,820	9,279,307	24,117,729	22,463,416	(1,654,313)	1,248,213	-	3,901,485	2,653,272	1,897,059	3,483,564	-
Bethesda Regional Health Center	9,574,227	26.60%	14.96%	1% MHR	11,633,222	4,077,515	3,970,307	19,681,044	18,571,887	(1,109,157)	705,256	-	2,622,465	1,917,209	808,052	3,361,404	-
Callaway Community Hospital	1,824,246	25.34%	26.10%	1% MHR	1,958,179	1,279,652	1,200,829	4,564,660	3,020,744	(1,543,916)	120,956	-	678,405	557,449	(986,467)	417,798	-
Cameron Community Hospital	3,484,513	32.55%	16.36%	1% MHR	5,279,600	97,644	1,111,747	6,488,991	6,381,645	(107,346)	128,444	-	1,281,844	953,400	845,254	1,179,672	-
Capital Region Medical Center	5,577,283	19.99%	12.35%	1% MHR	9,939,587	5,194,068	4,554,477	19,688,132	15,284,539	(4,803,613)	546,456	-	2,687,610	2,141,154	(2,662,459)	2,423,726	-
Cardinal Glennon Children's Hospital	28,114,420	41.76%	45.72%	1% MHR	94,007,870	78,814,796	67,412,230	240,234,896	189,734,680	(50,500,216)	1,554,503	-	8,222,228	6,667,725	(43,832,491)	9,119,269	376,557
Carroll County Memorial Hospital	720,554	28.68%	13.52%	1% MHR	1,497,210	48,172	85,474	1,630,856	1,589,487	(41,369)	50,633	-	169,501	109,420	166,051	143,895	-
Carthage Medical Center	3,098,222	22.08%	9.38%	1% MHR	3,658,191	674,698	219,355	4,552,244	4,872,799	320,555	156,303	-	1,164,006	1,004,713	1,324,334	1,446,628	-
Cedar County Memorial Hospital	1,216,974	32.87%	18.39%	1% MHR	1,479,943	451,917	112,115	2,043,975	1,902,698	(50,147)	104,514	-	349,736	244,192	195,045	143,529	-
Centerpoint Medical Center	18,219,966	20.95%	13.50%	1% MHR	16,736,349	5,687,136	10,603,793	33,027,278	29,247,379	(3,779,899)	560,515	10,068	7,453,524	6,782,941	3,003,042	6,181,661	-
Children Mercy Hospital	21,274,219	5.18%	46.87%	1% MHR	51,065,874	99,261,618	73,393,449	223,726,011	211,435,534	(12,292,477)	442,189	-	13,471,615	13,029,426	744,019	7,883,695	8,887,466
Christian Hospital Northeast	22,669,541	38.82%	19.29%	1% MHR	43,309,346	3,277,302	11,544,888	58,131,536	60,703,415	2,571,879	574,529	-	7,908,912	7,334,383	9,755,971	7,454,227	-
Citizens Memorial Hospital	4,580,082	57.44%	17.70%	1% MHR	10,248,546	2,716,488	3,201,725	16,166,682	14,184,733	(1,954,948)	518,455	-	2,312,962	1,794,507	(250,442)	1,418,297	-
Columbia Regional Hospital	2,993,919	47.76%	37.38%	1% MHR	13,564,221	13,385,716	16,287,338	43,240,345	38,554,705	(4,685,640)	408,574	-	2,099,294	1,690,720	(3,994,920)	1,859,496	-
Community Hospital Assn - Fairfax	841,960	21.69%	11.36%	1% MHR	1,428,159	235	68,660	1,496,054	1,297,598	(192,456)	82,710	-	303,901	221,211	28,755	382,789	-
Cooper County Memorial Hospital	1,244,743	23.68%	18.56%	1% MHR	868,741	225,606	348,446	1,442,793	1,572,938	140,141	92,013	-	479,970	387,957	528,100	422,371	-
Cox (Leslie E.) Medical Center	66,396,561	30.79%	14.52%	1% MHR	73,271,400	70,1,204	30,706,037	106,715,721	89,210,617	(17,205,104)	4,344,761	-	20,719,285	15,874,524	(1,330,580)	22,412,293	-
Cox-Monett Hospital	4,349,013	44.48%	21.50%	1% MHR	7,339,978	4,454	571,103	7,766,415	6,916,016	(850,398)	138,012	-	1,435,357	1,196,345	345,946	1,400,664	-
Depaul Health Center	25,549,934	36.30%	23.23%	1% MHR	39,282,692	13,094,909	12,666,745	65,046,346	59,214,754	(5,831,592)	410,314	-	10,456,752	10,046,438	4,214,846	11,599,975	-
Des Peres Hospital	5,610,764	22.92%	7.33%	1% MHR	16,110,457	824,373	5,403,609	22,340,439	18,365,245	(3,975,194)	274,391	16	1,494,322	1,219,915	(2,755,279)	1,711,593	-
Doctor's Hospital of Springfield	4,862,554	30.40%	31.79%	1% MHR	16,704,749	175,803	856,767	17,121,369	14,149,511	(2,671,858)	576,444	-	1,296,280	719,836	(2,952,022)	1,433,194	-
Dubuis Hospital of St. Louis (All Saints)	20,497	21.55%	9.53%	1% MHR	2,615,993	-	255,180	2,871,256	3,003,682	111,806	-	-	-	-	111,806	4,790	-
Elsie Memorial Hospital	356,333	29.86%	11.31%	1% MHR	1,097,423	162,600	340,36	1,300,159	1,371,548	71,439	26,759	-	144,851	113,072	186,511	121,708	-
Excelsior Springs Medical Center	1,612,962	17.36%	9.47%	1% MHR	1,727,372	307,080	120,142	2,155,064	2,163,336	8,241	104,763	-	657,339	553,076	561,318	145,089	-
Forest Park Hospital	16,484,433	52.88%	37.11%	1% MHR	13,888,794	844,462	29,137,843	43,871,099	23,430,659	(20,440,460)	170,511	-	3,849,331	3,678,820	(16,761,640)	5,160,836	-
Freeman Neosho Hospital	3,873,961	36.66%	17.74%	1% MHR	5,334,816	2,938	278,618	5,616,182	5,229,837	(392,353)	172,149	4,983	1,468,349	1,291,215	898,862	1,307,687	-
Freeman Oak Hill Health System	23,379,366	38.48%	14.58%	1% MHR	31,961,750	1,694,639	13,239,636	66,896,025	56,721,124	(10,174,881)	1,736,181	8,371	7,315,638	5,570,086	(4,401,823)	7,906,475	-
Golden Valley Memorial Hospital	4,543,813	29.15%	17.89%	1% MHR	4,984,173	2,220,054	3,691,666	10,895,893	9,189,589	(1,706,304)	326,603	-	1,973,873	1,646,272	(139,912)	1,467,090	-
Hannibal Regional Hospital	6,097,113	30.27%	14.86%	1% MHR	12,811,363	2,954,839	4,531,346	20,297,548	17,998,439	(2,299,159)	575,688	-	2,985,186	2,409,498	(289,661)	2,860,331	-
Harrison County Community Hospital	715,823	31.87%	16.33%	1% MHR	3,207,892	-	69,868	3,276,900	3,131,890	(145,010)	131,817	-	523,638	391,821	246,811	145,100	-
Heartland LTAC	162,869	48.54%	30.39%	1% MHR	438,858	-	21,632	455,310	874,659	419,349	-	-	-	-	419,349	162,869	-
Heartland Regional Medical Center	20,203,393	32.29%	26.27%	1% MHR	72,495,925	592,644	15,287,212	88,376,381	74,361,297	(14,015,084)	1,212,294	-	13,295,914	11,280,920	(2,932,858)	10,211,274	-
Hedrick Medical Center	2,546,552	37.32%	17.53%	1% MHR	4,135,751	145,370	268,234	4,549,355	3,900,832	(1,127,897)	95,615	-	798,502	702,947	(1,832,864)	792,306	-
Hermann Area District Hospital	1,130,496	22.47%	14.78%	1% MHR	1,092,687	454,883	95,961	1,643,531	1,609,667	54,136	131,546	-	200,685	69,139	123,305	183,057	-
I-70 Medical Center	220,309	25.45%	7.33%	1% MHR	667,675	-	87,809	755,484	746,364	(9,120)	-	-	-	-	(9,120)	120,309	-
Iron County Hospital	217,410	27.98%	19.15%	1% MHR	1,317,079	32,811	87,809	1,437,699	1,683,139	200,440	41,106	-	412,572	371,466	571,906	217,410	-
Jefferson Memorial Hospital	9,618,840	21.56%	14.70%	1% MHR	19,069,217	3,625,127	4,216,644	26,224,998	23,006,213	(3,218,785)	421,812	-	3,597,692	2,960,810	(232,975)	3,267,647	-
John Fitzgibbon Memorial Hospital	2,529,030	44.75%	15.43%	1% MHR	2,796,241	1,857,128	1,258,314	5,911,683	5,914,100	90,082,423	(635,687)	125,955	1,340,796	1,018,811	503,124	571,118	-
Kindred Hospital (Formerly) - Kansas City	512,911	52.85%	32.51%	1% MHR	11,119,656	-	2,311,774	13,431,430	14,997,129	1,565,699	-	-	-	-	1,565,699	101,468	-
Kindred Hospital (Formerly) St. Louis	342,143	34.25%	21.57%	1% MHR	8,537,729	-	3,168,461	11,706,190	9,281,262	(2,424,928)	-	-	-	-	(2,424,928)	115,160	-
Lafayette Regional Health Center	2,531,092	37.95%	15.75%	1% MHR	4,496,017	894,913	159,247	5,550,247	5,572,457	22,210	86,063	-	944,900	858,837	881,047	933,164	-
Lake Regional Health System	19,495,219	27.54%	15.35%	1% MHR	13,483,174	5,254,122	7,887,729	26,624,755	24,173,513	(2,451,242)	1,425,888	-	6,077,229	4,651,341	1,200,099	6,473,146	-
Landmark Hospital	432,890	14.08%	10.75%	1% MHR	1,375,241	-	1,252,789	2,628,030	1,461,425	(966,605)	-	-	-	-	(966,605)	432,890	-
Landmark Hospital of Columbia	22,218	0.00%	0.00%	1% MHR	-	-	-	-	-	-	-	-	-	-	-	22,218	-
Landmark Hospital of Joplin	434,820	20.65%	12.52%	1% MHR	2,448,229	-	87,809	2,536,038	2,335,721	(200,317)	-	-	-	-	(200,317)	434,820	-
Lee's Summit Hospital	4,624,471	12.09%	4.49%	1% MHR	3,153,028	735,341	730,528	4,622,897	6,119,383	1,496,486	157,919	520	1,804,259	1,540,820	3,042,306	1,151,446	-
Liberty Hospital	16,412,647	11.85%	10.53%	1% MHR	10,499,666	3,901,471	3,213,322	17,614,459	18,908,246	1,615,787	601,130	-	4,944,327	4,343,197	5,359,004	4,815,655	-
Lincoln County Memorial Hospital	3,232,739	28.00%	16.52%	1% MHR	2,817,970	1,430,992	272,623	4,521,587	4,799,262	277,675	241,659	-	1,333,436	1,091,777	1,369,452	1,188,155	-
Macon County Samaritan Memorial Hospital	1,273,976	13.97%	8.14%	1% MHR	2,511,719	-	102,816	2,614,535	2,462,459	(152,076)	130,385	-	428,402	298,017	137,941	431,748	-
Madison Medical Center	1,523,096	44.65%	13.36%	1% MHR	1,993,138	33,132	85,986	2,414,256	2,166,929	(247,327)	77,806	-	445,657	367,851	120,524	315,405	-
McCune Brooks Hospital	5,279,954	20.46%	11.79%	1% MHR	5,335,880	-	350,984	5,686,864	6,058,071	371,207	142,351	-	1,456,812	1,314,461	1,685,668	1,279,288	-
Mineral Area Regional Medical Center	5,248,846	48.38%	25.55%	1% MHR	6,654,767	1,607,313	4,574,518	12,836,598	10,806,237	(2,130,361)	196,729	-	1,279,748	1,082,919	(1,041,342)	1,773,364	-

State of Missouri
Schedule of Annual Reporting Requirements
For the Medicaid State Plan Rate Year Ended June 30, 2009

Definition of Uncompensated Care: The definition of uncompensated care was based on guidance published by CMS in the final rule (73 Fed. Reg. 77904, December 31, 2008) and the proposed rule (77 Fed. Reg. 2510, January 18, 2012). The calculated uncompensated care costs (UCC) represent the net uncompensated costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage. The UCC for these patient groups was calculated using Medicare cost reporting methods, and utilized the Medicare cost report, Medicaid Paid Claims Summaries, and Hospital-Provided Data. Total uncompensated care costs represents the net uncompensated care costs of providing inpatient and outpatient hospital services to patients that fall into one of the following Medicaid in-State and out-of-State payment categories: Fee-for-Service Medicaid primary, Fee-for-Service Coinsurance, Managed Care Medicaid primary, Managed Care Medicaid Coinsurance, and Uninsured individuals with no source of third party coverage. The cost of services for each of these payment categories was calculated using the appropriate per diems or cost-to-charge ratios from each hospital's Medicare Cost Report. These costs were then reduced by the total payments received for the services provided, including any supplemental Medicaid payments and Section 1011 payments where applicable.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Hospital Name	State Estimated Hospital-Specific DSH Limit	Medicaid I/P Utilization Rate	Low-Income Utilization Rate	State-Defined Eligibility Statistic	Regular IP/OP Medicaid FFS Rate Payments	IP/OP Medicaid MCO Payments	Supplemental / Enhanced IP/OP Medicaid Payments	Total Medicaid IP/OP Payments (F+G+H)	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care Costs (I-J)	Total IP/OP Indigent Care/Self-Pay Revenues	Total Applicable Section 1011 Payments	Total IP/OP Uninsured Cost of Care	Total Uninsured Uncompensated Care Costs (M-M-L)	Total Eligible Uncompensated Care Costs (SCO)	Total In-State DSH Payments Received	Total Out-of-State DSH Payments Received
Missouri Baptist Hospital of Sullivan	6,004,202	42.99%	19.78%	1% MAUR	6,978,693	1,455,200	1,296,973	9,730,871	11,472,265	741,094	143,144	-	1,180,566	1,037,422	2,478,516	1,278,469	-
Missouri Baptist Medical Center	7,773,148	12.15%	4.74%	1% MAUR	20,134,074	3,483,468	6,746,189	30,363,731	33,836,281	448,550	617,155	-	3,468,487	2,851,332	3,279,878	2,625,371	-
Missouri Delta Medical Center	8,542,580	40.66%	27.30%	1% MAUR	18,854,781	-	5,405,745	24,262,526	21,973,567	(3,288,959)	415,308	-	2,645,139	2,189,829	(1,1 9,130)	2,869,696	-
Missouri Rehabilitation Center	1,111,576	68.36%	103.37%	1% MAUR	6,401,288	77,140	11,181,214	17,665,642	14,764,569	(2,901,073)	15,651	-	662,206	592,155	(2,3 0,118)	413,614	-
Missouri Southern Healthcare (Center)	1,362,272	40.25%	14.63%	1% MAUR	4,236,075	-	502,686	4,738,761	4,542,361	(197,400)	156,445	-	494,140	337,695	140,295	459,429	-
Mistery Regional Medical Center	9,283,819	31.02%	14.34%	1% MAUR	8,443,243	4,762,979	2,921,784	16,128,006	15,807,806	(4,584,919)	219,709	3,051	980,388	757,621	(3,827,298)	1,695,421	-
Mercy Regional Medical Center	6,907,738	46.11%	22.35%	1% MAUR	5,304,303	651,182	1,850,096	7,825,511	7,721,273	(104,238)	241,175	-	1,223,530	979,371	875,137	1,657,002	-
North Kansas City Hospital	29,966,870	16.31%	6.27%	1% MAUR	25,723,307	1,310,114	8,746,328	35,779,749	31,264,715	504,966	236,610	-	10,301,844	10,095,234	10,600,200	10,150,921	-
Northeast Regional Medical Center	3,825,383	33.16%	15.35%	1% MAUR	12,380,742	652,434	3,265,262	16,298,438	14,329,973	(1,972,463)	389,982	645	1,226,136	835,509	(1,1 6,954)	1,284,653	-
Northland CARE Hospital	507,290	12.31%	9.39%	1% MAUR	1,062,467	-	85,809	1,150,276	1,281,740	31,464	-	-	-	-	31,464	507,290	-
Northwest Medical Center (Century)	671,376	24.76%	11.21%	1% MAUR	1,754,039	-	63,140	1,817,186	1,949,311	131,725	117,902	-	604,119	486,217	617,942	231,648	-
Ozarks Medical Center	9,381,386	41.44%	23.66%	1% MAUR	15,803,616	12,162	2,351,857	22,173,675	21,716,287	(1,457,388)	944,652	-	3,574,155	2,629,503	1,172,115	3,181,490	-
Parkland Health Center - Farmington	6,415,807	47.15%	19.72%	1% MAUR	9,721,099	5,539,650	2,934,655	18,195,384	15,870,822	(324,562)	179,795	-	1,638,381	1,458,586	1,133,819	1,492,056	-
Penniroyal Memorial Hospital	3,561,772	53.90%	23.42%	1% MAUR	11,290,277	-	876,717	12,166,994	14,287,169	(2,271,912)	319,404	-	1,293,830	954,429	(1,317,496)	1,218,283	-
Perry County Memorial Hospital	1,905,112	30.56%	15.40%	1% MAUR	2,163,544	1,735,461	140,086	4,042,491	3,577,332	(465,159)	74,956	-	378,530	303,574	(161,585)	457,319	-
Pershing Memorial Hospital	1,002,783	19.85%	9.32%	1% MAUR	1,246,219	453,393	76,648	1,776,259	1,996,996	220,819	159,236	-	356,447	196,591	660,486	339,732	-
Phelps County Regional Medical Center	15,751,935	42.61%	18.53%	1% MAUR	28,461,272	4,944,562	8,366,103	41,771,937	41,015,898	283,961	755,353	-	4,261,395	3,505,840	3,789,801	5,644,877	-
Pike County Memorial Hospital	2,180,041	23.77%	21.34%	1% MAUR	1,629,136	489,718	145,963	2,264,817	2,211,911	(14,906)	286,870	-	315,944	215,874	300,968	739,021	-
Poplar Bluff Regional Medical Center	11,871,301	40.31%	23.23%	1% MAUR	42,318,293	-	4,325,450	46,643,743	41,008,749	(4,632,994)	854,526	-	4,512,007	3,657,481	(975,513)	4,084,240	-
Progress West Healthcare Center	1,238,544	14.78%	7.70%	1% MAUR	1,780,903	1,477,042	156,581	3,417,526	4,716,990	1,339,464	97,365	-	1,782,308	1,694,748	3,034,209	1,238,544	-
Putnam County Memorial Hospital	462,230	30.52%	15.35%	1% MAUR	1,829,265	-	85,700	1,889,965	1,319,488	295,535	85,451	-	345,668	294,181	413,720	1,457,745	-
Ray County Memorial Hospital	1,696,232	20.22%	7.34%	1% MAUR	2,241,726	118,960	114,648	2,474,334	2,692,610	128,876	10,601	-	366,136	285,525	414,411	272,455	-
Rehab Institute of St. Louis	1,144,687	27.51%	20.14%	1% MAUR	6,707,038	164,346	681,013	7,552,397	6,815,808	726,589)	113,076	-	441,059	257,987	(668,602)	392,714	-
Research Belton Hospital	5,601,942	15.20%	16.17%	1% MAUR	4,072,019	2,439,840	311,761	6,823,620	6,088,916	(2,734,704)	245,174	2,394	1,705,213	1,457,245	(1,277,459)	1,510,879	-
Research Medical Center	30,406,879	31.19%	20.31%	1% MAUR	35,217,075	8,819,495	29,281,983	73,318,553	61,773,782	(12,605,571)	1,015,993	18,779	11,397,881	10,363,309	(2,242,262)	12,564,452	-
Ripley County Memorial Hospital	1,003,238	33.11%	20.32%	1% MAUR	2,879,805	-	179,169	3,058,974	3,346,666	(287,980)	140,839	-	384,796	306,048)	(522,754)	232,348	-
Rush Rehabilitation Center	908,253	30.93%	23.34%	1% MAUR	4,482,095	135,036	1,241,366	5,859,367	4,967,227	931,860)	45,308	-	134,112	88,804	(843,236)	338,113	-
Ste Genie Hospital	1,004,318	29.72%	24.80%	1% MAUR	1,681,902	193,112	428,591	2,303,605	1,717,336	(546,269)	86,958	-	322,864	285,906	(260,363)	353,044	-
Salem Memorial District Hospital	2,333,521	32.66%	21.23%	1% MAUR	2,666,348	49,354	156,900	3,875,602	3,670,962	(204,640)	34,917	-	678,965	654,048	449,408	786,348	-
Scotland County Memorial Hospital	900,255	29.60%	18.33%	1% MAUR	1,994,039	899	52,665	2,048,403	1,811,165	(237,238)	113,104	-	319,052	205,948	(31,290)	313,233	-
Select Specialty Hospital - Springfield	631,238	32.93%	22.75%	1% MAUR	2,697,937	-	85,109	2,783,366	3,000,899	214,933	-	-	-	-	214,933	631,238	-
Select Specialty Hospital - St. Louis	467,284	36.81%	26.76%	1% MAUR	4,015,673	15,703	824,794	4,856,169	4,368,779	487,391	-	-	-	-	487,391	467,284	-
Select Specialty Hospital - Western Mo	733,167	23.77%	12.27%	1% MAUR	2,268,606	-	428,814	2,697,420	3,135,562	(511,858)	-	-	-	-	(511,858)	241,472	-
Skaggs Community Hospital	20,824,487	23.32%	13.35%	1% MAUR	12,612,679	24,520	4,665,450	17,302,649	15,485,371	(1,899,078)	1,014,373	-	6,572,978	5,488,706	3,589,627	6,592,516	-
South Barry County Memorial Hospital	2,696,162	33.42%	28.73%	1% MAUR	4,096,248	-	120,861	4,189,409	3,064,929	(1,124,480)	214,674	-	1,265,693	1,051,019	(142,471)	513,213	-
Southeast Missouri Hospital	22,224,557	35.35%	11.24%	1% MAUR	38,367,426	37,184	10,030,523	48,435,133	53,190,062	5,765,719	1,118,221	-	5,901,008	4,877,182	10,642,911	7,098,759	-
St. Alexius Hospital	19,303,496	68.06%	31.91%	1% MAUR	22,664,368	1,003,956	12,070,569	36,700,893	31,261,890	(4,439,003)	212,463	-	3,612,734	3,400,271	(1,038,732)	6,314,637	-
St. Anthony's Medical Center	29,197,396	19.60%	9.48%	1% MAUR	30,100,802	7,350,792	8,696,918	46,342,512	41,814,062	(1,511,450)	2,134,465	-	9,725,314	7,730,875	6,012,426	9,840,214	-
St. Francis Hospital - Maryville	6,537,753	31.52%	9.92%	1% MAUR	4,156,203	-	1,606,688	5,764,591	5,765,870	(59,121)	132,633	-	1,835,145	1,682,512	1,623,391	1,538,921	-
St. Francis Hospital - Mountain View	1,269,670	34.28%	25.43%	1% MAUR	4,421,960	92,662	162,248	4,676,870	4,512,492	(164,378)	12,325	-	783,240	704,911	540,533	429,908	-
St. Francis Medical Center - Cape Girardeau	20,609,546	37.44%	11.30%	1% MAUR	44,317,438	38,393	11,777,391	56,133,222	61,140,637	5,907,375	1,868,384	-	6,918,268	4,674,683	10,642,805	6,537,914	-
St. John's Hospital - Lebanon (Breeds)	7,139,211	30.88%	17.39%	1% MAUR	6,746,599	3,150,998	1,688,716	11,586,313	11,723,996	1,136,683	515,468	-	2,122,206	2,256,737	3,393,420	2,434,151	-
St. John's Mercy Hospital - Washington	12,681,426	23.40%	23.52%	1% MAUR	8,183,549	4,961,553	5,127,248	18,272,350	23,014,525	1,732,175	770,932	-	9,992,003	8,201,191	10,013,273	6,279,933	-
St. John's Mercy Medical Center - Creve Coeur	36,418,922	21.22%	15.12%	1% MAUR	46,025,797	40,355,447	35,825,814	122,210,058	99,896,968	(22,313,090)	6,514,787	-	18,646,258	12,131,471	(181,619)	18,385,767	-
St. John's Mercy Rehabilitation Hospital	880,100	10.81%	7.87%	1% MAUR	2,430,985	45,393	156,581	2,646,361	1,364,338	(252,003)	14,136	-	948,838	156,299	664,296	860,100	-
St. John's Regional Health Center	73,393,364	31.46%	18.54%	1% MAUR	89,854,511	2,022,647	49,444,397	141,321,735	137,015,619	(2,295,116)	3,915,435	-	38,328,008	34,592,393	22,206,457	24,993,938	-
St. John's Regional Medical Center - Joplin	32,845,888	37.82%	17.16%	1% MAUR	45,965,574	5,582,384	12,714,364	62,262,322	61,993,167	4,720,915	1,480,312	-	11,912,005	10,451,521	15,172,308	11,673,887	-
St. Joseph Health Center - Kansas City	14,647,880	17.59%	8.14%	1% MAUR	14,856,382	5,334,575	5,535,179	25,726,136	21,613,981	(3,244,155)	719,693	-	4,909,082	4,189,389	1,945,234	4,532,403	-
St. Joseph Health Center - St. Charles	22,904,147	30.35%	19.18%	1% MAUR	24,665,949	3,792,288	5,438,362	33,896,599	33,717,200	(2,204,399)	512,123	-	6,839,236	6,077,113	3,872,714	7,352,531	-
St. Joseph Hospital - Kirkwood	6,879,137	13.44%	12.19%	1% MAUR	5,115,148	2,577,928	4,712,314	12,405,390	11,140,423	(264,967)	219,542	-	3,496,432	3,276,499	3,011,523	2,325,345	-
St. Joseph Hospital West	7,900,322	22.00%	15.54%	1% MAUR	6,637,230	2,246,875	3,908,860	12,793,465	14,063,369	(2,730,096)	340,186	-	3,803,134	2,662,848	(67,248)	2,880,402	-
St. Louis Children's Hospital	8,961,146	53.02%	46.31%	1% MAUR	56,819,731	46,467,280	66,301,969	172,603,371	151,268,713	(21,341,858)	433,907	-	2,908,688	2,504,701	(18,837,157)	2,344,037	127,399
St. Louis University Medical Center	53,549,582	37.32%	27.42%	1% MAUR	98,221,957	4,782,286	35,504,792	138,509,035	91,043,502	(27,652,593)	816,196	309,127	11,954,389	10,828,661	(16,823,872)	18,346,963	18,780
St. Luke's Cancer Institute	2,931,092	16.79%	16.46%	1% MAUR	3,615,542	304,594	1,183,318	5,104,454	4,775,792	(2,328,252)	88,529	-	302,108	263,581	(2,164,681)	975,153	-
St. Luke's East - Lee's Summit	940,207	12.40%	12.80%	1% MAUR	3,228,407	4,488,842	915,217	10,640,466	8,630,484	(2,009,982)	210,474	251	1,926,538	1,705,708	(384,274)	940,207	-
St. Luke's Hospital of Kansas City	43,478,097	27.60%	20.34%	1% MAUR	41,026,427	12,297,013	33,855,324	87,178,764	81,274,330	(5,612,614)	1,289,481	15,232	10,220,869	8,976,159	3,363,542	14,684,520	18,182
St. Luke's Hospital West	9,963,190	7.57%	3.93%	1% MAUR	16,766,536	1,899,932	4,961,240	23,627,708	21,539,528	(1,688,237)	1,515,605	-	3,333,799	1,968,181	(1,078,903)	3,360,836	-
St. Luke's Northland Hospital	14,289,124	21.70%	17.47%	1% MAUR	7,729,294	1,775,379	5,090,817	14,595,490	12,066,799	(2,099,691)	415,378	477	4,611,773	4,186,611	2,086,920	4,824,963	-
St. Luke's Rehabilitation Hospital	310,441	5.75%	6.32%	1% MAUR	331,815	-	52,445	384,260	303,483	(80,777)	-	-	-	-	(80,777)	310,441	-
St. Mary's Health Center - Jefferson City	11,481,555	26.69%	10.96%	1% MAUR	15,689,516	3,507,650	4,794,755	23,991,921	21,845,172	(1,146,719)	614,675	-	3,728,948	3,074,269	1,927,550	3,877,303	-

See Independent Accountant's Report

State of Missouri
Schedule of Annual Reporting Requirements
For the Medicaid State Plan Rate Year Ended June 30, 2009

Definition of Uncompensated Care: The definition of uncompensated care was based on guidance published by CMS in the final rule (73 Fed. Reg. 77904, December 19, 2008) and the proposed rule (77 Fed. Reg. 2500, January 18, 2012). The calculated uncompensated care costs (UCC) represent the net uncompensated costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage. The UCC for these patient groups was calculated using Medicare cost reporting methods, and utilized the Medicare cost report, Medicaid Paid Claims Summaries, and Hospital-Provided Data. Total uncompensated care costs represents the net uncompensated care costs of providing inpatient and outpatient hospital services to patients that fall into one of the following Medicaid in-State and out-of-State payment categories: Fee-for-Service Medicaid primary, Fee-for-Service Crossovers, Managed Care Medicaid primary, Managed Care Medicaid Crossovers, and Uninsured individuals with no source of third party coverage. The cost of services for each of these payment categories was calculated using the appropriate per diems or cost-to-charge ratios from each hospital's Medicare Cost Report. These costs were then reduced by the total payments received for the services provided, including any supplemental Medicaid payments and Section 1011 payments where applicable.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Hospital Name	State Estimated Hospital-Specific DSH Limit	Medicaid I/P Utilization Rate	Low-Income Utilization Rate	State-Defined Eligibility Statistic	Regular IP/OP Medicaid FFS Rate Payments	IP/OP Medicaid MCO Payments	Supplemental / Enhanced IP/OP Medicaid Payments	Total Medicaid IP/OP Medicaid Payments (F+G+H)	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care Costs (J-I)	Total IP/OP Indigent Care/Self-Pay Revenues	Total Applicable Section 1011 Payments	Total IP/OP Uninsured Cost of Care	Total Uninsured Uncompensated Care Costs (N-M-L)	Total Eligible Uncompensated Care Costs (K+O)	Total In-State DSH Payments Received	Total Out-of-State DSH Payments Received
St. Mary's Hospital - Blue Springs	7,315,904	18.08%	11.31%	1% MIUR	5,538,307	4,150,320	2,304,319	11,992,946	10,973,195	(1,019,751)	270,524	-	3,024,480	2,753,956	1,734,205	2,467,810	-
Ste. Genevieve County Memorial	1,087,925	14.05%	9.11%	1% MIUR	2,013,258	-	161,488	2,174,746	1,949,449	(225,297)	525	-	191,323	190,798	(34,499)	367,808	-
Sullivan County Memorial Hospital	742,627	25.61%	24.76%	1% MIUR	1,045,367	1,988	52,653	1,100,008	1,186,028	86,020	36,051	-	215,905	179,854	265,874	249,736	-
Texas County Memorial Hospital	3,498,705	40.40%	22.28%	1% MIUR	3,545,992	-	1,324,111	4,870,103	4,415,639	(454,464)	382,854	-	1,044,629	661,775	207,311	1,181,407	-
Truman Medical Center Hospital Hill	211,816,492	64.84%	74.60%	1% MIUR	76,418,804	16,679,036	67,625,648	160,723,488	149,819,480	(10,904,008)	1,251,022	-	65,004,672	63,753,650	52,849,642	81,651,807	-
Truman Medical Center Lakewood	75,482,735	60.83%	77.86%	1% MIUR	16,372,113	7,214,988	24,418,175	48,005,978	41,841,658	(6,164,320)	703,696	-	21,466,101	20,762,405	14,598,085	28,541,921	-
Twin Rivers Regional Medical Center	5,021,801	36.69%	50.04%	1% MIUR	32,056,240	-	1,728,329	33,784,569	20,515,246	(13,269,323)	230,336	-	2,307,512	2,077,176	(11,192,147)	1,695,243	-
University of Missouri Hospital and Clinics	44,319,559	45.74%	34.33%	1% MIUR	83,583,398	17,562,442	55,440,085	156,585,925	118,948,471	(37,637,454)	2,983,373	-	14,762,996	11,779,623	(25,857,831)	16,506,916	-
Washington County Memorial	3,276,390	52.84%	27.97%	1% MIUR	4,064,315	805,785	293,221	5,163,321	4,596,340	(566,981)	63,441	-	999,670	936,229	369,248	1,102,356	-
Western Missouri Medical Center	5,297,724	27.08%	13.66%	1% MIUR	3,441,477	2,613,155	3,985,691	10,040,323	8,422,061	(1,618,262)	171,523	-	1,941,778	1,770,255	151,993	1,786,201	-
Wright Memorial Hospital	1,448,591	30.82%	21.94%	1% MIUR	4,030,535	2,864	178,163	4,211,662	4,465,706	254,044	201,295	-	713,944	512,649	766,693	488,659	-

Institute for Mental Disease

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Centerpointe Hospital (Spirit of St. Louis)	1,365,423	42.33%	32.27%	1% MIUR	7,671,240	464,200	3,786,603	11,922,043	8,649,145	(3,272,898)	35,454	-	141,076	105,622	(3,167,276)	456,312	28,857
Crittenton Center	542,386	81.06%	79.23%	1% MIUR	5,774,225	1,063,040	2,490,748	9,328,013	8,760,388	(567,625)	3,652	-	134,658	131,006	(436,619)	182,292	-
Fulton State Hospital	73,864,249	1.43%	101.03%	1% MIUR	776,740	-	2,615,365	3,392,100	1,104,760	(2,287,340)	3,477,850	-	65,256,391	61,778,541	59,491,201	69,982,014	-
Hawthorn Children's Psychiatric Hospital	2,116,667	83.29%	126.13%	1% MIUR	3,614,421	153,312	5,887,103	9,654,833	9,050,043	(604,790)	15,068	-	59,016	43,948	(560,842)	2,090,315	-
Heartland Behavioral Health Svcs (HSA)	160,824	87.05%	103.00%	1% MIUR	4,359,104	274,599	5,627,445	10,261,148	4,908,176	(5,352,972)	3,338	-	36,901	33,550	(5,319,422)	53,300	-
Lakeland Regional Hospital	35,142	41.29%	50.04%	1% MIUR	5,096,387	122,615	1,739,662	6,958,364	5,332,428	(1,625,936)	6,387	-	38,183	31,796	(1,594,140)	28,448	-
Metropolitan St. Louis Psychiatric Center	19,005,701	7.25%	85.08%	1% MIUR	991,120	162,787	505,924	1,659,831	1,850,287	190,456	2,243,737	-	13,984,603	11,740,866	11,931,322	18,769,085	-
Mid-Missouri Mental Health Center	9,577,379	17.94%	87.80%	1% MIUR	1,778,139	258,230	1,310,478	3,346,847	2,555,826	(791,021)	1,022,826	-	9,162,645	8,139,819	7,348,798	9,458,146	-
Northwest Missouri Psychiatric Rehabilitation Center	23,850,893	5.48%	103.72%	1% MIUR	910,152	-	415,608	1,326,460	965,717	(360,743)	178,898	-	16,022,470	15,843,572	15,482,829	20,591,307	-
Research Psychiatric Center	3,934,372	31.25%	19.30%	1% MIUR	2,884,136	2,005,008	1,083,818	5,972,962	4,968,511	(1,004,451)	43,906	-	715,451	671,545	(332,906)	1,325,935	-
Royal Oaks Hospital	3,373,964	66.39%	105.23%	1% MIUR	1,728,227	1,046,300	5,739,102	8,513,629	5,956,890	(2,556,739)	24,365	-	522,411	498,046	(2,058,693)	1,193,839	-
Southeast Missouri Mental Health	26,068,629	4.90%	98.80%	1% MIUR	1,183,920	19,254	1,770,216	2,973,390	1,298,816	(1,674,574)	2,458,536	-	18,925,802	16,467,266	14,792,692	25,744,085	-
St. Louis Psychiatric Rehabilitation Center	36,669,879	2.40%	99.70%	1% MIUR	520,390	-	652,312	1,173,302	716,938	(456,364)	945,708	-	23,295,548	22,349,840	21,893,476	36,213,353	-
Two Rivers Psychiatric Hospital	1,530,979	19.31%	14.55%	1% MIUR	2,156,551	755,652	629,203	3,541,406	3,145,237	(396,169)	143,771	-	233,664	89,893	(306,276)	515,272	-
Western Missouri Mental Health	11,700,862	9.05%	91.60%	1% MIUR	2,231,303	-	2,042,369	4,273,372	3,299,883	(973,489)	2,556,010	-	16,145,074	13,589,064	12,615,575	18,468,043	-

Out of State DSH Hospitals

N/A

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See Independent Accountant's Report

Independence Declaration

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

To Whom it May Concern:

Myers and Stauffer declares it is independent of the state of Missouri and its DSH hospitals for the state plan rate year June 30, 2009.

Myers and Stauffer LC

Myers and Stauffer LC

October 19, 2012

DEDICATED TO GOVERNMENT HEALTH PROGRAMS 11440 Tomahawk Creek Pkwy | Leawood, KS 66211
PH 913.234.1166 | PH 800.374.6858 | FX 913.234.1104
www.mslc.com

F: Sample Survey

State of
Disproportionate Share Hospital (DSH) Audit Survey Part I
For State DSH Year 2010

A. General Instructions and Identification of Cost Reports that Cover the DSH Year:

1. Select the "Sec. A-C DSH Year Data" tab in Excel workbook. In row 1, select your facility from the drop-down menu provided. When your facility is selected, the following fields will be populated: in-state Medicaid provider number and Medicare provider number. Review information and indicate whether it is correct or incorrect. If incorrect, provide correct information.

2. Provide your cost reporting periods that are needed to completely cover the DSH year. If the end date for cost report period 1 is before the end date of the DSH year, report your next cost reporting period (cost report 2). If this cost report ends prior to the end of the DSH year, report your next cost reporting period (cost report 3). The cost reporting periods must cover the entire DSH year.

   NOTE: For the 2010 DSH Survey, if your hospital completed the DSH survey for 2009, the first cost report year should follow the last cost report year reported on the 2009 DSH survey. The last cost report year on the 2010 survey must end on or after the end of the 2010 DSH year. If your hospital did not complete the 2009 survey, your cost reports for 2010 must cover the entire 2010 DSH year.

3. Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years.

B. DSH OB Qualifying Information:

1. Answer "B. DSH OB Qualifying Information" questions 1, 2 and 3 to determine if your hospital is eligible to receive DSH payments.

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid supplemental payments should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.

Certification:

1. The hospital CEO or CFO must certify the accuracy of the survey responses. Provide hospital and outside preparer contacts who can respond to requests for additional information and answer questions related to the hospital's responses.

Please submit your completed survey Sections A through C and the certification electronically to Myers and Stauffer LC. Also include Sections D-L included in the separate DSH survey Part II file.

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State of
Disproportionate Share Hospital (DSH) Audit Survey Part I
For State DSH Year 2010

DSH Version 5.11 1/7/2013

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2009	06/30/2010

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1		
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

	Data
6. Medicaid Provider Number:	M'Caid #
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	M'caic Sub 1#
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	M'caic Sub 2#
9. Medicare Provider Number:	M'care #

B. DSH OB Qualifying Information

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

During the DSH Year 07/01/2009 - 06/30/2010:

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

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2009 - 06/30/2010**
(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

State of
Disproportionate Share Hospital (DSH) Audit Survey Part I
For State DSH Year 2010

Certification:

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

Explanation for "No" answers:

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

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

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:		**Outside Preparer:**	
Name		Name	
Title		Title	
Telephone Number		Firm Name	
E-Mail Address		Telephone Number	
Mailing Street Address		E-Mail Address	
Mailing City, State, Zip			

State of
Disproportionate Share Hospital (DSH) Audit Survey Part I
For State DSH Year 2010

DSH Survey Submission Checklist

Please indicate with an "X" each item included or a "N/A" if not included. Consider a separate cover letter to explain any "N/A" answers to avoid additional documentation requests.

	1. Electronic copy of the DSH Survey Part I - DSH Year Data - 07/01/2009 - 06/30/2010
	2. Electronic copy of the DSH Survey Part II - Cost Report Data - Cost Report Year -
	3. N/A
	4. N/A
	5 (a). Electronic copy of Exhibit A - Uninsured Charges / Days - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)
	5 (b). Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
	6 (a). Electronic copy of Exhibit B - Self-Pay Payments - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)
	6 (b). Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.
	7 (a). Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare crossover, Medicaid MCO, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report) - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)
	7 (b). Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
	8. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
	9. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
	10. Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
	11. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B
	12. Documentation supporting out-of-state DSH payments received. - Examples may include remittances, detailed general ledgers, or add-on rates
	13. Financial statements to support total charity care charges reported
	14. Revenue code cross-walk used to prepare cost report
	15a. A detailed working trial balance used to prepare each cost report (including revenues)
	15b. 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)
	16. Electronic copy of all cost reports used to prepare each DSH Survey Part II.
	17. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligible cost report payments).

All electronic (CD or DVD) and paper documentation can be mailed (using certified or other traceable delivery) to:

Myers and Stauffer LC
ATTN: DSH Examinations
9515 Deereco Road, Suite 500
Timonium, MD 21093
Fax: (410) 453-0914
Phone: (410) 308-8184
E-Mail:

Please Call Myers and Stauffer if you have any questions on completing the DSH survey.

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General Instructions and Identification of Cost Reports that Cover the DSH Year:

Macro Settings for Microsoft Excel 2007 Software

1. Please make sure Macros are enabled under the Excel options. If Macros are disabled, the DSH survey will not have full functionality. Macros can be enabled for Microsoft Excel 2007 software by first selecting "Excel Options" under the Microsoft Office File Menu Button (upper left hand corner of the screen). Then under the Excel Options dialog box select the "Trust Center" option. Under the Trust Center Dialog box select the "Trust Center Settings" button. Then select "Macro Settings" and click the "Enable all macros" button. Then press the OK button. After the Macro settings have been enabled it will be necessary to save changes and close the Excel program and re-open the DSH Survey Part II Excel workbook so the setting changes can take place.

   OR

   Select the Developer tab on the Excel Ribbon Menu. If the Developer tab is not displayed, click the Microsoft Office File Menu Button (upper left hand corner of the screen), then select the "Excel Options" button. Under Excel Options, Select the "Popular" category, then under "Top Options for working with Excel" select the "Show Developer Tab in The Ribbon" option. Once the Developer tab is available select the "Macro Security" option under the Code Group. Under Macro Security settings select the "Enable All Macros" option or the option that allows you to disable macros with notification (if the notification option is chosen, you will see a "SECURITY WARNING" message). Then close and re-open the Excel workbook so the settings changes can take place.

Macro Settings for Older Versions of Microsoft Excel Software

For older versions of Microsoft Excel software (before Microsoft Excel 2007) select the "**Tools**" menu. Under the Tools Menu select **"Macro" - "Security**". Then select **"Low"** or **"Medium"** security. Then close and re-open the Excel workbook for the settings changes to take place.

2. DSH Survey Sections A, B, and C are part of a separate Excel workbook titled DSH Survey Part I and should be submitted along with the completed DSH Survey Part II Excel workbook. DSH Survey sections A, B, and C contain DSH eligibility and certification questions.

3. Select the "Survey - Sec. D, E, F CR Data" tab in the Excel workbook. On Line 1, select your facility from the drop-down menu provided. When your facility is selected, the following Lines will be populated with your facility specific information: Line 2 - applicable cost report years, Line 4 - Hospital Name, Line 5 - in-state Medicaid provider number, Line 6 - Medicaid Subprovider Number 1 (Psychiatric or Rehab), Line 7 - Medicaid Provider Number 2 (Psychiatric or Rehab), and Line 8 -Medicare provider number. The provider must manually select the appropriate option from the drop down menu for Line 3 - Status of Cost Report Used for the Survey. Review the information and indicate whether it is correct or incorrect. If incorrect, provide correct information in the provided space and submit supporting documentation when you submit your survey.

4. You must complete a separate DSH Survey Part II Excel workbook for each cost report year needed to cover the State DSH year and not previously submitted for a DSH examination. To indicate the proper time period for the current survey select an "X" from the drop down menu on the appropriate box of Line 2 of the "Survey - Sec. D, E, F CR Data" tab in this Excel workbook. If two cost report years are selected at the same time the survey will generate an error message as only one cost report year may be selected per Excel workbook.

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NOTE: For the 2010 DSH Survey, if your hospital completed the DSH survey for 2009, the first cost report year should follow the last cost report year reported on the 2009 DSH survey. The last cost report year on the 2010 survey must end on or after the end of the 2010 DSH year. If your hospital did not complete the 2009 survey, you must report data on all cost report periods that cover the 2010 DSH year.

5. Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years.

Exhibit A - Support of Uninsured I/P and O/P Hospital Services:

1. See Exhibit A for an example format of the information that needs to be available to support the data reported in Section H of the survey related to uninsured services provided in each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit A for each cost reporting period included in the survey.

2. Complete Exhibit A based on your individual state Medicaid hospital reimbursement methodology (if your state reimburses based on discharge date then only include claims in Exhibit A that were discharged during the cost reporting period for which you are pulling the data).

3. Exhibit A population should include all uninsured patients whose dates of service (see above) fall within the cost report period.

4. The total inpatient and outpatient *hospital (excluding professional fees, and other non-hospital items)* charges from Exhibit A, column N should tie to Section H, line 103 of the DSH survey.

Exhibit B - Support for Self-Pay I/P and O/P Hospital Payments Received:

1. See Exhibit B for an example format of the information that needs to be available to support the data reported in Section E of the survey related to ALL patient payments received during each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit B for each cost reporting period included in the survey.

   Note: Include Section 1011 payments received related to undocumented aliens if they are applied at a patient level.

2. Exhibit B population should include all payments **received** from patients **during the cost report year *regardless of dates of service and insurance status***.

3. Only the payments received from *uninsured* patients should be included on Section H of the DSH survey, line 115. Payments from both the uninsured and insured patients should be reported on Section E of the DSH survey, lines 9 and 10, respectively. The total payments from Section H, line 115 should reconcile to Section E, line 9.

Section D - General Cost Report Year Information

1. For Lines 1 through 8 of Section D, please refer to the instructions listed above in the "General Information and Identification of Cost Reports that Cover the DSH Year" section.

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2. For Lines 9 through 15, provide the name and Medicaid provider number for each state (other than your home state) where you had a current Medicaid provider agreement during the term of the DSH year. Per federal regulation, the DSH examination must review both in-state Medicaid services as well as out-of-state Medicaid services when determining the Medicaid shortfall or longfall.

Section E - Disclosure of Medicaid / Uninsured Payments Received

1. Please read "Note 1" located at the bottom of Section E before entering information for Lines 1 through 7. After reading through Note 1, please provide the applicable Section 1011 payment information as indicated.

2. Please read "Note 2" located at the bottom of Section E before entering information for Line 8. After reading through Note 2, please provide the total Out-of-State DSH payments as indicated.

3. Lines 9 and 10 should reconcile to the Exhibit B information provided by the facility.

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Section F - MIUR / LIUR Qualifying Data from the Cost Report

Section F-1 Total Hospital Days Used in Medicaid Inpatient Utilization Ration (MIUR)

1. Section F-1 is required to calculate the Medicaid Inpatient Utilization Rate (MIUR). The MIUR is a federal DSH eligibility criteria that must be met in order to receive DSH payments.

Section F-2 Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges

2. For Lines 2 through 5 report all state or local government cash subsidies received for patient care services. If the subsidies are directed specifically for inpatient or outpatient services, record the subsidies in the appropriate box. If the subsidies do not specify inpatient or outpatient services, record the subsidies in the unspecified column.

3. The unspecified subsidies will be allocated between inpatient and outpatient using your hospital volume statistics. State and local subsidies do not include regular Medicaid payments, supplemental (UPL) Medicaid payments or Medicaid/Medicare DSH payments. Subsidies are funds the hospital received from state or local government sources to assist hospitals to provide care to uninsured or underinsured patients.

4. Cash subsidies are used to calculate Medicaid DSH eligibility under the federal low income utilization rate formula. They are **NOT** used to reduce your net uninsured cost for DSH payment programs.

5. For Lines 6 through 8 report the applicable charity care charges. Charity care charges are used in the calculation of the low income utilization rate. Report the hospital's inpatient and outpatient charity care charges for the applicable cost reporting period. These charges must reconcile to the charity care charges reported in your financial statements and/or annual audit or they must be in compliance with the definition of charity per your state's DSH payment program.

Section F-3 Calculation of Net Hospital Revenue from Patient Services (Used for LIUR)

6. For purposes of the low-income utilization rate (LIUR) calculation, it is necessary to calculate net hospital revenue from patient services. This section of the survey requests a breakdown of charges reported on cost report Worksheet G-2 between hospital and non-hospital services. The form directs you to allocate your total contractual adjustments, as reported on cost report Worksheet G-3, Line 2, between hospital and non-hospital services. The form provides space for an allocation of contractual allowances among service types. If contractual adjustment amounts are not maintained by service type in your accounting system, a reasonable allocation method must be used. This will allow for the calculation of net "hospital" revenue. Total charges and contractual adjustments must agree to your cost report. Contractuals may have been spread on the survey using formulas but you can overwrite those amounts with actual contractuals if you have the data.

7. A separate Excel workbook must be used for each cost reporting period needed to completely cover the DSH year as indicated in the "General Information and Identification of Cost Reports that Cover the DSH Year" section of the instructions.

Section G - CR Data

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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.

1. The provider should enter all applicable Routine and Ancillary Cost Centers not currently provided in Section G. Once the Routine and Ancillary Cost Centers have been entered into Section G of the DSH survey, they will populate in the Routine and Ancillary Cost Centers on DSH survey "Sec. H - In-State", "Sec. I - Out-of-State.

2. If your teaching hospital removed intern and resident costs in Column 26 of Worksheet B, Part I, you will need to enter those amounts in the column provided so the amounts can be added back to your total cost per diems and CCRs for Medicaid/Uninsured. If intern and resident cost was not removed in Column 26 of Worksheet B, Part I then no entry is needed. Teaching costs should be included in the final cost per diems and CCRs.

3. After the Routine and Ancillary Cost Centers have been identified, it will be necessary for the provider to fill in the remaining information required by Section G. The location of the specific cost report information required by Section G for both Routine and Ancillary Cost Centers is identified in each column heading. The provider will **NOT** need to enter data into the "Net Cost", or "Medicaid Per Diem/Cost-to-Charge Ratios" columns as these are calculated columns.

4. Once the "Medicaid Per Diem/Cost-to-Charge Ratios" column has been calculated, the values will also populate on DSH Survey "Sec. H - In-State", and "Sec. I - Out-of-State".

Section H - Calculation of In-State Medicaid and Uninsured I/P and O/P Costs:

1. This section of the survey is used to collect information to calculate the hospital's Medicaid shortfall or longfall. By federal Medicaid DSH regulations, the shortfall/longfall must be calculated using Medicare cost report costing methodologies.

2. The routine per diem cost per day for each hospital routine cost center present on the Medicaid cost report will automatically populate in Section H after DSH Survey "Sec. G - CR Data" has been completed. These amounts are calculated on Worksheet D-1 of the cost report. The ancillary cost-to-charge ratio for each ancillary cost center on your cost report will also automatically be populated in Section H after DSH Survey "Sec. G - CR Data" has been completed.

3. Record your routine days of care, routine charges and I/P and O/P ancillary charges in the next several columns. This information, when combined with cost information from the cost report, will calculate the total cost of hospital services provided to Medicaid and uninsured individuals.

In-State Medicaid FFS Primary

Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)
In these two columns, record your in-state Medicaid fee-for-service days and charges. The days and charges should reconcile to your Medicaid provider statistics and reimbursement (PS&R) report, or your state's version generated from the MMIS. Record in the box labeled "Total Allowed Amount from PS&R," the total (gross) payments, prior to reductions for third party liability (TPL), your hospital received for these services. Reconcile your responses on the survey with the PS&R total at the bottom of each column. Provide an explanation for any unreconciled amounts.

In-State Medicaid Managed Care Primary

Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)
Same requirements as above. If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient).

In-State Medicare FFS Cross-Overs (with Medicaid Secondary)

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary
Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.

In-State Other Medicaid Eligibles (Not Included Elsewhere)

In-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)

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Enter claim charges, days, and payments for any other Medicaid-Eligible patients that have not been reported anywhere else in the survey. The patients must be Medicaid-eligible for the dates of service and they must be supported by Exhibit C and include the patient's Medicaid ID number.

Uninsured

Federal requirements mandate the uninsured services must be costed using Medicare cost reporting methodologies. As such, a hospital will need to report the uninsured days of care they provided each cost reporting period, by routine cost center, as well as inpatient and outpatient ancillary service revenue by cost report cost center. Exhibit A has been prepared to assist hospitals in developing the data needed to support responses on the survey. This data must be maintained in a reviewable format. It must also only include charges for inpatient and outpatient hospital services, excluding physician charges and other non-hospital charges. **Per federal guidelines uninsured patients are individuals with no source of third party healthcare coverage (insurance).**

4. Federal requirements mandate the hospital cost of providing services to the uninsured during the DSH year must be reduced by uninsured self-pay payments received during the DSH year. Exhibit B will assist hospitals in developing the data necessary to support uninsured payments received during each cost reporting period. The data must be maintained in a reviewable format and made available upon request.

Section I - Calculation of Out-of-State Medicaid Costs:

1. This schedule is formatted similar to Schedule H. It should be prepared to capture all out-of-state Medicaid FFS, managed care, FFS cross-over, other Medicaid eligible and managed care cross-over services the hospital provided during the cost reporting year. Like Schedule H, a separate schedule is required for each cost reporting period needed to completely cover the DSH year. Amounts reported on this schedule should reconcile to the out-of-state PS&R (or equivalent schedule) produced by the Medicaid program or managed care entity.

Out-of-State Medicaid FFS Primary
Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Out-of-State Medicaid Managed Care Primary
Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)
Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary

Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)
Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)

Section J - Calculation of In-State Medicaid and Uninsured Organ Acquisition Costs:

1. **This section is to be completed by hospitals that have incurred in-state Medicaid or uninsured organ acquisition costs only.** Information is collected in a format similar to Section H.
2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.

Section K - Calculation of Out-of-State Medicaid Organ Acquisition Costs:

1. **This section is to be completed by hospitals that have incurred out-of-state Medicaid organ acquisition costs only.** Information is collected in a format similar to Section I.
2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.
3. The following columns will **NOT** need to be entered by the provider as they will automatically populate after Section J has been completed: "Total Organ Acquisition Cost", "Revenue for Medicaid/Uninsured Organs Sold", and "Total Useable Organs (Count)".

Section L. Provider Tax Assessment Reconciliation / Adjustment

1. **This section is to be completed by all hospitals in states that assess a provider tax on hospitals. Complete all lines as instructed below.**

   The objective of this form is to determine the state-assessed total hospital provider tax not included in your cost-to-charge ratios and per diem cost on the cost report.

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2. Line 1 should be the total hospital Provider Tax Assessment from the general ledger, whether it is included as an expense, a revenue offset, etc..

   It should exclude non-hospital assessments such as a nursing facility tax unless an adjustment is made on W/S A-8 to remove the non-hospital expense.

3. Line 2 should be the total amount of the Provider Tax Assessment from line 1 that is included in Expense on Worksheet A, Column 2 of the cost report. Please report the cost report line number in which the expense is included in the box provided.
4. If there is a difference in the values you are reporting in lines 1 and 2, please explain that difference in the box provided (or attach separate explanation if it won't fit).
5. Lines 4-7 should identify any amount of the Provider Tax expense that was reclassified on Worksheet A-6 of the cost report. Please report the reasons for the reclassifications and the cost report line numbers affected in the boxes provided.
6. Lines 8-11 should identify any amount of the hospital allowable Provider Tax expense (assessed by the state) that was adjusted on Worksheet A-8 of the cost report.

   Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.

7. Lines 12-15 should identify Provider Tax expense adjustments on Worksheet A-8 of the cost report that are not related to the actual tax assessed by the state (e.g., association fees, other funding arrangments outside of the state's assessed tax).

   Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.

8. Line 16 calculates the net Provider tax expense included in the cost report after all reclassifications and adjustments.
9. Line 17 calculates the total Provider Tax expense that has been excluded from the cost report - this amount is used to determine the amount that will be added back to your hospital's DSH UCC.
10. Lines 18-24 show the calculation of the total add-back, and Line 25 shows the total Provider Tax expense that will be added back to your hospital's DSH UCC.

    The amount on Line 25 may NOT be the final amount added into your DSH UCC. The audit will review the various adjustments and reconciliations and make a final determination.

Please submit your completed cost report year surveys (Part II), along with your Part I DSH Year Survey, and uninsured data analyses (exhibits A and B) electronically to Myers and Stauffer LC. This information contains protected health information (PHI), and as such, should be sent on CD or DVD via U.S. mail, or via other carrier authorized to transfer PHI.

Submit To:

Myers and Stauffer LC
Attention: DSH Examinations

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9515 Deereco Road, Suite 500
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Include In Hospital Uninsured Charges:

To the extent hospital charges pertain to services that are medically necessary under applicable Medicaid standards and the services are defined as inpatient or outpatient hospital services under the Medicaid state plan the following charges are generally considered to be "uninsured":

Hospital inpatient and outpatient charges for services to patients who did not have any hospital health insurance or other legally liable third party coverage in effect at the time the services were rendered (reported based on date of service). *(42 CFR 447.299 (14) / Creditable coverage is further defined in the 45 CFR 146.113)*

- Include facility fee charges generated for hospital provider based sub-provider services to uninsured patients. Such services are identified as psychiatric or rehabilitation services, as identified on the facility cost report, Worksheet S-2, Line 3. The costs of these services are included on the provider's cost report.
- Include hospital charges for undocumented aliens with no source of third party coverage for hospital services. (73 FR dated 12/19/08, page 77916 / 42 CFR 447.299 (13))
- Include lab and therapy outpatient hospital services.
- Include services paid for by religious charities with no legal obligation to pay.

Include In Hospital Uninsured Payments:

Include all payments received for hospital patients that met the uninsured definition at the time of the service. The payments must be reported on a cash basis (report in the year received, regardless of the year of service). *(73 FR dated 12/19/08, pages 77913 & 77927)*

- Include uninsured liens and uninsured accounts sold, when the cash is collected. (73 FR dated 12/19/08, pages 77942 & 77927)
- Include Section 1011 payments for hospital services without insurance or other third party coverage (undocumented aliens). (42 CFR 447.299 (13))
- Include other waiver payments for uninsured such as Hurricane Katrina/Rita payments. (73 FR dated 12/19/08, pages 77942 & 77927)

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Do NOT Include In Hospital Uninsured Charges:

Exclude charges for patients who had hospital health insurance or other legally liable third party coverage in effect at the time the services were rendered. Exclude charges for all non-hospital services. *(42 CFR 447.299 (14) / Creditable coverage is further defined in the 45 CFR Section 146.113)*

- Exclude professional fees for hospital services to uninsured patients, such as Emergency Room (ER) physician charges and provider-based outpatient services. Exclude all physician professional services fees and CRNA charges. (42 CFR 447.299 (15) / 73 FR dated 12/19/08, pages 77924-77926)
- Exclude bad debts and charity care associated with patients that have insurance or other third party coverage (have coverage). *(42 CFR 447.299 (15))*
- Exclude claims denied by an active health insurance carrier (have coverage). *(73 FR dated 12/19/08, pages 77910-77911, 77913)*
- Exclude uninsured charges for services that are not medically necessary (including elective procedures), under applicable Medicaid standards (if the service does not meet definition of a hospital service covered under the Medicaid state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77930)*
- Exclude charges for services to prisoners (wards of the state). *(73 FR dated 12/19/08, page 77915 / State Medicaid Director letter dated August 16, 2002)*
- Exclude Medicaid eligible patient charges (even if claim was not paid or denied). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77916)*
- Exclude patient charges covered under an automobile or liability policy that actually covers the hospital service (insured). *(45 CFR 146.113, 45 CFR 146.145, 73 FR dated 12/19/08, pages 77911 & 77916)*
- Exclude contractual adjustments required by law or contract with respect to services provided to patients covered by Medicare, Medicaid or other government or private third party payers (insured). *(42 CFR 447.299 (15), 73 FR dated 12/19/08, page 77922)*
- Exclude charges for services to patients where coverage has been denied by the patient's public or private payer on the basis of lack of medical necessity, regardless as to whether they met Medicaid's medical necessity and coverage criteria (still insured). *(73 FR dated 12/19/08, page 77916)*
- Exclude unpaid Medicaid or Medicare deductible or co-payment amounts (patient has coverage). *(42 CFR 447.299 (15))*
- Exclude charges associated with the provision of durable medical equipment (DME) or prescribed drugs that are for "at home use", because the goods or services upon which these charges are based are not hospital services. *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

- Exclude charges associated with services not billed under the hospital's provider numbers, as identified on the facility cost report, Worksheet S-2, Lines 2 and 3. These include non-hospital services offered by provider owned or provider based nursing facilities (SNF) and home health agencies (HHA). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude facility fees generated in provider based rural health clinic outpatient facilities (not a hospital service in state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77926)*
- Exclude charges for provider's swing bed SNF services (not a hospital service in state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude non-Title XIX charges including stand-alone Supplemental Children's Hospital Insurance Programs (SCHIP / CHIP).
- Exclude Independent Clinical ("Reference") Laboratory Charges (not a hospital service). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

Do NOT Include In Hospital Uninsured Payments:

- Exclude State, county or other municipal subsidy payments made to hospitals for indigent care. *(42 CFR 447.299 (12))*
- Exclude any individual payments or third party payments on deductibles and co-insurance on Commercial and Medicare accounts (cost not included so neither is payment). *(42 CFR 447.299 (15))*
- Exclude collections for non-hospital services: Skilled Nursing Facility, Nursing Facility, Rural Health Clinic, Federally Qualified Health Clinic, and non-hospital clinics (i.e. clinics not reported on Worksheet "C" Part I) (not hospital services). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

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Example of Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D	Patient Identifier Code (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name]]	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 Third Party Payments for Services Provided (Q) **	Claim Status (Exhausted or Non-Covered Service ***, if applicable) (R)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7			
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3			
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	$ 16,000.75				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25				
Uninsured Charges	Self-Pay		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/5/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00		Exhausted
Uninsured Charges	Self-Pay		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/5/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00		Exhausted
Uninsured Charges	Self-Pay		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	6/10/2010	6/10/2010	Outpatient	450	$ 1,100.00			$ 100.00	Non-Covered Service

Notes for Completing Exhibit A:

* All charges for non-hospital services should be excluded.

** Payments reported in Columns N &O are not reported in the survey. These amounts are used for examination purposes only. Amount should include all payments received to date on the account.

*** Report services not covered under the patient's insurance package as a "Non-Covered Service". **Note - the service must be covered under the state Medicaid plan.**

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

Example of Section I - Self Pay Collections

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Sheet 4
Disproportionate Share Hospital (DSH) Audit Survey Part 1
3/31/2013

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)*	Hospital's Medicaid Provider # (E)	Patient Identifier Code (PIC) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collection (N)	Indicator if 1011 Payment (O)	Service Indicator (Inpatient / Outpatient) (P)	Total hospital charges for Service Provided (Q)	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S)**	Insurance Status Where Service Provided (T)**	Claim Status (Insured or Non-Covered Service)*** (If applicable) (U)	Calculated Hospital Uninsured Collections (T="Uninsured" or (U)="Excluded" or "Non-Covered Service") (Q)-(R)-(S)-(N) (V) ====
Self Pay Patients	Medicare		100	12345	8000000	2/7/2005	999-99-9999	Male	Doe, John	5/1/2003	5/5/2003	4/1/2010	$ 75.00	Yes	OP	$ 80,000	$ 1,000	$ -	Uninsured		$ 34
Self Pay Patients	Medicare	Medicaid	100	12345	8000000	2/7/2005	999-99-9999	Male	Doe, John	5/1/2003	5/5/2003	5/1/2010	$ 25.00	No	OP	$ 80,000	$ 1,000	$ -	Uninsured		$ 25
Self Pay Patients	Medicare	Medicaid	100	12345	8000000	2/7/2005	999-99-9999	Male	Doe, John	5/1/2003	5/5/2003	6/1/2010	$ 45.00	No	OP	$ 80,000	$ 1,000	$ -	Uninsured		$ 34
Self Pay Patients	Family Health Plan	Self Pay	100	12345	7777777	6/25/1979	999-99-9999	Male	Smith, Mike	7/1/2004	7/15/2004	2/1/2010	$ 600.00	No	IP	$ 32,000	$ 900	$ 300	Insured		$ -
Self Pay Patients	Family Health Plan	Self Pay	100	12345	7777777	6/25/1979	999-99-9999	Male	Smith, Mike	7/1/2004	7/15/2004	3/1/2010	$ 250.00	No	IP	$ 32,000	$ 900	$ 300	Insured		$ -
Self Pay Patients	Family Health Plan	Self Pay	100	12345	7777777	6/25/1979	999-99-9999	Male	Smith, Mike	7/1/2004	7/15/2004	4/1/2010	$ 1,000.00	No	IP	$ 32,000	$ 900	$ 300	Insured		$ -
Self Pay Patients	Uninsured Discount Plan		100	12345	7777777	7/6/2000	999-99-9999	Male	Smith, Mike	7/1/2004	7/15/2004	8/1/2010	$ 285.00	No	IP	$ 32,000	$ 900	$ 300	Insured		$ -
Self Pay Patients	Uninsured Discount Plan		100	12345	7777777	7/6/2000	999-99-9999	Male	Smith, Mike	7/1/2004	7/15/2004	9/1/2010	$ 285.00	No	IP	$ 32,000	$ 900	$ 300	Insured		$ -
Self Pay Patients	Uninsured Discount Plan		100	12345	8000005	2/28/1980	999-99-9999	Male	Jones, Joe	6/1/2005	6/5/2005	10/1/2010	$ 100.00	No	IP	$ 10,000	$ 500	$ 100	Insured	Excluded	$ 85
Self Pay Patients	Self Pay		100	12345	8000005	2/28/1980	999-99-9999	Male	Jones, Joe	6/1/2005	6/5/2005	11/1/2010	$ 100.00	No	IP	$ 14,004	$ 400	$ 90	Insured	Non-Covered Service	$ 135

Notes for completing this chart:

- Charges and insurance data will be the same when listing multiple payments for the same patient and dates of service.
- Enter non-hospital charges in columns R=MD, S=RC, Pharmacy, etc.
- If Section I.G1 (Undocumented Adm) payments are applied at a patient level include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.

**** Report services not covered under the patient's insurance package as a "Non-Covered Service" Note: the service must be covered under the state Medicaid plan.

***** The final Calculated Hospital Uninsured Collections (column V) should be for the total Inpatient and Outpatient payments reported in Section H, Line 115 of the 2014 Survey.

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

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D. General Cost Report Year Information -

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

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

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

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

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	#N/A		
5. Medicaid Provider Number:	#N/A		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	#N/A		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	#N/A		
8. Medicare Provider Number:	#N/A		

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

	State Name	Provider No.
9. State Name & Number		
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)

E. Disclosure of Medicaid / Uninsured Payments Received: (-)

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)**		

	Inpatient	Outpatient	Total
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 (H) on Exhibit B)	$-	$-	$-
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.00%	0.00%	0.00%

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (-)

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. 6, Sum of Lns. 12, 14, 14.x less lines 3 & 4)	- (See Note in Section F-3, below)

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

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

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 ECRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
9. Hospital	$0.00			$ -	$ -	$ -	$ -
10. Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
11. Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
12. Swing Bed - SNF			$0.00			$ -	
13. Swing Bed - NF			$0.00			$ -	
14. Skilled Nursing Facility			$0.00			$ -	
15. Nursing Facility			$0.00			$ -	
16. Other Long-Term Care			$0.00			$ -	
17. Ancillary Services	$0.00	$0.00		$ -	$ -	$ -	$ -
18. Outpatient Services		$0.00			$ -	$ -	$ -
19. Home Health Agency			$0.00			$ -	
20. Ambulance			$0.00			$ -	
21. Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
22. ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
23. Hospice			$0.00			$ -	
24. Other	$0.00	$0.00		$ -	$ -	$ -	$ -
28. Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29. Total Hospital and Non Hospital		Total from Above	$ -		Total from Above	$ -	
30. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	-		Total Contractual Adj. (G-3 Line 2)	-	
31. Unreconciled Difference		Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -	

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G. Cost Report - Cost / Days / Charges

Cost Report Year (-) #N/A

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
	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 HCRS 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.	*Cost Report Worksheet B, Part I, Col. 27*	*Cost Report Worksheet D, Part I, Col. 26 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report WS D-1, Pt. I, Line 2 for Adults & Peds; WS D-1, Pt. 2, Lines 42-47 for others*			*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	02500 ADULTS & PEDIATRICS	$ -	$ -	$ -	$0.00	$ -	-			$ -
2	02600 INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-			$ -
3	02700 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-			$ -
4	02800 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-			$ -
5	02900 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-			$ -
6	03000 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-			$ -
7	03100 SUBPROVIDER I	$ -	$ -	$ -		$ -	-			$ -
8	03101 SUBPROVIDER II	$ -	$ -	$ -		$ -	-			$ -
9	03300 NURSERY	$ -	$ -	$ -		$ -	-			$ -
10		$ -	$ -	$ -		$ -	-			$ -
11		$ -	$ -	$ -		$ -	-			$ -
12		$ -	$ -	$ -		$ -	-			$ -
13		$ -	$ -	$ -		$ -	-			$ -
14		$ -	$ -	$ -		$ -	-			$ -
15		$ -	$ -	$ -		$ -	-			$ -
16		$ -	$ -	$ -		$ -	-			$ -
17		$ -	$ -	$ -		$ -	-			$ -
18	Total Routine	$ -	$ -	$ -	$ -	$ -	-			
19	Weighted Average									$ -

	Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report WS S-3, Pt. I, Line 26, Col. 6	Subprovider I Observation Days - Cost Report WS S-3, Pt. I, Line 26.01, Col. 6	Subprovider II Observation Days - Cost Report WS S-3, Pt. I, Line 26.02, Co. 6	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 5	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
20	0820 Observation (Non-Distinct)	-	-	-	$ -	$0.00	$0.00	$ -	-

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State of
Disproportionate Share Hospital (DSH) Audit Survey Part II
1/31/2010

G. Cost Report - Cost / Days / Charges

Cost Report Year ()

style

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	HCE and Therapy Add-Backs (If Applicable)		Net Cost	IP	OP Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
		Cost Report Worksheet B, Part I, Col. 27	Cost Report Worksheet B, Part I, Col. 26 (Interns & Residents Offset ONLY)*	Cost Report Worksheet C, Part I, Col 2 and Col. 4		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	Medicare Calculated Cost-to-Charge Ratio
	Ancillary Cost Centers (from WSC excluding Observation) (list below):									
21		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
22		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
23		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
24		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
25		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
26		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
27		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
28		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
29		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
30		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
31		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
32		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
33		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
34		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
35		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
36		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
37		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
38		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
39		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
40		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
41		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
42		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
43		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
44		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
45		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
46		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
47		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
48		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
49		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
50		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
51		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
52		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
53		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
54		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
55		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
56		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
57		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
58		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
59		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
60		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
61		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
62		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
63		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
64		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
65		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
66		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
67		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
68		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
69		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
70		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
71		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
72		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
73		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
74		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
75		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
76		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
77		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
78		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
79		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -
80		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	$ -

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G. Cost Report - Cost / Days / Charges

Cost Report Year :-) #N/A

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101		Tota Ancillary	$ -	$ -	$ -		$ -	$ -	$ -	$ -	
102		Weighted Average									-
103		Grand Totals	$ -	$ -	$ -						

* Note A - Fina cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 26 of Worksheet B, Pt. I of the cost report you are using.

Worksheet 0E

State of
Disproportionate Share Hospital (DSH) Audit Survey Part III
3/26/2010

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

Cost Report Year >>> N/A

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary				In-State Medicaid Managed Care Primary				In-State Other Medicaid Eligibles (Not Included Elsewhere)				Uninsured				Total In-State Medicaid			
				Inpatient		Outpatient		Inpatient		Outpatient		Inpatient		Outpatient		Inpatient (See Exhibit A)		Outpatient (See Exhibit A)		Inpatient		Outpatient	
		From Section G	From Section G	From PS&R Summary (Note a)	Days	From PS&R Summary (Note a)	Ancillary Charges	From PS&R Summary (Note a)	Days	From PS&R Summary (Note a)	Ancillary Charges	From PS&R Summary (Note a)	Days	From PS&R Summary (Note a)	Ancillary Charges	From Hospital's Own Internal Analysis	Days	From Hospital's Own Internal Analysis	Ancillary Charges		Days		Ancillary Charges
	Routine Cost Centers (from Section D):																						
1	0200 ADULTS & PEDIATRICS	$ -																					
2	0300 INTENSIVE CARE UNIT	$ -																					
3	0400 CORONARY CARE UNIT	$ -																					
4	0500 BURN INTENSIVE CARE UNIT	$ -																					
5	0600 SURGICAL INTENSIVE CARE UNIT	$ -																					
6	0700 OTHER SPECIAL CARE UNIT	$ -																					
7	0800 SUBPROVIDER I	$ -																					
8	0900 SUBPROVIDER II	$ -																					
9	0990 NURSERY	$ -																					
10		$ -																					
11		$ -																					
12		$ -																					
13		$ -																					
14		$ -																					
15		$ -																					
16		$ -																					
17		$ -																					
18					Total Days				Total Days				Total Days				Total Days				Total Days		
19	Total Dialysis (PS&R or Other Paid Claims Summary																						
20					Uncompensated Days (Explain Variances)																		
21	Routine Charges				Routine Charges				Routine Charges				Routine Charges				Routine Charges				Routine Charges		
2101	Calculated Routine Charge Per Diem				$ -				$ -				$ -				$ -				$ -		
	Ancillary Cost Centers (from H.S. C) (from Section D):																						
22	0250 Emergency (See Note 2)																						
23																							
24																							
25																							
26																							
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State of
Disproportionate Share Hospital (DSH) Audit Survey Part II
3/31/2010

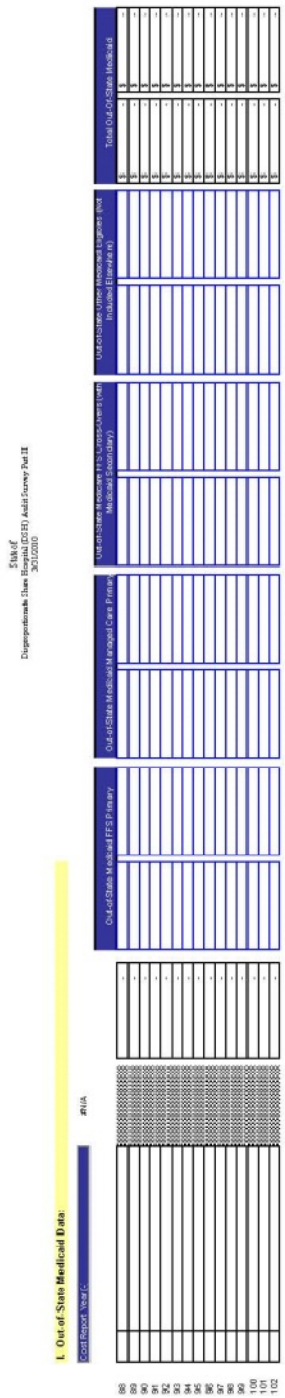
Version 6.00

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

Cost Report Year (-) — #N/A

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	
81			-											$ -	$ -
82			-											$ -	$ -
83			-											$ -	$ -
84			-											$ -	$ -
85			-											$ -	$ -
86			-											$ -	$ -
87			-											$ -	$ -
88			-											$ -	$ -
89			-											$ -	$ -
90			-											$ -	$ -
91			-											$ -	$ -
92			-											$ -	$ -
93			-											$ -	$ -
94			-											$ -	$ -
95			-											$ -	$ -
96			-											$ -	$ -
97			-											$ -	$ -
98			-											$ -	$ -
99			-											$ -	$ -
100			-											$ -	$ -
101			-											$ -	$ -
102			-											$ -	$ -
	Totals / Payments														
103	**Total Charges** *(includes organ acquisition from Section J)*			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ - (Agrees to Exhibit A)	$ - (Agrees to Exhibit A)	$ -	$ -
104	Total Charges per PS&R or Other Paid Claims Summary														
105	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-		
106	**Total Calculated Cost (includes organ acquisition from Section J)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
107	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)													$ -	$ -
108	Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding dollares re-processed													$ -	$ -
109	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ -	$ -	$ -								
110	Medicaid Cost Settlement Payments (See Note B)													$ -	$ -
111	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -
112	Medicare Paid Amount (excludes coinsurance/deductibles)													$ -	$ -
113	Medicare Cross-Over Bad Debt Payments													$ -	$ -
114	Other Medicare Cross-Over Payments (See Note D)											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -
115	Payment from Hospital Uninsured During Cost Report Year (Cash Basi														
116	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ -	$ -		
117	**Calculated Payment Shortfall / (Longfall)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
118	**Calculated payments as a Percentage of Cost**			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care and Cross-Over data, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (R & summary or PS&R)
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).



Version 6.00

State of
Disproportionate Share Hospital (DSH) Audit Survey Part II
2012/2013

I. Out of State Medicaid Data:

2012 Report Year >> #N/A

		Out of State Medicaid FFS Patients	Out of State Medicaid Managed Care Patients	Out-of-State Medicare (i.e. Includes Dual Eligibles Enrolled in Medicaid Secondary)	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Total Out Of State Medicaid
	Totals / Payments					
103	**Total Charges (Included on acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -
104	Total Charges per PS&R or Other Paid Claims Summary					
105	Unreconciled Charges (Explain Variance					
106	**Total Calculated Cost (Includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -
107	Total Medicaid Paid Amount (Includes TPL, Co-Pay and Spend-Down					$ -
108	Other Total Third Party Liability (Including Co-Pay and Spend-Down) but excluding Medicare or crossover					$ -
109	Total Allowed Amount from 4 edicaid PS&R or#A Detail (All Payment					$ -
110	Medicaid Cost Settlement Payments (See Note E	$ -	$ -			$ -
111	Total Medicaid Payment for Cost Report Year					$ -
112	Medicare Paid Amount for Medicare Cost Report Year (See Note I					$ -
113	Medicare Crossover Paid Paid Payment					$ -
114	Other Medicare Cross-Over payments (See Note E					$ -
115	**Calculated Payment Shortfall / (Enough)**	$ -	$ -	$ -	$ -	$ -
116	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%

Note A - These amounts must agree to your Incident and outpatient Medicaid calculations summary. For Managed Care and Cross-Over cells, use the hospital's top of PS&R; summaries are not available (submit hgm with survey).
Note B - Medicaid cost settlement payments refer to payments made by reliefed during a cost report settlement that are not reflected on the claims paid summary (A's summary or P).
Note C - Other Medicaid Payments such as Dollars and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the in
Note D - Should include other Medicare cross-over payments and exclude the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education pay

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

Cost Report Year (-) #N/A

		Total Organ Acquisition Cost	Revenue for Medicaid/ Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
					Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-6, Pt. III, Col. 1, Ln 53	*See Instructions from Cost Report WS D-4, Pt. III, Col. 1, Ln 58 (substitute Medicare with Medicaid/ uninsured). See Note C below.*	*Cost Report Worksheet D-6, Pt. III, Line 54*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
Organ Acquisition Cost Centers (list below):														
1	Lung Acquisition	$0.00		0										
2	Kidney Aquisition	$0.00		0										
3	Liver Aquisition	$0.00		0										
4	Heart Aquisition	$0.00		0										
5	Pancreas Acquisition	$0.00		0										
6	Intestine Aquisition	$0.00		0										
7	Islet Acquisition	$0.00		0										
8														
9	**Totals**	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**					-		-		-		-		-

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

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

Cost Report Year (-) #N/A

		Total Organ Acquisition Cost	Revenue for Medicaid/ Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
					Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-6, Pt. III, Col. 1, Ln 53	*See Instructions from Cost Report WS D-4, Pt. III, Col. 1, Ln 58 (substitute Medicare with Medicaid/ uninsured). See Note C below.*	*Cost Report Worksheet D-6, Pt. III, Line 54*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
Organ Acquisition Cost Centers (list below):												
11	Lung Aquisition	$ -	$ -	0								
12	Kidney Aquisition	$ -	$ -	0								
13	Liver Aquisition	$ -	$ -	0								
14	Heart Aquisition	$ -	$ -	0								
15	Pancreas Aquisition	$ -	$ -	0								
16	Intestine Aquisition	$ -	$ -	0								
17	Islet Aquisition	$ -	$ -	0								
18		$ -	$ -	0								
19	**Totals**	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**					-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available) if not, use hospital's logs and submit with survey
Note B Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (-) #N/A

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger) *				
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)				(Where is the cost included on w/s A?)
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				(Reclassified to / (from))
5	*Reclassification Code*				(Reclassified to / (from))
6	*Reclassification Code*				(Reclassified to / (from))
7	*Reclassification Code*				(Reclassified to / (from))
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				(Adjusted to / (from))
9	*Reason for adjustment*				(Adjusted to / (from))
10	*Reason for adjustment*				(Adjusted to / (from))
11	*Reason for adjustment*				(Adjusted to / (from))
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report** *		$ -	
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:			
18	Medicaid Hospital	Inpatient Days	-	
19	Uninsured Hospital	Inpatient Days	-	
20	Total Hospital	Inpatient Days	-	
21	Percentage of Provider Tax Assessment Adjustment to Include in DSH Medicaid UCC		0.00%	
22	Percentage of Provider Tax Assessment Adjustment to Include in DSH Uninsured UCC		0.00%	
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -	
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -	
25	Provider Tax Assessment Adjustment to DSH UCC		$ -	(May change after examination of analysis at audit)

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

*** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and Uninsured based on Inpatient Days unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.*

Instructions

General Instructions for Submitting Patient Detail that Supports the Services Reported on the DSH Survey:

1. **For all data reported on the DSH survey that is supported by *internally-generated* data:**
When running the internal reports for the DSH examination, please be sure that all applicable data elements are included. These required data elements are listed as the headings in the Excel templates in this document. *If these data elements are not included, the data is considered incomplete, and will not be accepted for the DSH examination.* You may include additional column data fields as you see fit, as long as the necessary data fields are also included.

**** Please do not alter column headings! These column headings will be used to summarize patient detail into reports that can be reviewed for the DSH examination.**

Exhibit A must be submitted by all hospitals. This is the charges/days for all services meeting the DSH examination uninsured definition.

EXHIBIT A REQUIRED DATA FIELDS

a. Claim Type
b. Primary Payor Plan
c. Secondary Payor Plan
d. Hospital's Medicaid Number
e. Patient Identification Number (PCN)
f. Patient's Birth Date
g. Patient's Social Security Number
h. Patient's Gender
i. Patient Name
j. Admit Date
k. Discharge Date
l. Service Indicator (inpatient/outpatient)
m. Revenue Code
n. Revenue Code Charges
o. Routine Days of Care
p. All patient payments received on the claim for services provided from the admit date through the present
q. All third party payments received on the claim for services provided from the admit date through the present
r. If the uninsured claim is being claimed as uninsured due to exhausted benefits or meeting lifetime/annual maximums, please enter "Exhausted" in this column. If it is being claimed because it is not a covered service under the insurance package enter "Non-Covered Service" (it must be a covered service under the Medicaid state plan). If neither apply, leave

Exhibit B must be submitted by all hospitals. This is the cash-based patient payments (cash-based self-pay payments).

EXHIBIT B REQUIRED DATA FIELDS

a. Claim Type
b. Primary Payor Plan
c. Secondary Payor Plan
d. Transaction Code
e. Hospital's Medicaid Number
f. Patient Identification Number (PCN)
g. Patient's Birth Date
h. Patient's Social Security Number
i. Patient's Gender
j. Patient Name
k. Admit Date
l. Discharge Date
m. Date of Cash Collection
n. Amount of Cash Collections
o. Indicate if Collection is a 1011 Payment
p. Service Indicator (inpatient/outpatient)
q. Total Hospital Charges for Services Provided
r. Total Physician Charges for Services Provided
s. Total Other Non-Hospital Charges for Services Provided
t. Insurance Status at Time of Service (Must Enter "Insured" or "Uninsured")
u. If the uninsured claim is being claimed as uninsured due to exhausted benefits or meeting lifetime/annual maximums, please enter "Exhausted" in this column. If it is being claimed because it is not a covered service under the insurance package enter "Non-Covered Service" (it must be a covered service under the Medicaid state plan). If neither apply, leave

Instructions

v. Calculated Hospital Collections IF(O) = "Uninsured" or (P)="Exhausted" or (P)="Non-Covered Service",

Exhibit C is required only if you are submitting Medicaid, Medicare crossover, Medicaid MCO, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report. If state data or MCO reports are used, this Exhibit is not necessary. Otherwise, you must submit an Exhibit C for each type of data (Medicare Crossover, Medicaid MCO, etc.,)

EXHIBIT C - REQUIRED DATA FIELDS (not all are applicable to all payer types - for example, Medicare payments will only apply to crossover data)

a. Claim Type
b. Primary Payor Plan
c. Secondary Payor Plan
d. Hospital Medicaid Number
e. Patient Identification Number (PCN)
f. Patient's Medicaid Recipient Number
g. Patient's Birth Date*
h. Patient's Social Security Number*
i. Patient's Gender*
j. Patient Name
k. Admit Date
l. Discharge Date
m. Service Indicator (inpatient/outpatient)
n. Revenue Code
o. Revenue Code Charges
p. Routine Days of Care
q. Medicare Payments (all payments received for the services provided from the admit date through the present)
r. Medicaid Payments (all payments received for the services provided from the admit date through the present)
s. Other Third Party Liability Payments including patient payments and private insurance (all payments received for the services provided from the admit date through the present)
t. Self-Pay payments (all payments received for the services provided from the admit date through the present)
u. Total Payments received on the claim (sum of all payments listed above)

*** You only need to provide these data items if the Patient's Medicaid Recipient # is NOT provided.**

2. Please input any internally-generated DSH survey data into the templates. Then submit the completed template to Myers and Stauffer with the DSH Survey Submission documentation. **Internally-generated DSH survey data must be submitted using this Excel template (either .xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data will not be accepted if not in**

G: Audit Program

Please note that this proposal includes data that shall not be disclosed outside the State Government and shall not be duplicated, used, or disclosed - in whole or in part - for any purpose other than to evaluate this proposal. All data marked CONFIDENTIAL herein are subject to this restriction.

Below is the rationale for those items marked as confidential

- *Audit Program:* The information contained in this Appendix contains proprietary information and/or trade secrets; therefore *Appendix G: Audit Program* is marked "Confidential – Not for Public Disclosure"

If you have any questions regarding the above, please contact Mark Hilton at 410-308-8184 or MHilton@mslc.com.

H: Draft Report

Please note that this proposal includes data that shall not be disclosed outside the State Government and shall not be duplicated, used, or disclosed - in whole or in part - for any purpose other than to evaluate this proposal. All data marked CONFIDENTIAL herein are subject to this restriction.

Below is the rationale for those items marked as confidential

- *Draft Report:* The information contained in this Appendix contains proprietary information and/or trade secrets*;* therefore *Appendix H: Draft Report* is marked "Confidential – Not for Public Disclosure"

If you have any questions regarding the above, please contact Mark Hilton at 410-308-8184 or MHilton@mslc.com.

I: Resumes

MARK K. HILTON, CPA

Mark Hilton, CPA, has over 29 years of audit experience relating exclusively to performing health care related services and applying Medicare and Medicaid principles of reimbursement. Since 1998, Mr. Hilton has directed Myers and Stauffer's health care fraud investigation services provided to various agencies of the Department of Justice including the Criminal and Civil divisions of the United States Department of Justice Commercial Litigation Branch, the Federal Bureau of Investigation, and various Assistant United States Attorneys.

Mark K. Hilton, *CPA*

Member/Project Director

EDUCATION

B.S., Accounting, Liberty University

EXPERIENCE

29 years professional experience

22 years with Myers and Stauffer LC

CORE COMPETENCIES

health care consulting with an emphasis on fraud investigation and litigation support

health care auditing and accounting with an emphasis on Medicaid and Medicare reimbursement

RELEVANT EXPERIENCE

West Virginia Department of Health and Human Resources (2010-2012)

- Project director responsible for completion of Disproportionate Share Hospital Audits for the State Fiscal Years 2005 through 2009.

Colorado Department of Health Care Policy and Financing (2010-present)

- Project director responsible for completion of Disproportionate Share Hospital Audits for the State Fiscal Years 2005 through 2008.
- Project director responsible for completion of Hospital, FQHC, RHC Audits.

State of South Carolina - Disproportionate Share (DSH) Program and Hospital Cost settlements (2006-present)

- Project director responsible for overseeing the contract with the Department of Health and Human Services to perform audit procedures on the state of South Carolina Disproportionate Share Hospital Payment Program. Responsibilities include modification of audit program, scheduling, reviewing completed engagements, supervising staff, interaction with state and hospital representatives. Project director responsible for performing Medicaid cost settlements on South Carolina hospitals. Responsibilities include cost settlement program development, scheduling, reviewing of completed work papers, supervising staff, and interaction with state and hospital representatives.

State of New Hampshire - Disproportionate Share (DSH) Program audits (2009-present)

- Project director responsible for overseeing the contract with the New Hampshire Department of Health and Human Services to perform audit procedures on the state of New Hampshire Disproportionate Share Hospital Payment Program. Responsibilities include modification of audit program, scheduling, reviewing completed engagements, supervising staff, interaction with state and hospital representatives.

State of Oregon - Disproportionate Share (DSH) Program audits (2009-present)

- Project director responsible for overseeing the contract with the Oregon Department of Human Services, Division of Medical Assistance Services to perform audit procedures on the Disproportionate Share Hospital Payment Program. Responsibilities include modification of audit program, scheduling, reviewing completed engagements, supervising staff, interaction with state and hospital representatives.

District of Columbia - Disproportionate Share (DSH) Program audits (2009-2011)

- Project director responsible for overseeing the contract with Williams, Adley & Company, the CPA firm contracted by the District of Office of the Chief Financial Officer for Medicaid Audits to perform audit procedures on the District of Columbia Disproportionate Share Hospital Payment Program. Responsibilities include modification of audit program, scheduling, reviewing completed engagements, supervising staff, interaction with state and hospital representatives.

U.S. Department of Justice (DOJ) (1997-present)

- Project director responsible for the oversight of the FBI Headquarters' Health Care Fraud Unit subcontract involving litigation support and the investigation of health care fraud cases across the United States. Provided litigation support assistance to FBI Special Agents, FBI Financial Analysts, Assistant United States Attorneys, U.S. DOJ Commercial Litigation Trial Attorneys, State Attorneys, Chief Investigators of Medicaid Fraud Control Units, U.S. Department of the Treasury Special Agents, U.S. Department of Treasury Intelligence Analysts, U.S. Food and Drug Administration Office of Criminal Investigations Special Agents, U.S. Department of Health and Human Services Office of Inspector General Special Agents, National Insurance Crime Bureau Agents, and Government Statisticians and Medical Experts.
- Project director responsible for providing litigation support services to the Department of Justice Assistant United States Attorneys and attorneys representing the Commercial Litigation Branch of the U.S. Department of Justice Civil and Criminal.

PRESENTATIONS

- "Medicare and Community Mental Health Centers," Colorado Mental Health Center and Clinics Association, Annual Conference; and Colorado Mental Health Associates, Annual Business Manager's Conference.
- "Medicare Reimbursable Bad Debts," and "Medicare Graduate Medical Education," District of Columbia Hospital Association.
- Medicaid Disproportionate Share Hospital Audits," South Carolina Hospital Association and state of South Carolina, National Association of State Human Service Finance. Officers (HSFO) annual training conference and Spring Planning and Business Meeting, Mississippi Hospitals for the Mississippi Medicaid Division, New Hampshire Hospitals for the New Hampshire Medicaid Division.

JOHN D. KRAFT, CPA, CHFP

For the past 27 years, John Kraft, CPA, CHFP, has performed Medicare and Medicaid audit, desk review and rate calculation services. He plays a key role in managing our Disproportionate Share Hospital contracts with the states of Massachusetts, South Carolina, New Hampshire, Oregon, Tennessee, and Rhode Island. In addition, he has provided litigation support for our state Medicaid clients' cost report appeals. He also has performed various cost report audit services for Carefirst of Maryland, the former Medicare fiscal intermediary. Most recently, he has been a key participant in the health care litigation support practice area.

John D. Kraft, *CPA, CHFP*

Member

EDUCATION

B.S., Accounting and Economics, Towson University

EXPERIENCE

27 years professional experience

25 years with Myers and Stauffer LC

CORE COMPETENCIES

health care consulting with an emphasis on fraud investigation and litigation support

health care auditing and accounting with an emphasis on Medicaid and Medicare reimbursement

RELEVANT EXPERIENCE

West Virginia Department of Health and Human Resources (2010-2012)

- Managed completion of Disproportionate Share Hospital Audits for the State Fiscal Years 2005 through 2009.

State of South Carolina - Disproportionate Share (DSH) Program and Hospital Cost settlements (2006-present)

- Manages and reviews field audits and desk reviews of hospital Medicare cost reports and Disproportionate Share Hospital (DSH) statistical data. Key participant in developing DSH and Medicaid cost settlement audit and desk review programs and engagement planning guides. Developed Microsoft Excel spreadsheets to calculate Medicaid cost settlements, and to summarize hospital uncompensated care costs, hospital-specific DSH payment limits and DSH qualification criteria. Experienced with HFS Medicare cost reporting software.

Disproportionate Share (DSH) Program Audits-States of Connecticut, Massachusetts, New Hampshire, Oregon, Rhode Island, Vermont and the District of Columbia (2010-present)

- Manages completion of Disproportionate Share Hospital Audits.

U.S. Department of Justice (DOJ) (1999-present)

- Provides litigation support services for healthcare fraud investigations. Analyzes and researches complex reimbursement issues and provides support for damage calculations. Entities investigated include hospitals, clinics, pharmacies, medical transcription agencies, durable medical equipment suppliers, among others. Experienced with Microsoft Access in developing and analyzing large financial and statistical databases. Provides assistance with witness depositions including development of

questioning strategy, analysis of witness testimony and preparation of exhibits. Experienced with maintaining and managing large inventories of case documents.

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (1986-2006)

- Managed and reviewed field audits and desk review verifications of hospitals, ICF/MRs, residential treatment centers, alcohol/drug treatment centers, home health agencies, federally qualified health centers and nursing homes. Established departmental objectives and managed the workload of a large staff of audit professionals. Developed detailed audit, desk review and interim rate calculation programs and engagement planning guides for a number of provider types. Monitored Medicare and Medicaid regulatory environment and updated programs and procedures. Reviewed TEFRA target rate adjustment requests for Maryland Medicaid providers.

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (1993-2011)

- Provided litigation support services for Medicaid cost report appeals. Analyzes appeal issues, prepares hearing exhibits, provides hearing testimony and assists with settlement negotiations. Testified as expert witness in healthcare accounting and Medicare and Medicaid reimbursement before the state of Maryland Office of Administrative Hearings. Researched and prepared position papers for presentation to the state of Maryland Hospital Appeal Board.

Centers for Medicare & Medicaid Services (CMS) (1990, 1997-1999)

- Reviewed and evaluated financial audit work of the Tennessee, Massachusetts and Pennsylvania state Medicaid programs in conjunction with CFO Act audit of financial statements.
- Key participant in the State Performance Evaluation and Comprehensive Test of Reimbursement Under Medicaid (SPECTRUM) of the state of New York for CMS.

PRESENTATIONS

- Disproportionate Share Hospital Auditing for State of MA Medicaid and hospital personnel
- Disproportionate Share Hospital Auditing for State of RI Medicaid and hospital personnel
- Hospital Audit and Reporting Rule Conference
- Presentation at Clifton Gunderson Training Session-South Carolina DSH & Cost Settlement Reviews
- Presentation at Clifton Gunderson Training Session -Understanding DSH

DIANE KOVAR, CPA

Diane Kovar, CPA, has over 14 years of experience with Myers and Stauffer working on health care-related audits, fraud investigations, and litigation support services. In addition to being the project manager for West Virginia, she has managed DSH audits in South Carolina and Connecticut. She has also worked on the DSH engagements in Rhode Island, Oregon, and New Hampshire. Outside of DSH, she has worked on health care engagements with the Maryland Department of Health and Mental Hygiene and CMS.

Diane Kovar, *CPA*

Senior Manager

EDUCATION

B.S., Accounting, Pennsylvania State University

EXPERIENCE

14 years professional experience

14 years with Myers and Stauffer LC

CORE COMPETENCIES

health care auditing with an emphasis on Medicare and Medicaid reimbursement

Medicaid DSH auditing

Medicaid DSH consulting

RELEVANT EXPERIENCE

West Virginia Department of Health and Human Resources (2010-2012)

- Project manager responsible for completion of Disproportionate Share Hospital Audits for the State Fiscal Years 2005 through 2009.

State of South Carolina - Department of Health and Human Services - Medicaid Program (2006-present)

- Perform verifications of Disproportionate Share (DSH) claims data submitted by hospitals to the state of South Carolina, Department of Health and Human Services in order to validate DSH payments made to the hospital providers.

State of New Hampshire - Disproportionate Share (DSH) Program audits (2009-present)

- Perform verifications of Disproportionate Share (DSH) claims data.

State of Rhode Island - Disproportionate Share (DSH) Program audits (2010-present)

- Perform verifications of Disproportionate Share (DSH) claims data.

State of Oregon - Disproportionate Share (DSH) Program audits (2009-present)

- Perform verifications of Disproportionate Share (DSH) claims data.

State of Maryland Department of Health and Mental Hygiene – Medicaid Program (2001-2006)

- Conducts desk reviews and field audits of federally qualified health centers, residential treatment centers, psychiatric hospitals, state facilities, and alcohol/drug treatment centers.
- Conducts Medicare focused reviews and desk reviews of hospitals, skilled nursing facilities, and rehabilitation facilities.

City of San Jose, California - Municipal Health Services Program (2001-present)

- Performs audit of cost reports.

Centers for Medicare & Medicaid Services (CMS) (2000-present)

- Assisted in the planning, directing, and completing the CMS CFO audit (FY 2000-2004)
- Assisted in the planning, directing and completing the FY 2001 CMS accounts receivable engagement (AdminaStar Federal - Cincinnati, Ohio).
- Participated in a CMS SAS-70 of a Medicare contractor in FY 2003 - FY 2006.
- Participated in a CMS accounts receivable agreed-upon procedures of a Medicare contractor (FY 2003-2005).
- Participated in a CMS Medicare Advantage and/or Prescription Drug bid plan audit (FY 2005 - FY 2006).

U.S. Department of Justice (2001-present)

- Provides litigation support.

KRISTIE MASILEK

Kristie Masilek has more than 16 years of experience working on health care-related audits including DSH audits in South Carolina, New Hampshire, Massachuetts, Rhode Island, Vermont, and Connecticut Her other clients have included the Maryland Department of Health and Mental Hygiene, Maryland Health Care Commission, DOJ and CMS.

Kristie Masilek

Manager

EDUCATION

B.A., Accounting, College of Notre Dame of Maryland

EXPERIENCE

16 years professional experience

16 years with Myers and Stauffer LC

CORE COMPETENCIES

health care auditing and accounting with an emphasis on Medicare and Medicaid reimbursement

Medicaid DSH auditing

health care consulting with an emphasis on investigation and litigation support

RELEVANT EXPERIENCE

West Virginia Department of Health and Human Resources (2010-2012)

- Manage and review desk reviews of hospital Medicare cost reports and Disproportionate Share Hospital (DSH) statistical data.

District of Columbia Department of Health Care Finance (2008 – Present)

- Planning, organization, scheduling, supervision, technical consulting, and completion of Medicaid Cost Report Audits of National Rehabilitation Hospital, Specialty Hospital of Washington, and Psychiatric Hospital of Washington.
- Perform audit of state Disproportionate Share procedures.

State of New Hampshire Department of Health and Human Services- Medicaid Program (20010-present)

- Manage and review desk reviews of hospital Medicare cost reports and Disproportionate Share Hospital (DSH) statistical data.

State of Vermont Department of Health and Human Services- Medicaid Program (2010-present)

- Perform audit of state Disproportionate Share procedures.

State of South Carolina Department of Health and Human Services- Medicaid Program (2009-present)

- Manage and review field audits and desk reviews of hospital Medicare cost reports and Disproportionate Share Hospital (DSH) statistical data.

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (1996-2005)

- Performed cost report desk reviews and auditing of costs for providers including federally qualified health centers, intermediate care facilities for the mentally retarded, psychiatric hospitals, rehabilitation hospitals, and residential treatment centers.

- Reviewed providers for general compliance with program regulations and requirements, for ongoing compliance with internal policies and statutory requirements, to assess the adequacy of internal control measures, and to test the accuracy and completeness of record-keeping and operational functions.

Centers for Medicare & Medicaid Services (CMS) (1997-2002)

- Performed general control and substantive testing to determine the validity, completeness, and existence of items reported in contractor financial reports as part of the Centers for Medicare and Medicaid Services' CFO Act audits for fiscal years 1997, 1998, 2000, and 2002.

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (2001-2005)

- Managed and reviewed desk review verifications of Home Health Agencies with Maryland Medicaid utilization.

U.S. Department of Justice - Civil Division (2001-present)

- Perform litigation support services related to health care entities under investigation for presenting false claims to the government
- Perform litigation support services related to contract law in procurement

Maryland Health Care Commission (2008-Present)

- Responsible for completion of verifications of Maryland Trauma Fund Semi-Annual Uncompensated Trauma Services Applications. This includes on-site visits, report preparation, and reviewing completed verifications.
- Responsible for completion of verifications of Maryland Trauma Fund Semi-Annual On-Call Trauma Services Applications. This includes on-site visits, report preparation, and reviewing completed verifications.
- Responsible for completion of verifications of Maryland Health Insurance Partnership Fund. This includes on-site visits, report preparation, and reviewing completed verifications.

ROBERT HICKS, CPA

Robert Hicks, CPA, is responsible for providing consulting and public accounting services to state Medicaid agencies addressing health care reimbursement issues. Mr. Hicks has been the project manager on various Medicare/Medicaid accounting, auditing, rate setting, and consulting engagements.

Mr. Hicks is responsible for managing supervisors and staff that run the daily activities of various Medicaid contracts. His duties include setting up the initial project requirements, communicating with the clients, ensuring adequate staffing, training and supervisory reviews.

Robert Hicks, *CPA*

Member

EDUCATION

B.S., Accounting, University of Missouri – Kansas City

EXPERIENCE

16 years professional experience

9 years with Myers and Stauffer LC

CORE COMPETENCIES

cost report auditing

Medicaid DSH auditing

Medicaid DSH consulting

nursing facility case-mix rate setting

cost report development

develops course curriculum and conducts training for Department personnel, providers and MSLC staff

RELEVANT EXPERIENCE

State of Louisiana, Department of Health and Hospitals, DSH Audit (2010-Present)

- Manage the federally mandated independent certified audits of the state's Disproportionate Share Hospital (DSH) payments.

State of Missouri, MO HealthNet, DSH Audit (2010-Present)

- Manage the federally mandated independent certified audits of the state's Disproportionate Share Hospital (DSH) payments.

State of New Jersey, Department of Health and Senior Services, Long Term Care Facility Audit (2003-present))

- Project manager to provide nursing facility auditing services to ensure that operating costs are reasonable, allowable, and classified in compliance with Medicaid guidelines

State of Louisiana, Department of Health and Hospitals, Case Mix Rate Setting System and Develop and Operate MDS Validation Program (2001-present)

- Project manager to assist in the development and operation of a case mix reimbursement system for nursing facilities participating in the Louisiana Medicaid Program

State of Kansas, Health Policy Authority, Disproportionate Share Hospital Audit (2002-present)

- Project manager to streamline and improve the DSH eligibility determination process and to provide technical expertise as needed. DSH calculations for SFY 2009.

State of Louisiana, Department of Health and Hospitals UPL and DSH Calculations (2005-present)

- Project manager overseeing developing data collection tools, preparing UPL and DSH calculations for review and acceptance by the Medicaid program, assisting with meetings attended by hospital representatives and their consultants and assisting with meetings and/or correspondence with CMS officials.

PRESENTATIONS

- "DSH SFY 2010", Louisiana Hospitals, February 2013, Baton Rouge, Louisiana
- "DSH SFY 2010 Update", Missouri Hospitals, February, 2013, Webinar
- "2552-10 Medicare Cost Report," Myers and Stauffer Audit/AUP Training Workshop, May 2011, Baltimore, Maryland.
- "DSH Data Collection," Louisiana Rural Hospital Coalition, May, 2010, Baton Rouge, Louisiana
- "DSH Audits," Missouri, Kentucky, and North Dakota, 2009, 2010, and 2011, 2012
- "Louisiana Case Mix," Louisiana Nursing Facility Case Mix Training Workshops, 2006 and 2008, Monroe and Baton Rouge, Louisiana.
- "Medicare Cost Report," Myers and Stauffer Audit/AUP Training Workshop, September 2006, Kansas City, Missouri.
- "Children's Hospitals Graduate Medical Education", HRSA Workshops, 2004, Chicago, San Francisco, Baltimore

DAVID MCMAHON, II, CPA

Throughout his more than 17 years of experience, David McMahon has performed audit and consulting work for the state agencies of North Carolina, South Carolina, Alabama, Mississippi, Nevada, and Texas. Also unique, Mr. McMahon has a wealth of experience pertaining to hospital reporting and operations, as he was previously employed by one of the nation's larger hospitals, where his responsibilities included generating the Medicare cost report each year. Mr. McMahon is a recognized expert in the area of Medicare and Medicaid hospital reimbursement. He has presented at numerous external and internal health care conferences. Furthermore, he presented Cost Report Audit Training for CMS Medicare Part A staff.

David McMahon, II, *CPA*

Senior Manager

EDUCATION

B.S., Accounting, Winthrop University

EXPERIENCE

17 years professional experience

8 years with Myers and Stauffer LC

CORE COMPETENCIES

health care auditing and accounting with an emphasis on Medicaid and Medicare reimbursement

cost report knowledge of issues including graduate medical education, transplant, home office Medicare audits of hospitals

reconciling Certified Public Expenditures (CPE)

RELEVANT EXPERIENCE

Colorado Department of Health Care Policy and Financing (2010-present)

- Senior manager responsible for completion of Disproportionate Share Hospital Audits for the State Fiscal Years 2005 through 2008.

Technical Advice for Various Contracts Held by Clifton Gunderson with State Medicaid Agencies (2005-present)

- Research topics ranging from definition of hospital services under Medicaid to definition of uninsured and assist in development of position statements for the various offices.
- Provided on-site assistance and guidance for work performed for the state of Texas related to its Disproportionate Share Hospital Payment program.
- Provided on-site assistance and guidance for work performed for the state of Mississippi related to its Hospital Services reimbursement programs.
- Provided on-site assistance and guidance for work performed for the state of Washington related to its Disproportionate Share Hospital Payment program.
- Provided on-site assistance and guidance for work performed for the state of Oklahoma related to its Disproportionate Share Hospital Payment program.
- Provided on-site assistance and guidance for work performed for the state of New Hampshire related to its Disproportionate Share Hospital Payment program.

Alabama Medicaid Agency (2008-present)

- Develop and perform agreed-upon procedures engagement to reconcile CPEs claimed by the Alabama Medicaid Agency for federal reimbursement. This includes reviewing allowable claims under the Disproportionate Share Hospital (DSH) program, a review of the Medicare Cost-to-Charge Ratio and an examination of the uninsured claims.
- Review of State Plan Amendment filings with CMS for funding of Medicaid Inpatient and Outpatient Hospital Services and Disproportionate Share Hospital payments.
- Review of CMS Form 64 filings for recertification by state.

Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (2008-present)

- Review of State Plan Amendment filings with CMS for funding of Inpatient and Outpatient Public Hospital Upper Payment Limit payments.
- Review of State Plan Amendment filings with CMS for funding of Inpatient Private Hospital Upper Payment Limit payments.
- Review of Nursing Facility Provider Tax Program.
- Review of Certified Public Expenditure Program related to Targeted Case Management
- Performed training of staff related to various topics including disproportionate share hospital payments, Medicare cost reporting, reimbursement methodologies, and rate setting.
- Performed training sessions for hospitals related to Disproportionate Share Hospital payment program and audits of the program.

South Carolina Department of Health and Human Services (2006-present)

- Develop various audit programs for Disproportionate Share Hospital (DSH) audit contract with the South Carolina Department of Health and Human Services.
- Supervise on-site engagements conducted under the DSH contract.
- Review of cost reporting related to administrative and program cost from various South Carolina state agencies contracted with DHHS.

North Carolina Division of Medical Assistance (2005-2009)

- Perform audits of large complex hospital facilities.
- Develop audit programs for home office operations and physician cost reporting.
- Provide guidance on various reimbursement issues as needed for staff of the North Carolina DMAS.

North Carolina Division of Medical Assistance for CPE Settlement Review (2008-2009)

- Senior Manager responsible for the completion of reviewing CPE Settlement of the 43 Public Hospitals for State Fiscal Year 2006 Disproportionate Share Hospitals Payment program.
- Assisted in the design of agreed upon procedures program and establishment of standard workpapers related to the project.

University of North Carolina Hospitals (1999-2005)

- Supervised the completion of Medicaid cost reports for 4 fiscal years for Academic Teaching Hospital with over $1 Billion of gross revenue in the final cost reporting period.
- Completed appeals and reconsideration reviews for settled Medicaid and Medicare cost reports.
- Liaison with both Medicare and Medicaid representatives regarding cost report audits, appeal filings and other Reimbursement related issues.

HUGH WEBSTER

The former CMS Atlanta Region Branch Manager of Financial and Programmatic Operations of Medicaid and State Children's Health Insurance Program (SCHIP), Hugh Webster has an extensive knowledge of a broad spectrum of complex Medicaid issues in various states that are critical to the ongoing success of state operations.

Previously responsible for the oversight of long-term care expenditures in eight of the largest Medicaid programs in the nation, Mr. Webster focused on complex hospital reimbursement programs and the state plans, audits, and regulations affecting them. He is highly qualified in areas related to Medicaid and SCHIP agency performance, State Medicaid/ SCHIP quarterly budget and expenditure reports, complex funding mechanisms (CPE, IGT, taxes, and donations), and the DSH program. In his professional capacity, Mr. Webster was charged with not only understanding the myriad of complexities associated with institutional reimbursement, but also possessing the ability to articulate these complexities in a manner that was understood by all stakeholders, including CMS leadership, state officials, provider associations, and the Office of Inspector General. Further, Mr. Webster maintains excellent personal and professional relationships with federal regulators and state leaders across the nation

Hugh Webster
Manager

EDUCATION
B.S., Accounting, Auburn University

EXPERIENCE
32 years professional experience
4 years with Myers and Stauffer LC

CORE COMPETENCIES
Medicaid/SCHIP agency performance
Medicaid/SCHIP quarterly budget and expenditures
Complex funding mechanisms (CPE, IGT, taxes, donations)

RELEVANT EXPERIENCE

West Virginia Department of Health and Human Resources (2010-present)

- Manages completion of Disproportionate Share Hospital Audits for the State Fiscal Years 2005 through 2009.

Centers for Medicare & Medicaid Services Manager, Medicaid/ SCHIP Financial and Program Operations, Division of Medicaid and Children's Health, Atlanta Regional Office, (1997-2008)

- Managed the financial and program operation activities of 32 staff assigned to eight Region IV states (NC, SC, TN, KY, MS, AL, GA, FL) including:
  - Reviews of all institutional and non-institutional State Plan Amendments.
  - Reviews of State's Medicaid/SCHIP Qtly Budget and Expenditure Reports.
  - Reviews of funding mechanisms such as donations, taxes, certified public expenditures, intergovernmental transfers, state and local appropriations.

- Reviews to resolve DHHS and General Accounting Office (GAO) audit reports of State Medicaid/SCHIP agency performance.
- Reviews of state agency MMIS/Managed care contracts for FFP.
- Development of review guides to supplement established financial management (FM) review processes.
- Reviews of Cost Allocation Plans submitted through DCA.
- Acting Associate Regional Administrator of the Division of Medicaid and Children's Health for 7 months in 2003.

Health Care Financing Administration (HCFA) State Financial Analyst, Medicaid Financial Mgt Branch, Division of Medicaid, Atlanta Regional Office, (1983-1997)

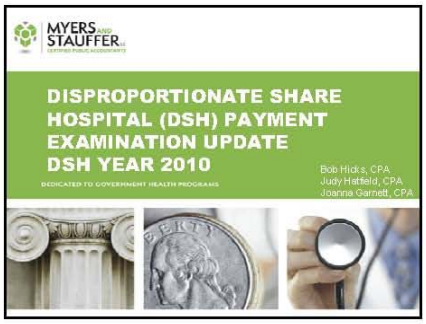
- Assigned responsibility at one time or another for the states of Georgia, North Carolina, Tennessee, Alabama, South Carolina, and Mississippi. Nationally known and recognized for knowledge of institutional reimbursement issues such as UPL and DSH and issues that deal with HIPAA, MMIS, cost allocation plans, financial aspects of 1115 demonstration waivers, prepaid health plans, and tax and donation programs. Served on several central office workgroups such as the UPL regulation team, SCHIP payment and allotment team, and Medicaid financial management team.

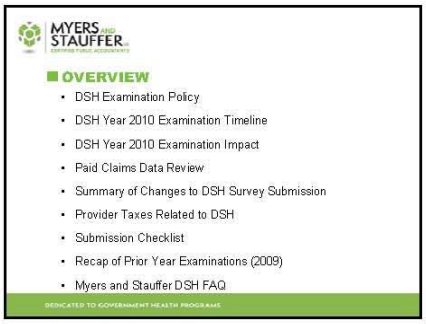
General Accounting Office (GAO), Program Evaluator Finance and Accounting Program Group, Atlanta Regional Office, (1980-1983)

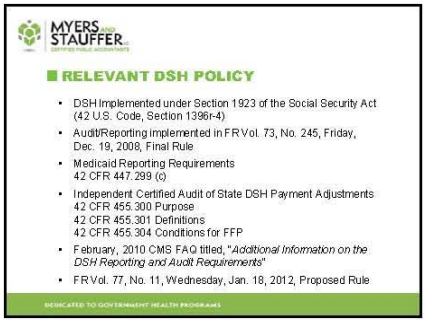
- Conducted audits of HCFA, U.S. Parole Commission, and U.S. Air Force

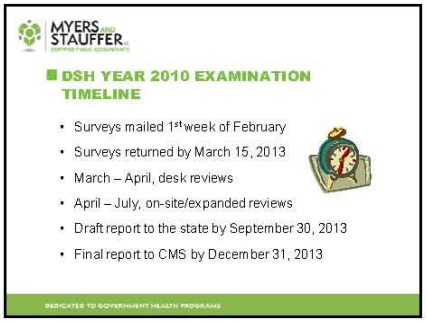
J: Sample Training Materials

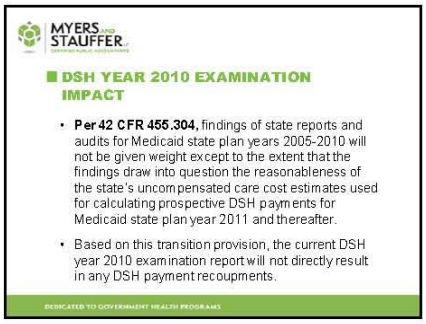
Missouri 2013 DSH Audit Update 2/17/2013

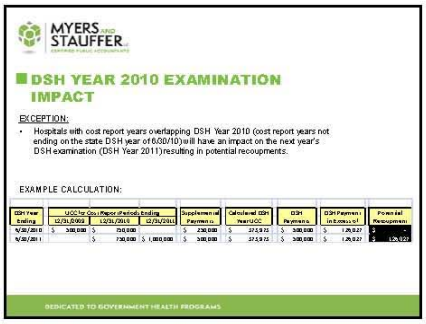












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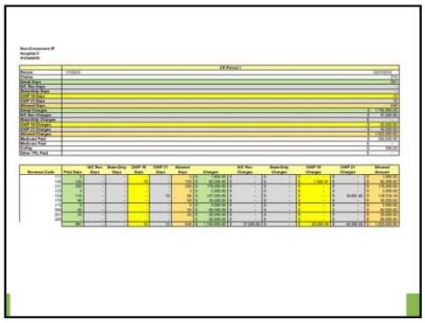
2/17/2013

PAID CLAIMS DATA UPDATE FOR 2010

- Medicaid fee-for-service paid claims data
  - Will be sent to hospitals with the survey
  - Similar format as last year.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Detailed data is available upon request.
  - Will include Medicare Managed Care cross-over non-QMBs.
  - Will exclude non-Title 19 services (such as SCHIP)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



PAID CLAIMS DATA UPDATE FOR 2010

- Medicare/Medicaid cross-over paid claims data
  - This data was provided last year, but was incomplete due to issues with cross-over claim data
  - eMOMed claims are missing all inpatient charge data but include days and payments.
    - Hospital will need to add inpatient charges for the eMOMed claims or estimate based on the non-eMOMed claim summary we provide

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PAID CLAIMS DATA UPDATE FOR 2010

- Medicare/Medicaid cross-over paid claims data
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Will not include Medicare Managed Care non-QMBs but should include QMBs.
  - Hospital is responsible for ensuring all Medicare payments are included in the final survey even if the payments are not reflected on the state's paid claim totals.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PAID CLAIMS DATA UPDATE FOR 2010

- Medicaid managed care paid claims data is not available
  - This data was not provided last year.
  - If the hospital cannot obtain a paid claims listing from the MCO, the hospital should send in a detailed listing in Exhibit C format.
  - If your charges/payments from the Medicaid MCOs include physician professional services, you need to remove the physician charges and allocate / remove payments to those physician charges based on your agreements.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PAID CLAIMS DATA UPDATE FOR 2010

- Medicaid managed care paid claims data is not available (cont.)
  - Must EXCLUDE SCHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

2/17/2013

PAID CLAIMS DATA UPDATE FOR 2010

- 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 SCHIP 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 2010

- "Other" Medicaid Eligibles
  - Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing may not be included in the state's data. The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).
  - Must EXCLUDE SCHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

PAID CLAIMS DATA UPDATE FOR 2010

- Uninsured Services
  - As in years past, uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.
  - Should be reported based on cost report year (using discharge date).

SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION

- 2 versions of the DSH Part II Survey
  - 2552-96 Version for use with the 2552-96 Cost Report Years
  - 2552-10 Version for use with the 2552-10 Cost Report Years

SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION

- Additional items required to be submitted with the survey:
  - Description of logic used to compile Exhibits A, B, and C.
    - Financial classes, payor plans, and transaction codes included or excluded.
  - List of financial classes, payor plan codes, and payment transaction codes for the period

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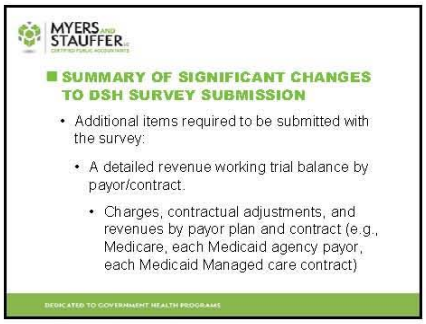
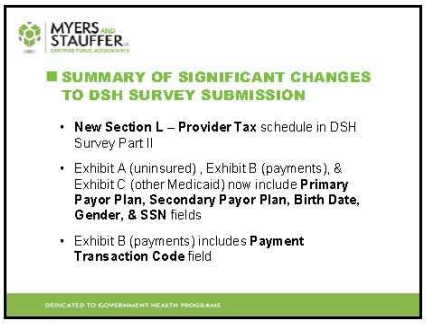
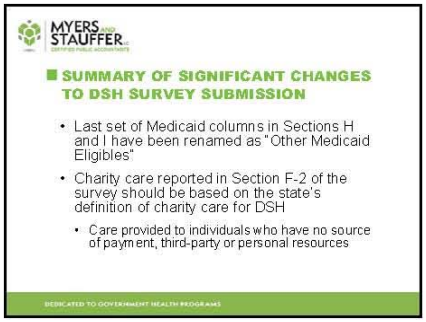
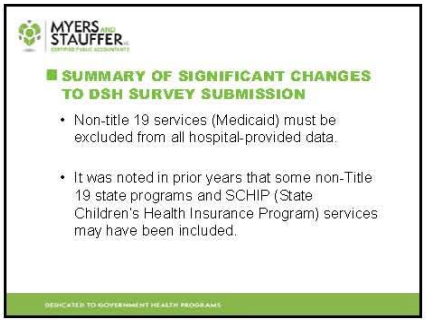
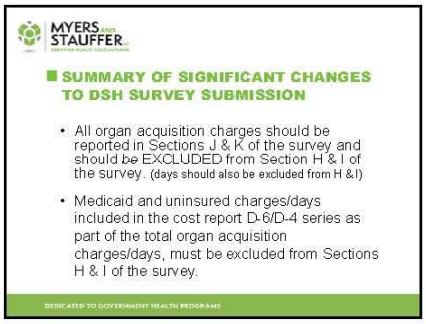
2/17/2013

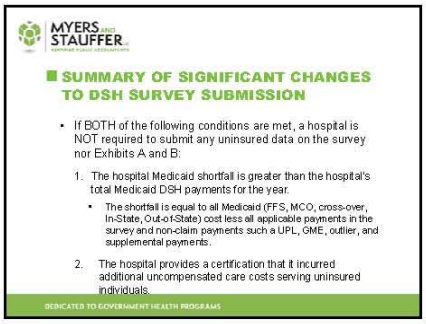

MYERS AND STAUFFER LC
SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION
• Additional items required to be submitted with the survey:
• A detailed revenue working trial balance by payor/contract.
• Charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION
• New Section L – Provider Tax schedule in DSH Survey Part II
• Exhibit A (uninsured), Exhibit B (payments), & Exhibit C (other Medicaid) now include Primary Payor Plan, Secondary Payor Plan, Birth Date, Gender, & SSN fields
• Exhibit B (payments) includes Payment Transaction Code field
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION
• Last set of Medicaid columns in Sections H and I have been renamed as "Other Medicaid Eligibles"
• Charity care reported in Section F-2 of the survey should be based on the state's definition of charity care for DSH
• Care provided to individuals who have no source of payment, third-party or personal resources
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION
• Non-title 19 services (Medicaid) must be excluded from all hospital-provided data.
• It was noted in prior years that some non-Title 19 state programs and SCHIP (State Children's Health Insurance Program) services may have been included.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION
• 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-6/D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION
• 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 a UPL, GME, outlier, and supplemental payments.
2. The hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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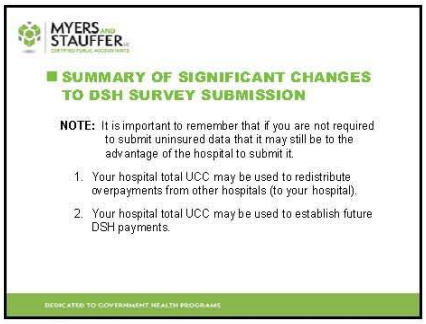
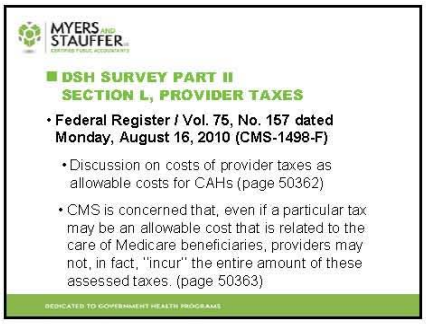
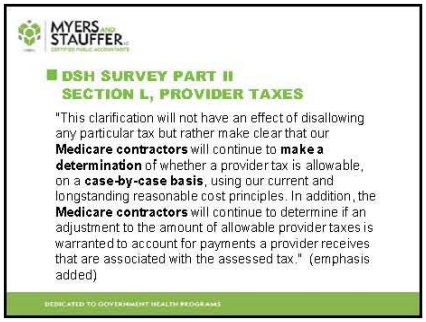
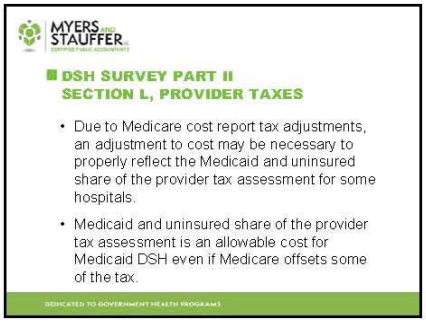
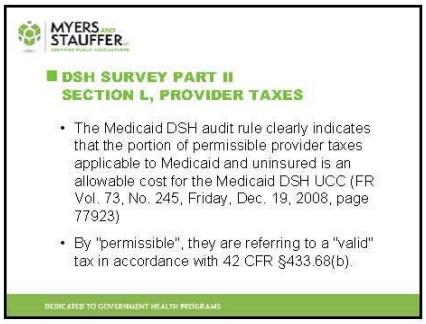
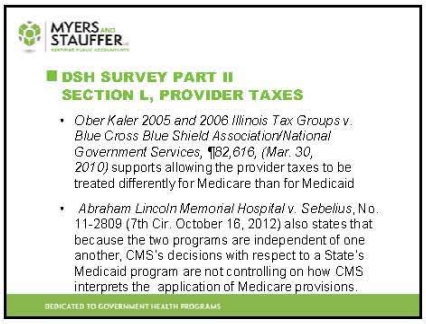

MYERS AND STAUFFER LC
SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION
NOTE: It is important to remember that if you are not required to submit uninsured data that it may still be to the advantage of the hospital to submit it.
1. Your hospital total UCC may be used to redistribute overpayments from other hospitals (to your hospital).
2. Your hospital total UCC may be used to establish future DSH payments.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
DSH SURVEY PART II SECTION L, PROVIDER TAXES
• Federal Register / Vol. 75, No. 157 dated Monday, August 16, 2010 (CMS-1498-F)
• Discussion on costs of provider taxes as allowable costs for CAHs (page 50362)
• CMS is concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, "incur" the entire amount of these assessed taxes. (page 50363)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
DSH SURVEY PART II SECTION L, PROVIDER TAXES
"This clarification will not have an effect of disallowing any particular tax but rather make clear that our Medicare contractors will continue to make a determination of whether a provider tax is allowable, on a case-by-case basis, using our current and longstanding reasonable cost principles. In addition, the Medicare contractors will continue to determine if an adjustment to the amount of allowable provider taxes is warranted to account for payments a provider receives that are associated with the assessed tax." (emphasis added)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
DSH SURVEY PART II SECTION L, PROVIDER TAXES
• Due to Medicare cost report tax adjustments, an adjustment to cost may be necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals.
• Medicaid and uninsured share of the provider tax assessment is an allowable cost for Medicaid DSH even if Medicare offsets some of the tax.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
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).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
DSH SURVEY PART II SECTION L, PROVIDER TAXES
• Ober Kaler 2005 and 2006 Illinois Tax Groups v. Blue Cross Blue Shield Association/National Government Services, ¶82,616, (Mar. 30, 2010) supports allowing the provider taxes to be treated differently for Medicare than for Medicaid
• Abraham Lincoln Memorial Hospital v. Sebelius, No. 11-2809 (7th Cir. October 16, 2012) also states that because the two programs are independent of one another, CMS's decisions with respect to a State's Medicaid program are not controlling on how CMS interprets the application of Medicare provisions.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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2/17/2013

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- Section L is a new Section
- 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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

DSH SURVEY PART II SECTION L, PROVIDER TAXES

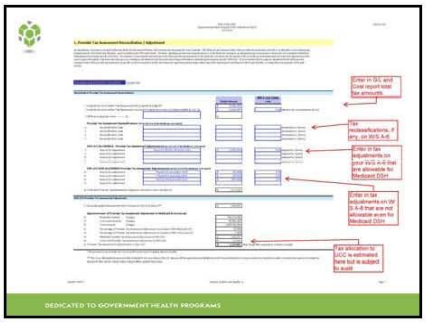
- All permissible provider tax not included in allowable cost on the cost report will be added back and allocated to the Medicaid and uninsured UCC on a reasonable basis (e.g., charges).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

SUBMISSION CHECKLIST

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

SUBMISSION CHECKLIST

1. Electronic copy of the DSH Survey Part I – DSH Year Data
2. Electronic copy of the DSH Survey Part II – Cost Report Year Data
3. Electronic Copy of Exhibit A – Uninsured Charges/Days
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)*
4. Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

2/17/2013

MYERS AND STAUFFER LC

SUBMISSION CHECKLIST

5. Electronic Copy of Exhibit B – Self-Pay Payments
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)*
6. Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC

SUBMISSION CHECKLIST

7. Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare cross-over, 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)*
8. Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC

SUBMISSION CHECKLIST

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC

SUBMISSION CHECKLIST

12. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B
13. Documentation supporting out-of-state DSH payments received. Examples may include remittances, detailed general ledgers, or add-on rates
14. Financial statements to support total charity care charges and state / local govt. cash subsidies reported
15. Revenue code cross-walk used to prepare cost report

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC

SUBMISSION CHECKLIST

16. A detailed working trial balance used to prepare each cost report (including revenues)
17. A detailed revenue working trial balance by payor/contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract)
18. Electronic copy of all cost reports used to prepare each DSH Survey Part II.
19. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligibles)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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2/17/2013

PRIOR YEAR DSH EXAMINATION (2009)

Significant Data Issues in Final Report

- Medicaid Managed Care paid claims were not available.
- Medicaid Managed Care data and Medicaid FFS data may have incorrectly included non-Title 19 services such as SCHIP.
- Hospitals couldn't obtain out-of-state Medicaid Paid Claims Summaries (PS&Rs).
- Some hospitals couldn't document their uninsured cost/payments.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION (2009)

Common Issues Noted During Examination

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION (2009)

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION (2009)

Common Issues Noted During Examination

- Patient-level documentation on uninsured Exhibit A and uninsured patient payments from Exhibit B didn't agree to totals on the survey.
- Under the proposed rule, hospitals reported "Exhausted" / "Insurance Non-Covered" on Exhibit A (Uninsured) but did not report the payments on Exhibit B

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION (2009)

Common Issues Noted During Examination

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION (2009)

Common Issues Noted During Examination

- Exhibit B – Patient payments didn't always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.
- Some hospitals didn't include their charity care patients in the uninsured even though they had no third party coverage.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

8

2/17/2013

PRIOR YEAR DSH EXAMINATION (2009)

Common Issues Noted During Examination

- Medicare cross-over payments didn't 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 audit date.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION (2009)

Common Issues Noted During Examination

- Liability insurance claims were incorrectly included in uninsured even when the insurance (e.g., auto policy) made a payment on the claim
- Hospitals didn't report their charity care in the LIUR section of the survey or didn't include a break-down of inpatient and outpatient charity.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

FAQ

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

Uninsured patients are individuals with no source of third party health care coverage (insurance). If the patient had health insurance, even if the third party insurer did not pay, those services are insured and cannot be reported as uninsured on the survey. Prisoners must be excluded.

- CMS released a proposed rule in the January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.
- Under this proposed rule, the DSH examination will now look at whether a patient is uninsured using a "service-specific" approach as opposed to the creditable coverage approach previously employed.
- The rule is still not "final" but the survey does allow for hospitals to report "exhausted" and "insurance non-covered" services as uninsured.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

FAQ

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

Excluded prisoners were defined in the proposed 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

FAQ

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

Under the January 18, 2012 proposed rule, hospitals can report services if insurance is "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.

Since the rule is not final, these services must be segregated on Exhibits A and B of the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

FAQ

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

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

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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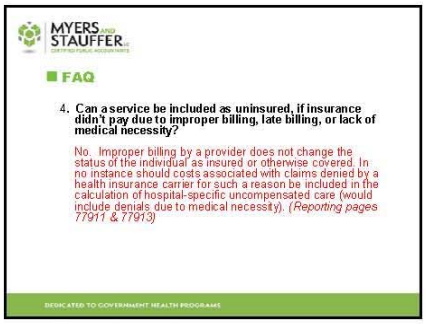
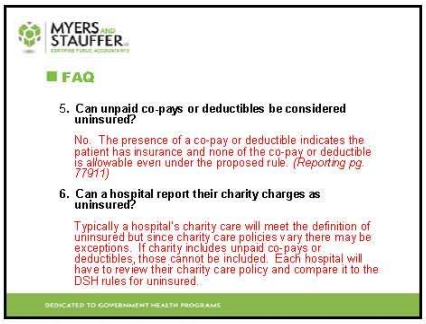
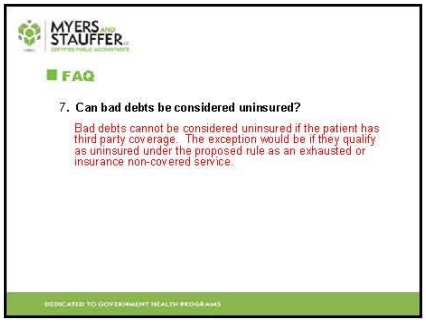
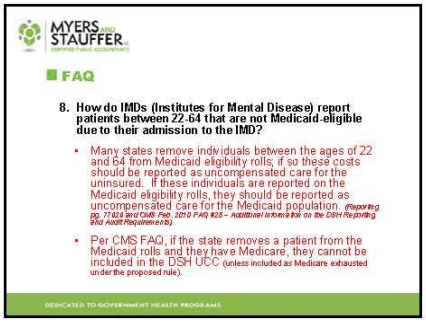
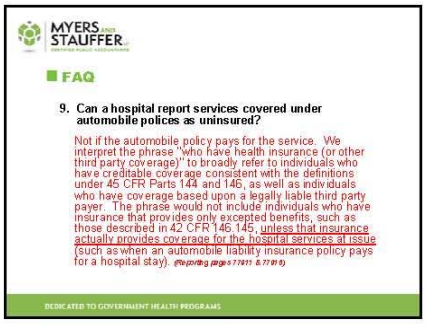
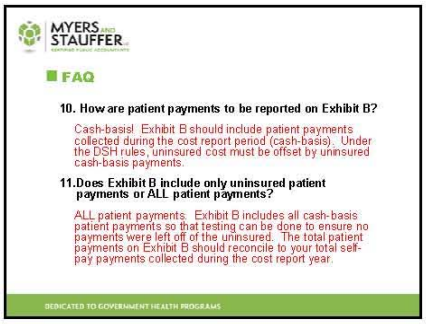

MYERS AND STAUFFER LC
FAQ
4. Can a service be included as uninsured, if insurance didn't pay due to improper billing, late billing, or lack of medical necessity?
No. Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care (would include denials due to medical necessity). (Reporting pages 77911 & 77913)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
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 proposed 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
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 proposed rule as an exhausted or insurance non-covered service.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

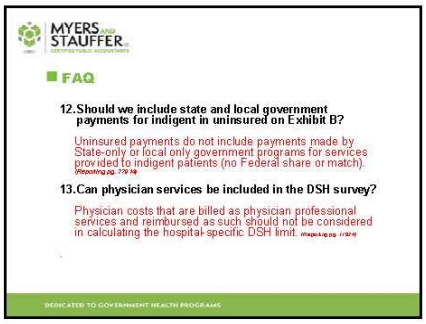

MYERS AND STAUFFER LC
FAQ
8. How do IMDs (Institutes for Mental Disease) report patients between 22-64 that are not Medicaid-eligible due to their admission to the IMD?
Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as 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. 77928 and CMS Fed. 2010 FAQ #28 – Additional information on the DSH Reporting and Audit Requirements)
Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare, they cannot be included in the DSH UCC (unless included as Medicare exhausted under the proposed rule).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


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


MYERS AND STAUFFER LC
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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

10

2/17/2013


MYERS AND STAUFFER LC
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).
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.
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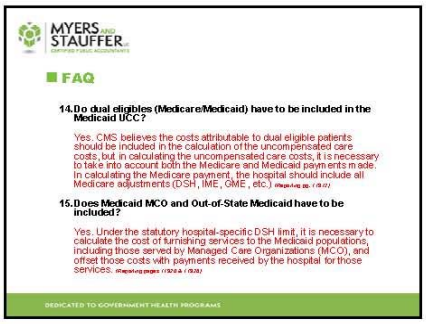
MYERS AND STAUFFER LC
FAQ
14. Do dual eligibles (Medicare/Medicaid) have to be included in the Medicaid UCC?
Yes. CMS believes the costs attributable to dual eligible patients should be included in the calculation of the uncompensated care costs, but in calculating the uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made. In calculating the Medicare payment, the hospital should include all Medicare adjustments (DSH, IME, GME, etc.)
15. Does Medicaid MCO and Out-of-State Medicaid have to be included?
Yes. Under the statutory hospital-specific DSH limit, it is necessary to calculate the cost of furnishing services to the Medicaid populations, including those served by Managed Care Organizations (MCO), and offset those costs with payments received by the hospital for those services.
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MYERS AND STAUFFER LC
OTHER INFORMATION
Please use the DSH Part I Survey Submission Checklist when preparing to submit your surveys and supporting documentation.
Send survey and other data to:
Myers and Stauffer LC
Attn: MO DSH Survey
11440 Tomahawk Creek Parkway
Leawood, KS 66211
(800) 374-6858
modsh@mslc.com
Note: Exhibits A-C include protected health information and must be sent accordingly (no e-mail).
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Louisiana 2013 DSH Audit Update | 2/17/2013

MYERS AND STAUFFER

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE DSH YEAR 2010

Bob Hicks, CPA
Janae Jensen, CPA
Beth Ann Stansbury, CPA

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MYERS AND STAUFFER

OVERVIEW

- Summary of Changes to DSH Survey Submission
- DSH Examination Policy
- DSH Year 2010 Examination Timeline
- DSH Year 2010 Examination Impact
- Paid Claims Data Review
- Review of DSH Year 2010 Survey and Exhibits
- Recap of Prior Year Examinations (2009)
- Myers and Stauffer DSH FAQ

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SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION

- 2 versions of the DSH Part II Survey
  - 2552-96 Version for use with the 2552-96 Cost Report Years
  - 2552-10 Version for use with the 2552-10 Cost Report Years

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SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION

- Additional items required to be submitted with the survey:
  - Description of logic used to compile Exhibits A, B, and C.
    - Financial classes, payor plans, and transaction codes included or excluded.
  - List of financial classes, payor plan codes, and payment transaction codes for the period

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SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION

- Additional items required to be submitted with the survey:
  - A detailed revenue working trial balance by payor/contract.
    - Charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract)

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SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION

- Exhibit A (uninsured) , Exhibit B (payments), & Exhibit C (other Medicaid) now include **Primary Payor Plan, Secondary Payor Plan, Birth Date, Gender, & SSN** fields
  - Consistent with DSH payment calculation data collection
- Exhibit B (payments) includes **Payment Transaction Code** field

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SUMMARY OF SIGNIFICANT CHANGES TO DSH SURVEY SUBMISSION

- Non-title 19 services (Medicaid) must be excluded from all hospital-provided data.
- It was noted in prior years that some non-Title 19 state programs and SCHIP (State Children's Health Insurance Program) services may have been included.

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RELEVANT DSH POLICY

- DSH Implemented under Section 1923 of the Social Security Act (42 U.S. Code, Section 1396r-4)
- Audit/Reporting implemented in FR Vol. 73, No. 245, Friday, Dec. 19, 2008, Final Rule
- Medicaid Reporting Requirements
  42 CFR 447.299 (c)
- Independent Certified Audit of State DSH Payment Adjustments
  42 CFR 455.300 Purpose
  42 CFR 455.301 Definitions
  42 CFR 455.304 Conditions for FFP
- February, 2010 CMS FAQ titled, "*Additional Information on the DSH Reporting and Audit Requirements*"
- FR Vol. 77, No. 11, Wednesday, Jan. 18, 2012, Proposed Rule

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DSH YEAR 2010 EXAMINATION TIMELINE

- Surveys mailed 3rd week of February
- Surveys returned by March 20, 2013
- March – May, desk reviews
- May – July, on-site/expanded reviews
- Draft report to the state by September 30, 2013
- Final report to CMS by December 31, 2013

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DSH YEAR 2010 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.
- Based on this transition provision, the current DSH year 2010 examination report will not directly result in any DSH payment recoupments.

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DSH YEAR 2010 EXAMINATION IMPACT

EXCEPTION:

- Hospitals with cost report years overlapping DSH Year 2010 (cost report years not ending on the state DSH year of 6/30/10) will have an impact on the next year's DSH examination (DSH Year 2011) resulting in potential recoupments.

EXAMPLE CALCULATION:

DSH Year Ending	UCC for Cost Report Periods Ending			Supplemental Payments	Calculated DSH Year UCC	DSH Payments	DSH Payment in Excess of	Potential Recoupment
	12/31/2008	12/31/2009	12/31/2010					
9/30/2010	$ 300,000	$ 750,000		$ 250,000	$ 372,972	$ 300,000	$ 129,027	$ -
9/30/2011		$ 750,000	$ 1,000,000	$ 300,000	$ 372,972	$ 300,000	$ 129,027	$ 129,027

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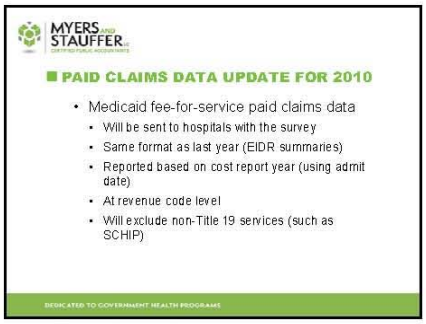
MYERS AND STAUFFER LC
PAID CLAIMS DATA UPDATE FOR 2010
• Medicaid fee-for-service paid claims data
• Will be sent to hospitals with the survey
• Same format as last year (EIDR summaries)
• Reported based on cost report year (using admit date)
• At revenue code level
• Will exclude non-Title 19 services (such as SCHIP)
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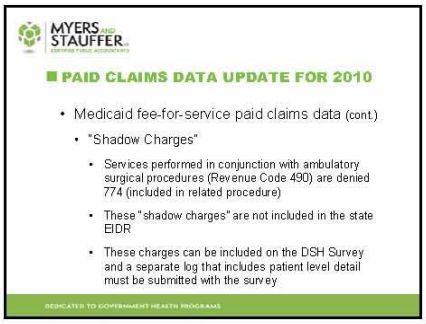
MYERS AND STAUFFER LC
PAID CLAIMS DATA UPDATE FOR 2010
• Medicaid fee-for-service paid claims data (cont.)
• "Shadow Charges"
• Services performed in conjunction with ambulatory surgical procedures (Revenue Code 490) are denied 774 (included in related procedure)
• These "shadow charges" are not included in the state EIDR
• These charges can be included on the DSH Survey and a separate log that includes patient level detail must be submitted with the survey
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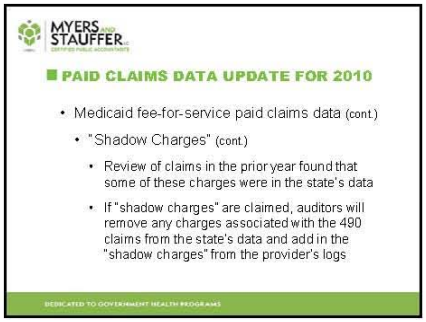
MYERS AND STAUFFER LC
PAID CLAIMS DATA UPDATE FOR 2010
• Medicaid fee-for-service paid claims data (cont.)
• "Shadow Charges" (cont.)
• Review of claims in the prior year found that some of these charges were in the state's data
• If "shadow charges" are claimed, auditors will remove any charges associated with the 490 claims from the state's data and add in the "shadow charges" from the provider's logs
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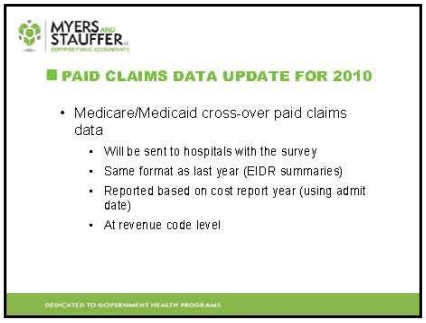
MYERS AND STAUFFER LC
PAID CLAIMS DATA UPDATE FOR 2010
• Medicare/Medicaid cross-over paid claims data
• Will be sent to hospitals with the survey
• Same format as last year (EIDR summaries)
• Reported based on cost report year (using admit date)
• At revenue code level
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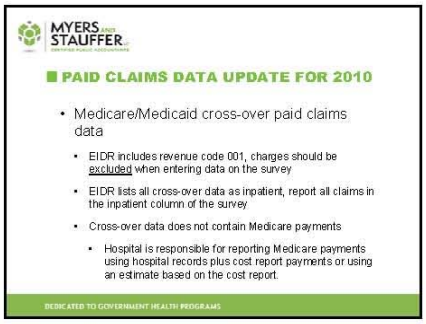
MYERS AND STAUFFER LC
PAID CLAIMS DATA UPDATE FOR 2010
• Medicare/Medicaid cross-over paid claims data
• EIDR includes revenue code 001, charges should be excluded when entering data on the survey
• EIDR lists all cross-over data as inpatient, report all claims in the inpatient column of the survey
• Cross-over data does not contain Medicare payments
• Hospital is responsible for reporting Medicare payments using hospital records plus cost report payments or using an estimate based on the cost report.
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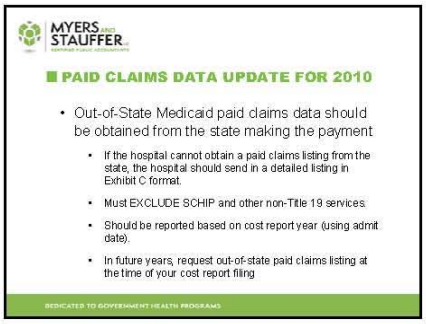
MYERS AND STAUFFER LC
PAID CLAIMS DATA UPDATE FOR 2010
• Out-of-State Medicaid paid claims data should be obtained from the state making the payment
• If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in Exhibit C format.
• Must EXCLUDE SCHIP and other non-Title 19 services.
• Should be reported based on cost report year (using admit date).
• In future years, request out-of-state paid claims listing at the time of your cost report filing
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PAID CLAIMS DATA UPDATE FOR 2010

- "Other" Medicaid Eligibles
  - Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing may not be included in the state's data. The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).
  - Must EXCLUDE SCHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using admit date).

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PAID CLAIMS DATA UPDATE FOR 2010

- Uninsured Services
  - As in years past, uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.
  - Should be reported based on cost report year (using admit date).

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

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

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- Don't complete a DSH Part II survey for a cost report year already submitted in a previous DSH exam year.
  - Example: Hospital A provided a survey for their year ending 12/31/09 with the DSH audit of SFY 2009 in the prior year. In the DSH year 2010 exam, Hospital A would only need to submit a survey for their year ending 12/31/10.

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- DSH RHC Survey
  - Only hospitals with Medicaid-certified hospital-based rural health clinics should complete this survey.
  - Includes all RHC cost report year-specific information
  - Complete a separate copy for each cost report year needed to cover the DSH year.
    - Year ends should be the same as the hospital cost report year ends (Part II DSH Survey)

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- All surveys have an Instructions tab that has been updated. Please refer to those tabs if you are unsure of what to enter in a section. If it still isn't clear, please contact Myers and Stauffer.

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DSH SURVEY PART I – DSH YEAR DATA

Section A

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

Section B

- Answer all OB questions using drop-down boxes

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DSH SURVEY PART I – DSH YEAR DATA

Section C

- Enter your total Medicaid Supplemental Payments for the DSH Year.
  - High Medicaid
  - GME
  - UPL
- Report any Medicaid supplemental payments, including UPL and Non-Claim Specific payments, for the state fiscal year. Do NOT include DSH payments.

Certification

- Answer the "Retain DSH" question but please note that IGTs and CPEs are not a basis for answering the question "No".
- Enter contact information.
- Have CEO or CFO sign this section after completion of Part II of the survey (and RHC Survey if applicable).

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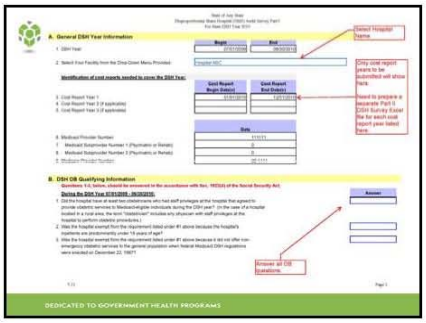

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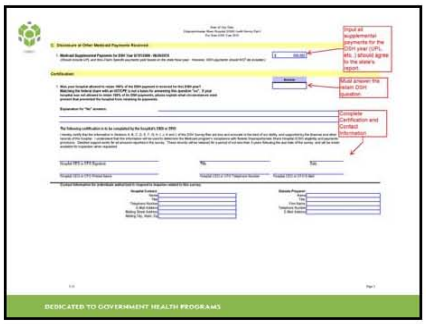

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DSH YEAR SURVEY PART II
SECTION D – GENERAL INFORMATION

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

- Question #2 – An "X" should be shown in the column of the cost report year survey you are preparing. (If you have multiple years listed, you will need to prepare multiple surveys). If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.
- Question #3 – Select the status of the cost report you are using with this drop-down box.

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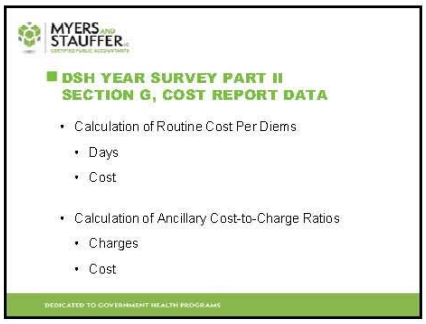
MYERS AND STAUFFER LC
DSH YEAR SURVEY PART II
SECTION G, COST REPORT DATA
• Calculation of Routine Cost Per Diems
• Days
• Cost
• Calculation of Ancillary Cost-to-Charge Ratios
• Charges
• Cost
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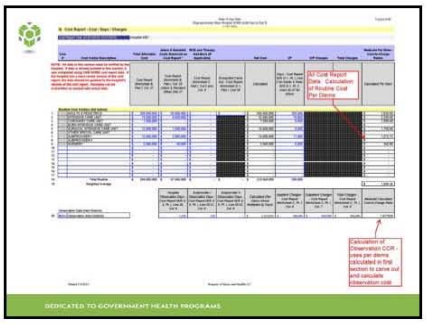
All Cost Report Data. Calculation of Routine Cost Per Diems
Calculation of Observation COR - uses per diems calculated in first section to carve out and calculate observation cost
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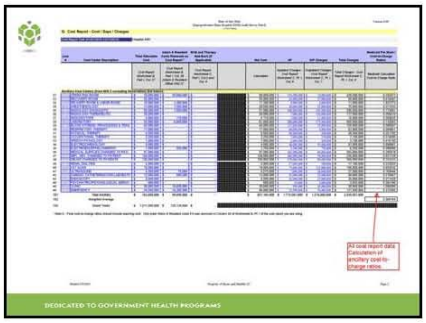
All cost report data. Calculation of ancillary cost-to-charge ratios.
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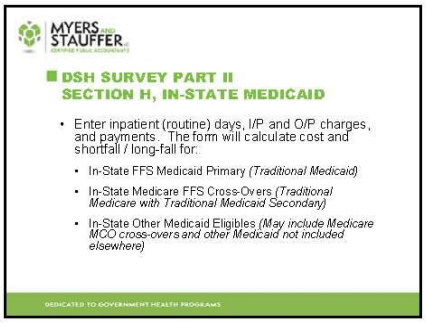
MYERS AND STAUFFER LC
DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID
• Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
• In-State FFS Medicaid Primary (Traditional Medicaid)
• In-State Medicare FFS Cross-Overs (Traditional Medicare with Traditional Medicaid Secondary)
• In-State Other Medicaid Eligibles (May include Medicare MCO cross-overs and other Medicaid not included elsewhere)
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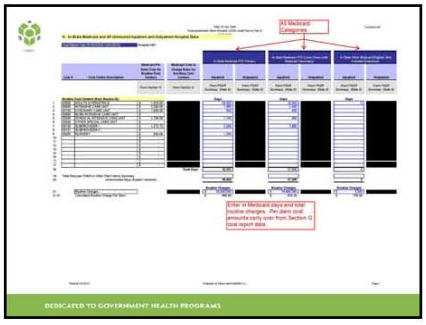
All Medicaid Categories
Enter in Medicaid days and total routine charges. Per diem cost amounts carry over from Section G cost report data.
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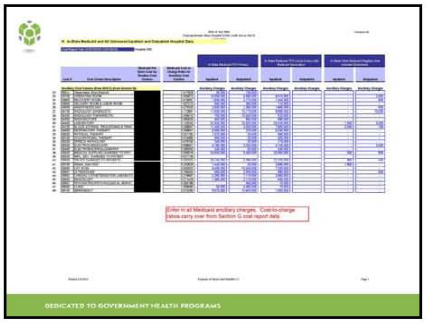
Enter in all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.
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DSH SURVEY PART II SECTION H, IN-STATE MEDICAID

- Medicaid Payments Include:
  - Claim payments
  - Medicaid outlier payments
  - Medicaid cost report settlements
    - Majority of cost reports have not been finalized; settlements will be estimated similar to the prior year using the state plan (if final – use the final settlement amount)

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DSH SURVEY PART II SECTION H, IN-STATE MEDICAID

- Medicaid Payments Include (cont.):
  - Medicare bad debt payments (cross-overs)
  - Medicare cost report settlement payments (cross-overs)
  - Other third party payments (TPL)

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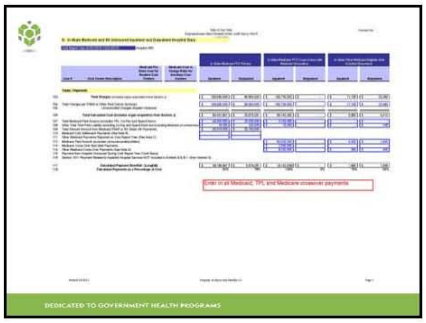

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DSH SURVEY PART II SECTION H, UNINSURED

- 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.

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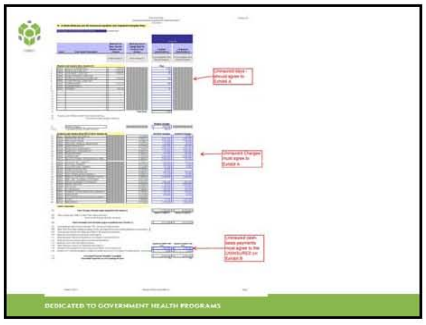

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DSH SURVEY PART II SECTION H, UNINSURED

- 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 a UPL, GME, outlier, and supplemental payments.
  2. The hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals.

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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 total UCC may be used to redistribute overpayments from other hospitals (to your hospital).
2. Your hospital total UCC may be used to establish future DSH payments.

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

- Additional Edits
  - In the far right column, you will see an edit message if your total charges or days by cost center exceed those reported from the cost report in Section G of the survey. Please clear these edits prior to filing the survey.
  - Calculated payments as a percentage of cost by payor (at bottom)
    - Review percentage for reasonableness

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DSH SURVEY PART II SECTION I, OUT OF STATE MEDICAID

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

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

- Enter the total organ acquisition cost and total useable organs from the cost report.
- These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured.
- Summary claims data (PS&R) or similar documents and provider records (organ counts) must be provided to support the charges and useable organ counts reported on the survey. The data for uninsured organ acquisitions should be reported separately from the Exhibit A.

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

- All organ acquisition charges should be reported in Sections J & K of the survey and should *be* EXCLUDED from Section H & I of the survey. (days should also be excluded from H &I)
- Medicaid and uninsured charges/days included in the cost report D-6/D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey.

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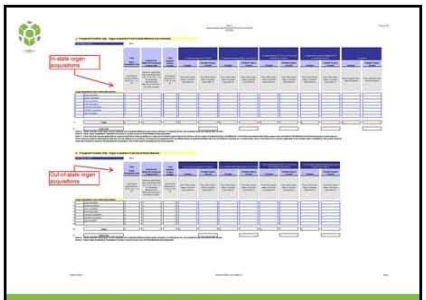

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EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

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

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MYERS AND STAUFFER LC

EXHIBIT A - UNINSURED

- Exhibit A Changes:
  - Added *Primary Payor Plan*, *Secondary Payor Plan*, *Birth Date*, *SSN*, and *Gender* fields
    - A complete list (key) of payor plans is required to be submitted separately with the survey.

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EXHIBIT A - UNINSURED

- Claim Status (Column R) is the same as the prior year – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the proposed rule since that rule is not final.
  - If exhausted / non-covered insurance services are included on Exhibit A, then they must also be included on Exhibit B for patient payments
- Submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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

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

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

- Patient payments received for uninsured services need to be reported on a cash basis.
  - For example, a cash payment received during the '10 cost report year that relates to a service provided in the '05 cost report year, must be used to reduce uninsured cost for the '10 cost report year.

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

- Changes to Exhibit B
  - Added *Primary Payor Plan*, *Secondary Payor Plan*, *Birth Date, SSN, Payment Transaction Code,* and *Gender* fields
    - A separate "key" for all payment transaction codes should be submitted with the survey
- Submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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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.

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that may require an Exhibit C are as follows:
  - Self-reported "Other" Medicaid eligibles (Section H)
  - All self-reported Out-of-State Medicaid categories (Section I)

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Changes to Exhibit C
  - Added *Primary Payor Plan*, *Secondary Payor Plan* fields
    - A complete list (key) of payor plans is required to be submitted separately with the survey.

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Changes to Exhibit C
  - Added *Birth Date, Social Security Number, and Gender* fields
    - Necessary to match to state's Medicaid eligibility files if the patient's Medicaid number is not provided or incorrect
- Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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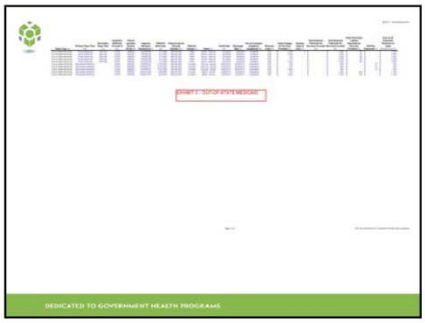

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DSH SURVEY PART I – DSH YEAR DATA

Checklist

- Separate tab in Part I of the survey.
  - If submitting an RHC survey there is a separate checklist for all RHC data in that survey
- Should be completed after all surveys are prepared
- Includes list of all supporting documentation that needs to be submitted with the survey for audit
- Includes Myers and Stauffer address and phone numbers

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist

1. Electronic copy of the DSH Survey Part I – DSH Year Data
2. Electronic copy of the DSH Survey Part II – Cost Report Year Data
3. Electronic Copy of Exhibit A – Uninsured Charges/Days
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)*
4. Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

5. Electronic Copy of Exhibit B – Self-Pay Payments
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)*
6. Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

7. Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, or Out-Of-State Medicaid data that isn't supported by a state-provided report)
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)*
8. Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

9. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs)
10. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs)

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

11. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B
12. Documentation supporting out-of-state DSH payments received. Examples may include remittances, detailed general ledgers, or add-on rates
13. Financial statements to support total charity care charges and state / local govt. cash subsidies reported
14. Revenue code cross-walk used to prepare cost report

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

15. A detailed working trial balance used to prepare each cost report (including revenues)
16. A detailed revenue working trial balance by payor/contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract)
17. Electronic copy of all cost reports used to prepare each DSH Survey Part II.
18. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligibles)

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DSH RHC SURVEY

Only Applies to Hospitals with Medicaid-certified hospital-based rural health clinics. Submit one copy for each cost report year not previously submitted.

Section L – General Information

- Question #1 – Select the hospital name from the drop-down box
- Question #2 – An "X" should be shown in the column of the cost report year survey you are preparing
- Question #3 – Select the status of the cost report you are using with this drop-down box

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DSH RHC SURVEY

Section M – Disclosure of Medicaid/Uninsured Payments Received

- 1011 Payments – If the RHC received 1011 payments, report them in this section. If all 1011 payments were reported on the separate hospital survey, do not report them in this section.
- Enter in total cash basis patient payments from the RHC Exhibit B as instructed. These are check totals to compare to the supporting RHC Exhibit B.

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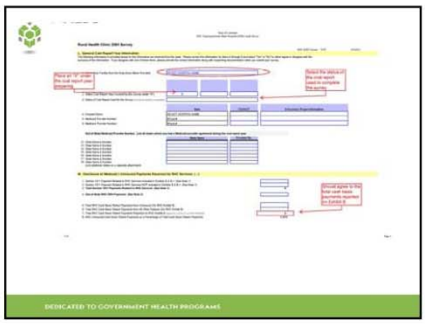
2/17/2013



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DSH RHC SURVEY

Section N – RHC LIUR Qualifying Data

- The state must report your actual LIUR for the DSH year – data is needed to calculate the LIUR
- Section N-2: Report RHC revenues and contractual adjustments
  - Input RHC patient revenues from worksheet G-2 of the cost report
  - Calculate a portion of contractuals that are related to the RHC and report the amount in this section

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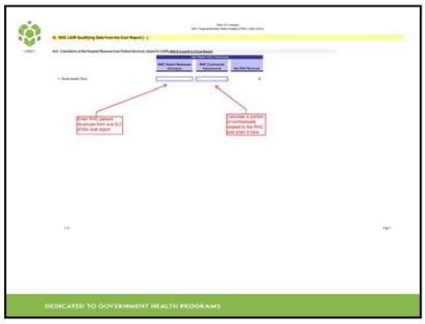

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DSH RHC SURVEY

Section O – In-State Hospital-Based RHC Services

- Report each RHC licensed as a hospital-service on a separate line
- Enter the cost and visits from the cost report
- Enter total visits and payments for each clinic. The form will calculate cost for:
  - In-State Medicaid Primary (Traditional Medicaid)
    - From EIDR summary report

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DSH RHC SURVEY

- Enter total visits and payments for each clinic. The form will calculate cost for (continued):
  - In-State Medicaid FFS Cross-Overs (Traditional Medicare Primary with Medicaid Secondary)
    - From EIDR summary reports
    - EIDR does not include Medicare payments. Hospital is responsible for including Medicare payments using actual data or estimating Medicare payments using the cost report.

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DSH RHC SURVEY

- Enter total visits and payments for each clinic. The form will calculate cost for (continued):
  - Other Medicaid Eligibles
    - May include Medicare MCO cross-overs and other Medicaid not included elsewhere
    - Must submit an Exhibit C to support reported data

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CERTIFIED PUBLIC ACCOUNTANTS

DSH RHC SURVEY

- Enter total visits and payments for each clinic. The form will calculate cost for (continued):
  - Uninsured RHC Data
    - RHC Survey form Exhibit A shows the data elements that need to be submitted. This data will allow us to cost your uninsured services using cost report mechanics. If the facility has multiple clinics, identify each one separately in the Service Indicator column.
    - For Uninsured payments, enter the uninsured patient payment totals from your RHC Survey form Exhibit B. Do NOT pick up the insured patient payments in Section O even though they are reported in Section M.

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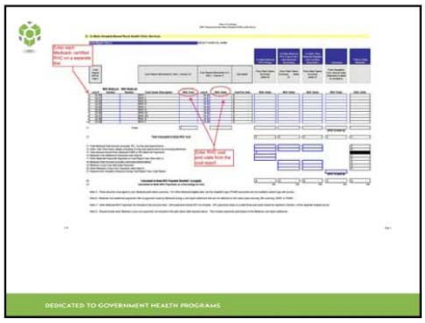

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH RHC SURVEY

Exhibit A – Uninsured Visits

- Survey form Exhibit A has been designed to assist hospitals in collecting and reporting all uninsured visits needed to cost out the uninsured services
  - The total clinic visits from RHC Exhibit A must agree to the total entered in Section O of the survey
  - Must be for dates of service in the cost report fiscal year
  - Patient level detail must be available to support the number of uninsured visits
  - Please submit RHC Exhibit A in the format shown in Excel

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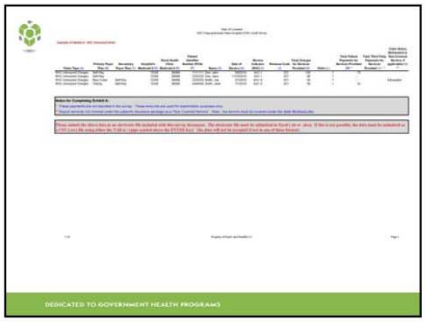

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CERTIFIED PUBLIC ACCOUNTANTS

DSH RHC SURVEY

RHC Exhibit B – All Patient Payments (Self-Pay) on a Cash Basis

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

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CERTIFIED PUBLIC ACCOUNTANTS

DSH RHC SURVEY

RHC Exhibit B – All Patient Payments (Self-Pay) on a Cash Basis (continued)

- RHC patient payments received for uninsured services need to be reported on a cash basis
  - For example, a cash payment received during the '10 cost report year that related to a service provided in '06 cost report year, must be used to reduce uninsured cost for the '10 cost report year.
  - Please submit RHC Exhibit B in the format shown using Excel

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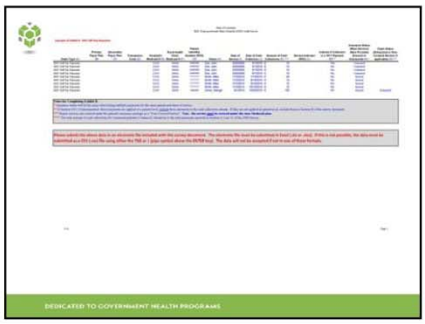


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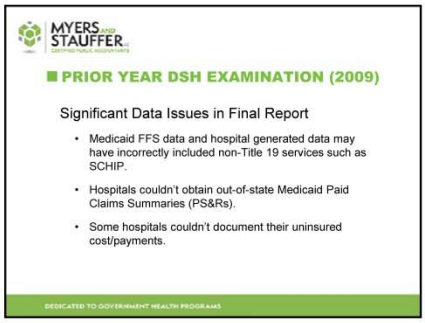
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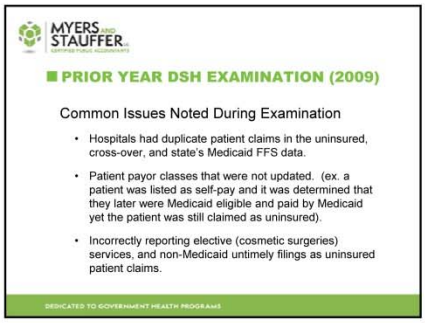
PRIOR YEAR DSH EXAMINATION (2009)
Significant Data Issues in Final Report
• Medicaid FFS data and hospital generated data may have incorrectly included non-Title 19 services such as SCHIP.
• Hospitals couldn't obtain out-of-state Medicaid Paid Claims Summaries (PS&Rs).
• Some hospitals couldn't document their uninsured cost/payments.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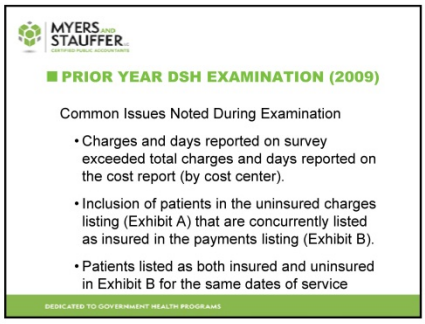
PRIOR YEAR DSH EXAMINATION (2009)
Common Issues Noted During Examination
• Hospitals had duplicate patient claims in the uninsured, cross-over, and state's Medicaid FFS data.
• Patient payor classes that were not updated. (ex. a patient was listed as self-pay and it was determined that they later were Medicaid eligible and paid by Medicaid yet the patient was still claimed as uninsured).
• Incorrectly reporting elective (cosmetic surgeries) services, and non-Medicaid untimely filings as uninsured patient claims.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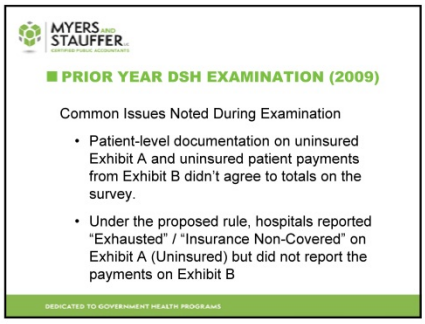
PRIOR YEAR DSH EXAMINATION (2009)
Common Issues Noted During Examination
• Charges and days reported on survey exceeded total charges and days reported on the cost report (by cost center).
• Inclusion of patients in the uninsured charges listing (Exhibit A) that are concurrently listed as insured in the payments listing (Exhibit B).
• Patients listed as both insured and uninsured in Exhibit B for the same dates of service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PRIOR YEAR DSH EXAMINATION (2009)
Common Issues Noted During Examination
• Patient-level documentation on uninsured Exhibit A and uninsured patient payments from Exhibit B didn't agree to totals on the survey.
• Under the proposed rule, hospitals reported "Exhausted" / "Insurance Non-Covered" on Exhibit A (Uninsured) but did not report the payments on Exhibit B

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PRIOR YEAR DSH EXAMINATION (2009)

Common Issues Noted During Examination

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

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PRIOR YEAR DSH EXAMINATION (2009)

Common Issues Noted During Examination

- Exhibit B – Patient payments didn't always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.
- Some hospitals didn't include their charity care patients in the uninsured even though they had no third party coverage.

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PRIOR YEAR DSH EXAMINATION (2009)

Common Issues Noted During Examination

- Medicare cross-over payments didn't 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 audit date.

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PRIOR YEAR DSH EXAMINATION (2009)

Common Issues Noted During Examination

- Liability insurance claims were incorrectly included in uninsured even when the insurance (e.g., auto policy) made a payment on the claim
- Hospitals didn't report their charity care in the LIUR section of the survey or didn't include a break-down of inpatient and outpatient charity.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

FAQ

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

Uninsured patients are individuals with no source of third party health care coverage (insurance). If the patient had health insurance, even if the third party insurer did not pay, those services are insured and cannot be reported as uninsured on the survey. Prisoners must be excluded.

- CMS released a proposed rule in the January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.
- Under this proposed rule, the DSH examination will now look at whether a patient is uninsured using a "service-specific" approach as opposed to the creditable coverage approach previously employed.
- The rule is still not "final" but the survey does allow for hospitals to report "exhausted" and "insurance non-covered" services as uninsured.

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FAQ

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

Excluded prisoners were defined in the proposed 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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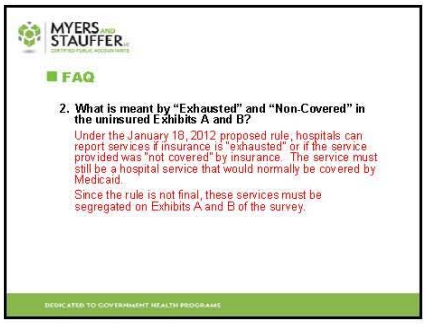
MYERS AND STAUFFER LC
FAQ
2. What is meant by "Exhausted" and "Non-Covered" in the uninsured Exhibits A and B?
Under the January 18, 2012 proposed rule, hospitals can report services if insurance is "exhausted" or if the service provided was "not covered" by insurance. The service must still be a hospital service that would normally be covered by Medicaid.
Since the rule is not final, these services must be segregated on Exhibits A and B of the survey.
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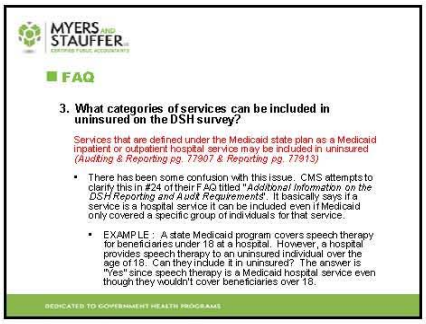
MYERS AND STAUFFER LC
FAQ
3. What categories of services can be included in uninsured on the DSH survey?
Services that are defined under the Medicaid state plan as a Medicaid inpatient or outpatient hospital service may be included in uninsured (Auditing & Reporting pg. 77907 & Reporting pg. 77913)
There has been some confusion with this issue. CMS attempts to clarify this in #24 of their FAQ titled "Additional Information on the DSH Reporting and Audit Requirements". It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.
EXAMPLE : A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is "Yes" since speech therapy is a Medicaid hospital service even though they wouldn't cover beneficiaries over 18.
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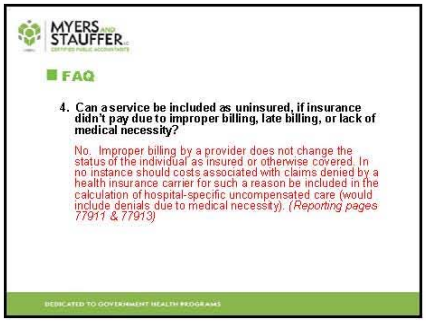
MYERS AND STAUFFER LC
FAQ
4. Can a service be included as uninsured, if insurance didn't pay due to improper billing, late billing, or lack of medical necessity?
No. Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care (would include denials due to medical necessity). (Reporting pages 77911 & 77913)
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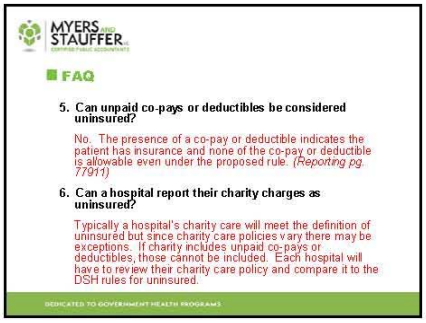
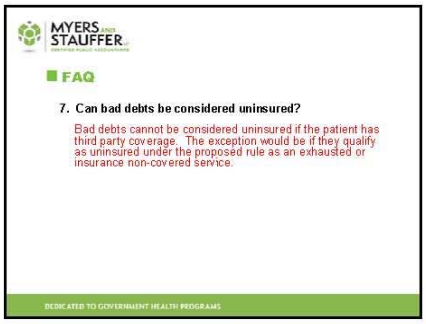
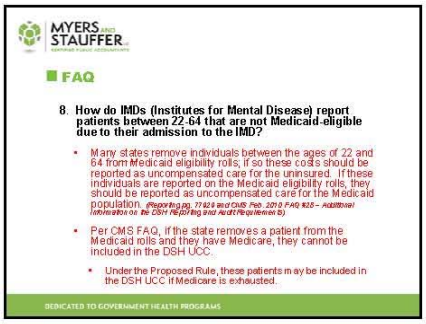

MYERS AND STAUFFER LC
FAQ
5. Can unpaid co-pays or deductibles be considered uninsured?
No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the proposed rule. (Reporting pg. 77911)
6. Can a hospital report their charity 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
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 proposed rule as an exhausted or insurance non-covered service.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
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. 77924 and CMS Feb. 2012 FAQ #20 – Additional Information on the DSH Reporting and Audit Requirements).
Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare, they cannot be included in the DSH UCC.
Under the Proposed Rule, these patients may be included in the DSH UCC if Medicare is exhausted.
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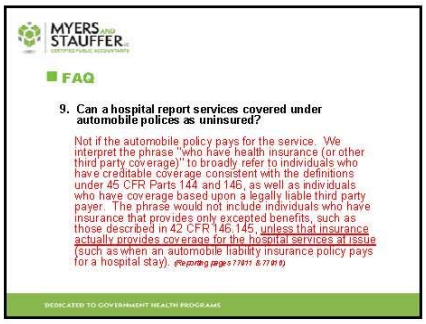
MYERS AND STAUFFER LC
FAQ
9. Can a hospital report services covered under automobile polices as uninsured?
Not if the automobile policy pays for the service. We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). (Reporting pages 77977 & 77978)
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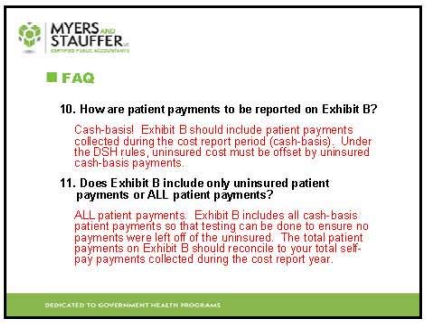
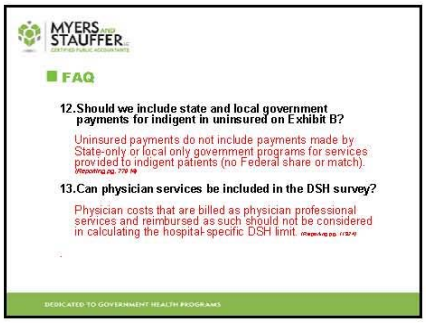
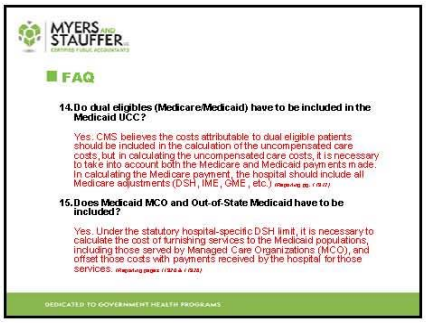
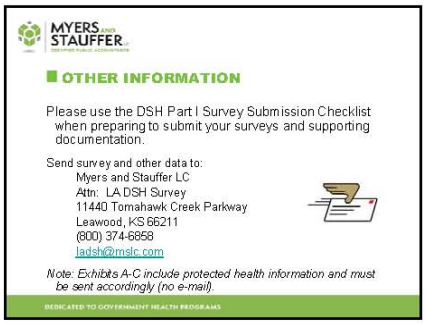
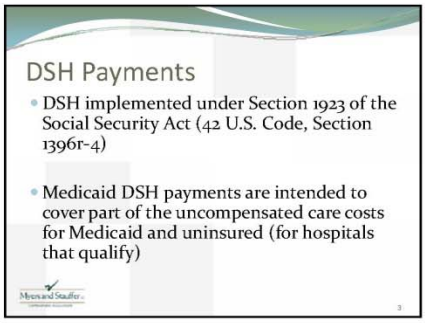

MYERS AND STAUFFER LC
FAQ
10. How are patient payments to be reported on Exhibit B?
Cash-basis! Exhibit B should include patient payments collected during the cost report period (cash-basis). Under the DSH rules, uninsured cost must be offset by uninsured cash-basis payments.
11. Does Exhibit B include 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

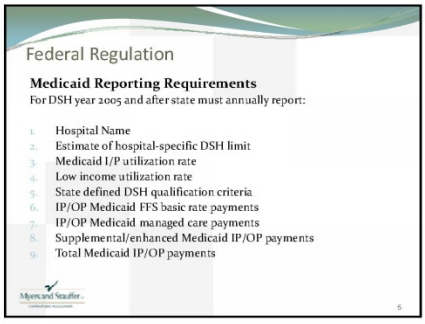

MYERS AND STAUFFER LC
FAQ
12. Should we include state and local government payments for indigent in uninsured on Exhibit B?
Uninsured payments do not include payments made by State-only or local only government programs for services provided to indigent patients (no Federal share or match). (Reporting pg. 77978)
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. 77974)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

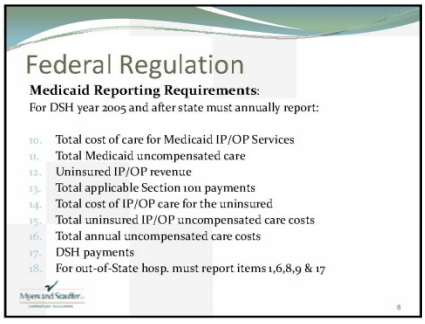

MYERS AND STAUFFER LC
FAQ
14. Do dual eligibles (Medicare/Medicaid) have to be included in the Medicaid UCC?
Yes. CMS believes the costs attributable to dual eligible patients should be included in the calculation of the uncompensated care costs, but in calculating the uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made. In calculating the Medicare payment, the hospital should include all Medicare adjustments (DSH, IME, GME, etc.) (Reporting pg. 77977)
15. Does Medicaid MCO and Out-of-State Medicaid have to be included?
Yes. Under the statutory hospital-specific DSH limit, it is necessary to calculate the cost of furnishing services to the Medicaid populations, including those served by Managed Care Organizations (MCO), and offset those costs with payments received by the hospital for those services. (Reporting pages 77974 & 77978)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
OTHER INFORMATION
Please use the DSH Part I Survey Submission Checklist when preparing to submit your surveys and supporting documentation.
Send survey and other data to:
Myers and Stauffer LC
Attn: LA DSH Survey
11440 Tomahawk Creek Parkway
Leawood, KS 66211
(800) 374-6858
ladsh@mslc.com
Note: Exhibits A-C include protected health information and must be sent accordingly (no e-mail).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

Texas 2012 DSH Audit Training







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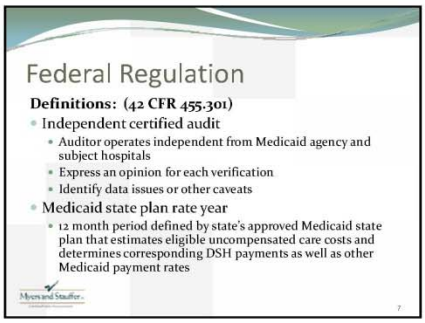
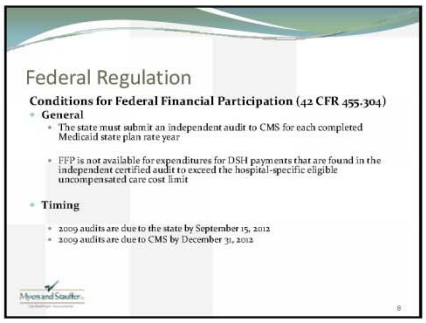
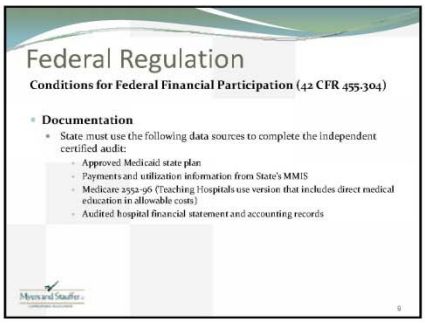
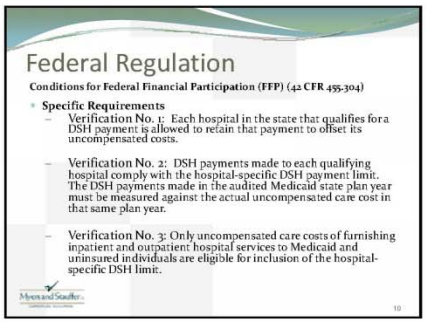
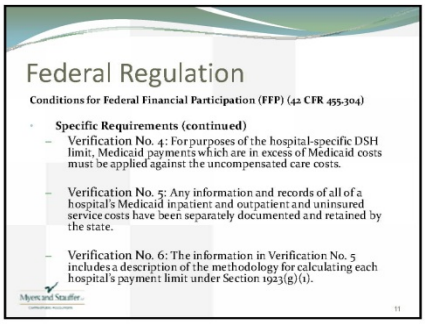
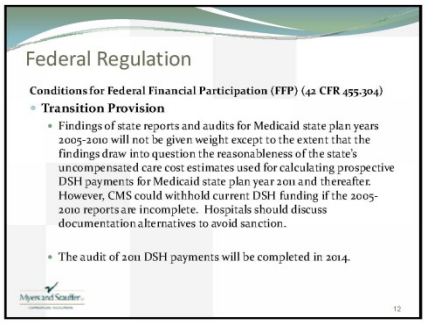

Federal Regulation
Definitions: (42 CFR 455.301)
Independent certified audit
Auditor operates independent from Medicaid agency and subject hospitals
Express an opinion for each verification
Identify data issues or other caveats
Medicaid state plan rate year
12 month period defined by state's approved Medicaid state plan that estimates eligible uncompensated care costs and determines corresponding DSH payments as well as other Medicaid payment rates
Myers and Stauffer
7

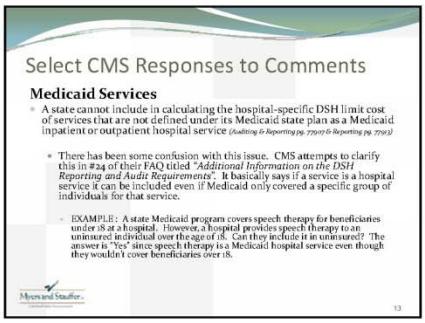

Federal Regulation
Conditions for Federal Financial Participation (42 CFR 455.304)
General
The state must submit an independent audit to CMS for each completed Medicaid state plan rate year
FFP is not available for expenditures for DSH payments that are found in the independent certified audit to exceed the hospital-specific eligible uncompensated care cost limit
Timing
2009 audits are due to the state by September 15, 2012
2009 audits are due to CMS by December 31, 2012
Myers and Stauffer
8

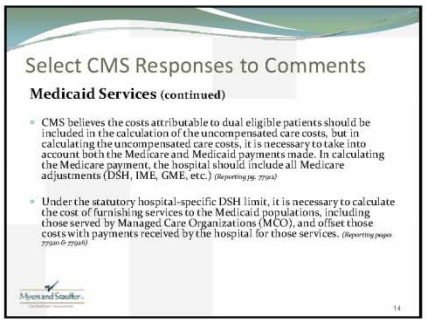

Federal Regulation
Conditions for Federal Financial Participation (42 CFR 455.304)
Documentation
State must use the following data sources to complete the independent certified audit:
Approved Medicaid state plan
Payments and utilization information from State's MMIS
Medicare 2552-96 (Teaching Hospitals use version that includes direct medical education in allowable costs)
Audited hospital financial statement and accounting records
Myers and Stauffer
9

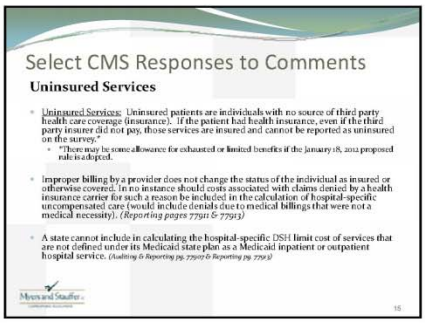

Federal Regulation
Conditions for Federal Financial Participation (FFP) (42 CFR 455.304)
Specific Requirements
Verification No. 1: Each hospital in the state that qualifies for a DSH payment is allowed to retain that payment to offset its uncompensated costs.
Verification No. 2: DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. The DSH payments made in the audited Medicaid state plan year must be measured against the actual uncompensated care cost in that same plan year.
Verification No. 3: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid and uninsured individuals are eligible for inclusion of the hospital-specific DSH limit.
Myers and Stauffer
10

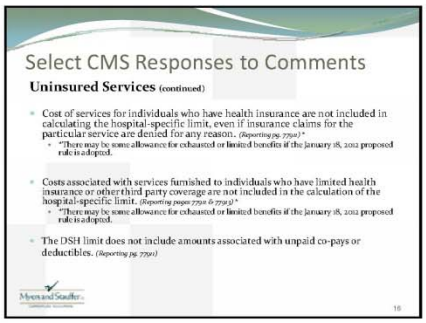

Federal Regulation
Conditions for Federal Financial Participation (FFP) (42 CFR 455.304)
Specific Requirements (continued)
Verification No. 4: For purposes of the hospital-specific DSH limit, Medicaid payments which are in excess of Medicaid costs must be applied against the uncompensated care costs.
Verification No. 5: Any information and records of all of a hospital's Medicaid inpatient and outpatient and uninsured service costs have been separately documented and retained by the state.
Verification No. 6: The information in Verification No. 5 includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1).
Myers and Stauffer
11

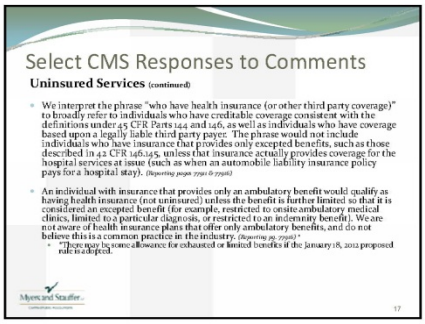

Federal Regulation
Conditions for Federal Financial Participation (FFP) (42 CFR 455.304)
Transition Provision
Findings of state reports and audits for Medicaid state plan years 2005-2010 will not be given weight except to the extent that the findings draw into question the reasonableness of the state's uncompensated care cost estimates used for calculating prospective DSH payments for Medicaid state plan year 2011 and thereafter. However, CMS could withhold current DSH funding if the 2005-2010 reports are incomplete. Hospitals should discuss documentation alternatives to avoid sanction.
The audit of 2011 DSH payments will be completed in 2014.
Myers and Stauffer
12

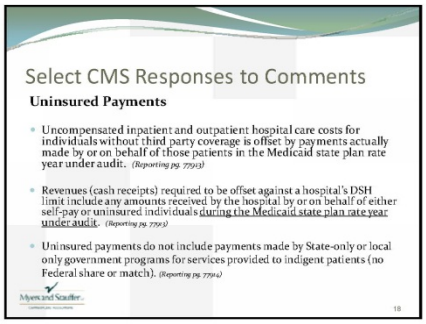

Select CMS Responses to Comments
Medicaid Services
A state cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid state plan as a Medicaid inpatient or outpatient hospital service (Auditing & Reporting pg. 77907 & Reporting pg. 77913)
There has been some confusion with this issue. CMS attempts to clarify this in #24 of their FAQ titled "Additional Information on the DSH Reporting and Audit Requirements". It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.
EXAMPLE: A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is "Yes" since speech therapy is a Medicaid hospital service even though they wouldn't cover beneficiaries over 18.
Myers and Stauffer
13

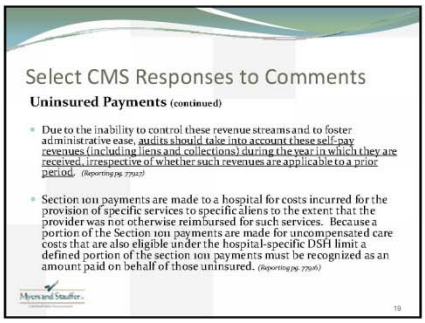

Select CMS Responses to Comments
Medicaid Services (continued)
CMS believes the costs attributable to dual eligible patients should be included in the calculation of the uncompensated care costs, but in calculating the uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made. In calculating the Medicare payment, the hospital should include all Medicare adjustments (DSH, IME, GME, etc.) (Reporting pg. 77912)
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 77910 & 77916)
Myers and Stauffer
14


Select CMS Responses to Comments
Uninsured Services
Uninsured Services: Uninsured patients are individuals with no source of third party health care coverage (insurance). If the patient had health insurance, even if the third party insurer did not pay, those services are insured and cannot be reported as uninsured on the survey."
"There may be some allowance for exhausted or limited benefits if the January 18, 2012 proposed rule is adopted.
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 billings that were not a medical necessity). (Reporting pages 77911 & 77913)
A state cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid state plan as a Medicaid inpatient or outpatient hospital service. (Auditing & Reporting pg. 77907 & Reporting pg. 77913)
Myers and Stauffer
15


Select CMS Responses to Comments
Uninsured Services (continued)
Cost of services for individuals who have health insurance are not included in calculating the hospital-specific limit, even if insurance claims for the particular service are denied for any reason. (Reporting pg. 77911)"
"There may be some allowance for exhausted or limited benefits if the January 18, 2012 proposed rule is adopted.
Costs associated with services furnished to individuals who have limited health insurance or other third party coverage are not included in the calculation of the hospital-specific limit. (Reporting pages 77911 & 77913)"
"There may be some allowance for exhausted or limited benefits if the January 18, 2012 proposed rule is adopted.
The DSH limit does not include amounts associated with unpaid co-pays or deductibles. (Reporting pg. 77911)
Myers and Stauffer
16


Select CMS Responses to Comments
Uninsured Services (continued)
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)
An individual with insurance that provides only an ambulatory benefit would qualify as having health insurance (not uninsured) unless the benefit is further limited so that it is considered an excepted benefit (for example, restricted to onsite ambulatory medical clinics, limited to a particular diagnosis, or restricted to an indemnity benefit). We are not aware of health insurance plans that offer only ambulatory benefits, and do not believe this is a common practice in the industry. (Reporting pg. 77911)"
"There may be some allowance for exhausted or limited benefits if the January 18, 2012 proposed rule is adopted.
Myers and Stauffer
17


Select CMS Responses to Comments
Uninsured Payments
Uncompensated inpatient and outpatient hospital care costs for individuals without third party coverage is offset by payments actually made by or on behalf of those patients in the Medicaid state plan rate year under audit. (Reporting pg. 77913)
Revenues (cash receipts) required to be offset against a hospital's DSH limit include any amounts received by the hospital by or on behalf of either self-pay or uninsured individuals during the Medicaid state plan rate year under audit. (Reporting pg. 77913)
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)
Myers and Stauffer
18


Select CMS Responses to Comments
Uninsured Payments (continued)
Due to the inability to control these revenue streams and to foster administrative ease, audits should take into account these self-pay revenues (including liens and collections) during the year in which they are received, irrespective of whether such revenues are applicable to a prior period. (Reporting pg. 77927)
Section 1011 payments are made to a hospital for costs incurred for the provision of specific services to specific aliens to the extent that the provider was not otherwise reimbursed for such services. Because a portion of the Section 1011 payments are made for uncompensated care costs that are also eligible under the hospital-specific DSH limit a defined portion of the section 1011 payments must be recognized as an amount paid on behalf of those uninsured. (Reporting pg. 77926)
Myers and Stauffer
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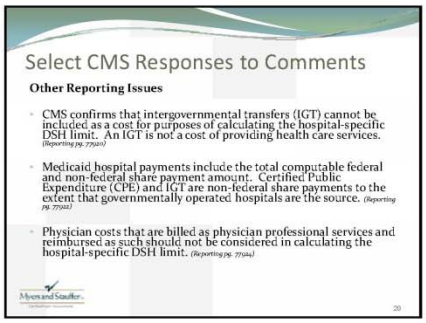
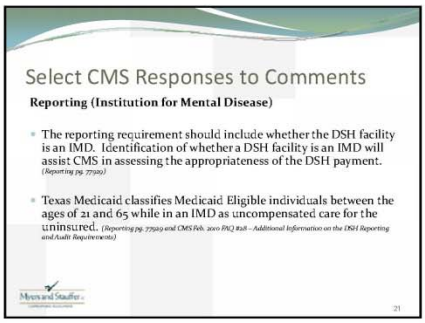
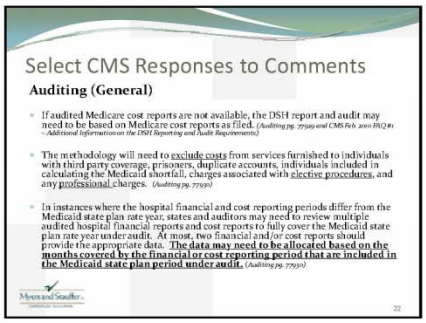
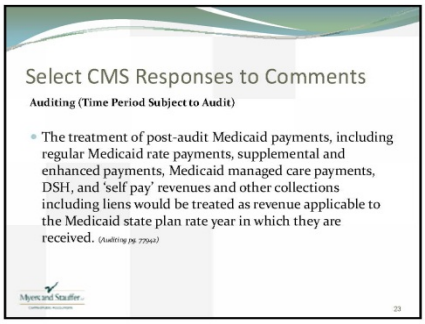
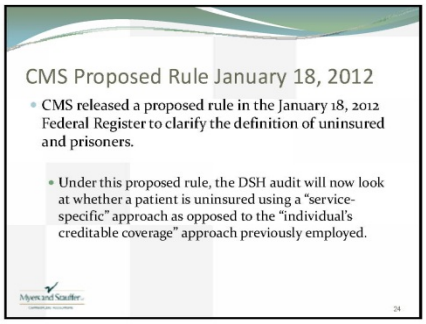
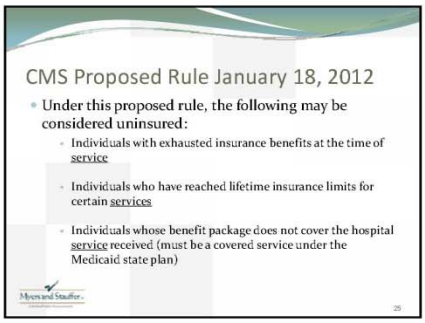

Select CMS Responses to Comments
Other Reporting Issues
CMS confirms that intergovernmental transfers (IGT) cannot be included as a cost for purposes of calculating the hospital-specific DSH limit. An IGT is not a cost of providing health care services. (Reporting pg. 77920)
Medicaid hospital payments include the total computable federal and non-federal share payment amount. Certified Public Expenditure (CPE) and IGT are non-federal share payments to the extent that governmentally operated hospitals are the source. (Reporting pg. 77921)
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)
Myers and Stauffer
20

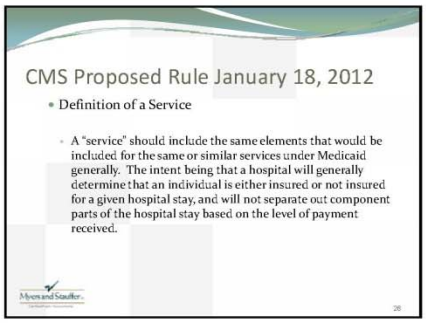

Select CMS Responses to Comments
Reporting (Institution for Mental Disease)
The reporting requirement should include whether the DSH facility is an IMD. Identification of whether a DSH facility is an IMD will assist CMS in assessing the appropriateness of the DSH payment. (Reporting pg. 77929)
Texas Medicaid classifies Medicaid Eligible individuals between the ages of 21 and 65 while in an IMD as uncompensated care for the uninsured. (Reporting pg. 77929 and CMS Feb. 2011 FAQ #28 – Additional Information on the DSH Reporting and Audit Requirements)
Myers and Stauffer
21

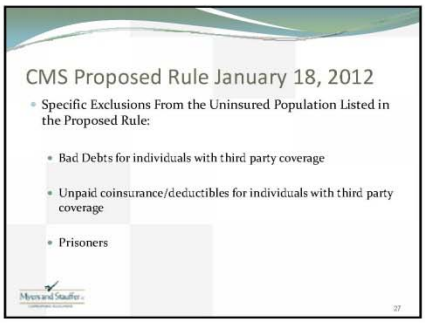

Select CMS Responses to Comments
Auditing (General)
If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. (Auditing pg. 77929 and CMS Feb. 2011 FAQ #1 – Additional Information on the DSH Reporting and Audit Requirements)
The methodology will need to exclude costs from services furnished to individuals with third party coverage, prisoners, duplicate accounts, individuals included in calculating the Medicaid shortfall, charges associated with elective procedures, and any professional charges. (Auditing pg. 77930)
In instances where the hospital financial and cost reporting periods differ from the Medicaid state plan rate year, states and auditors may need to review multiple audited hospital financial reports and cost reports to fully cover the Medicaid state plan rate year under audit. At most, two financial and/or cost reports should provide the appropriate data. The data may need to be allocated based on the months covered by the financial or cost reporting period that are included in the Medicaid state plan period under audit. (Auditing pg. 77931)
Myers and Stauffer
22

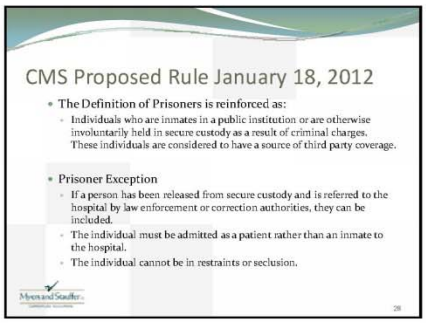

Select CMS Responses to Comments
Auditing (Time Period Subject to Audit)
The treatment of post-audit Medicaid payments, including regular Medicaid rate payments, supplemental and enhanced payments, Medicaid managed care payments, DSH, and 'self pay' revenues and other collections including liens would be treated as revenue applicable to the Medicaid state plan rate year in which they are received. (Auditing pg. 77942)
Myers and Stauffer
23

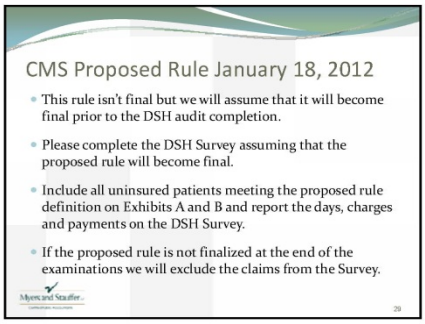

CMS Proposed Rule January 18, 2012
CMS released a proposed rule in the January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.
Under this proposed rule, the DSH audit will now look at whether a patient is uninsured using a "service-specific" approach as opposed to the "individual's creditable coverage" approach previously employed.
Myers and Stauffer
24

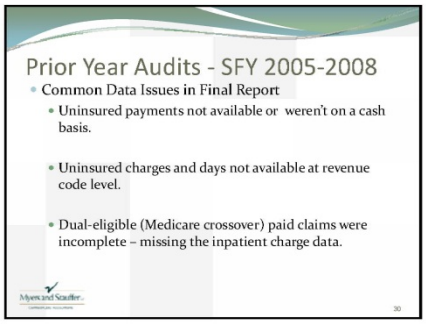

CMS Proposed Rule January 18, 2012
Under this proposed rule, the following may be considered uninsured:
Individuals with exhausted insurance benefits at the time of service
Individuals who have reached lifetime insurance limits for certain services
Individuals whose benefit package does not cover the hospital service received (must be a covered service under the Medicaid state plan)
Myers and Stauffer
25

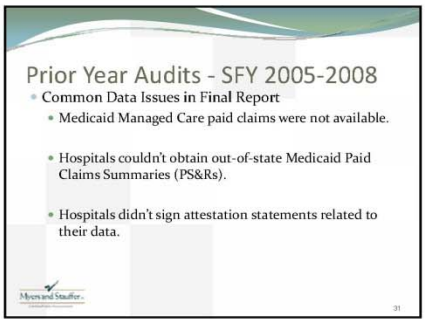

CMS Proposed Rule January 18, 2012
Definition of a Service
A "service" should include the same elements that would be included for the same or similar services under Medicaid generally. The intent being that a hospital will generally determine that an individual is either insured or not insured for a given hospital stay, and will not separate out component parts of the hospital stay based on the level of payment received.
Myers and Stauffer
26

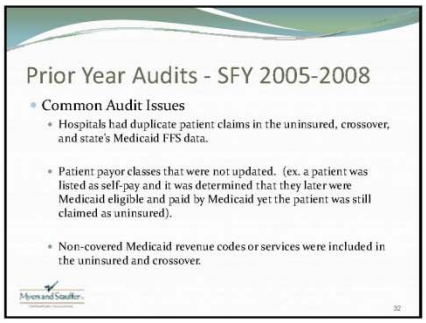

CMS Proposed Rule January 18, 2012
Specific Exclusions From the Uninsured Population Listed in the Proposed Rule:
Bad Debts for individuals with third party coverage
Unpaid coinsurance/deductibles for individuals with third party coverage
Prisoners
Myers and Stauffer
27

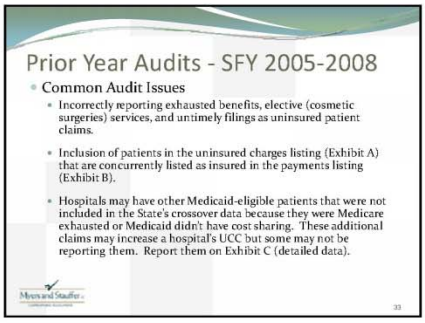

CMS Proposed Rule January 18, 2012
The Definition of Prisoners is reinforced as:
Individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as a result of criminal charges. These individuals are considered to have a source of third party coverage.
Prisoner 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.
Myers and Stauffer
28

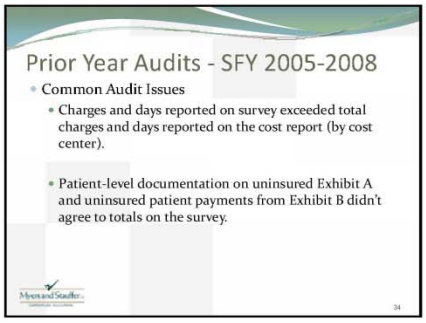

CMS Proposed Rule January 18, 2012
This rule isn't final but we will assume that it will become final prior to the DSH audit completion.
Please complete the DSH Survey assuming that the proposed rule will become final.
Include all uninsured patients meeting the proposed rule definition on Exhibits A and B and report the days, charges and payments on the DSH Survey.
If the proposed rule is not finalized at the end of the examinations we will exclude the claims from the Survey.
Myers and Stauffer
29

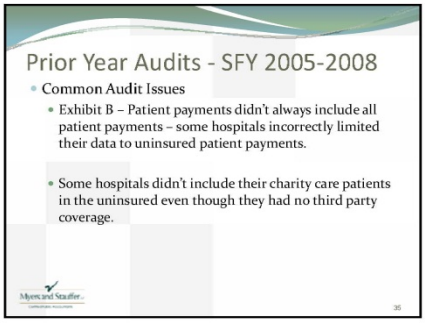

Prior Year Audits - SFY 2005-2008
Common Data Issues in Final Report
Uninsured payments not available or weren't on a cash basis.
Uninsured charges and days not available at revenue code level.
Dual-eligible (Medicare crossover) paid claims were incomplete – missing the inpatient charge data.
Myers and Stauffer
30

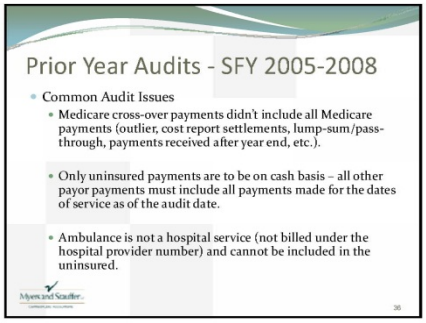

Prior Year Audits - SFY 2005-2008
Common Data Issues in Final Report
Medicaid Managed Care paid claims were not available.
Hospitals couldn't obtain out-of-state Medicaid Paid Claims Summaries (PS&Rs).
Hospitals didn't sign attestation statements related to their data.
Myers and Stauffer
31

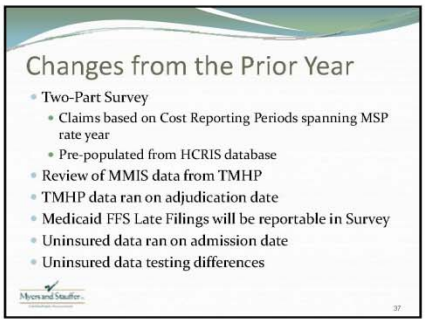

Prior Year Audits - SFY 2005-2008
Common Audit Issues
Hospitals had duplicate patient claims in the uninsured, crossover, and state's Medicaid FFS data.
Patient payor classes that were not updated. (ex. a patient was listed as self-pay and it was determined that they later were Medicaid eligible and paid by Medicaid yet the patient was still claimed as uninsured).
Non-covered Medicaid revenue codes or services were included in the uninsured and crossover.
Myers and Stauffer
32

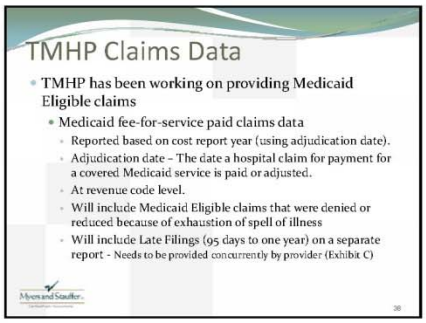

Prior Year Audits - SFY 2005-2008
Common Audit Issues
Incorrectly reporting exhausted benefits, elective (cosmetic surgeries) services, and untimely filings as uninsured patient claims.
Inclusion of patients in the uninsured charges listing (Exhibit A) that are concurrently listed as insured in the payments listing (Exhibit B).
Hospitals may have other Medicaid-eligible patients that were not included in the State's crossover data because they were Medicare exhausted or Medicaid didn't have cost sharing. These additional claims may increase a hospital's UCC but some may not be reporting them. Report them on Exhibit C (detailed data).
Myers and Stauffer
33

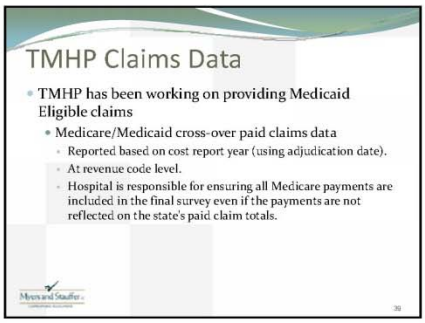

Prior Year Audits - SFY 2005-2008
Common Audit Issues
Charges and days reported on survey exceeded total charges and days reported on the cost report (by cost center).
Patient-level documentation on uninsured Exhibit A and uninsured patient payments from Exhibit B didn't agree to totals on the survey.
Myers and Stauffer
34

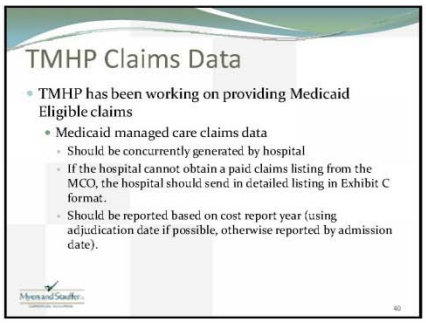

Prior Year Audits - SFY 2005-2008
Common Audit Issues
Exhibit B – Patient payments didn't always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.
Some hospitals didn't include their charity care patients in the uninsured even though they had no third party coverage.
Myers and Stauffer
35

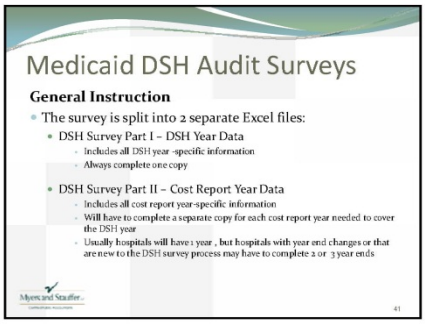

Prior Year Audits - SFY 2005-2008
Common Audit Issues
Medicare cross-over payments didn't include all Medicare payments (outlier, cost report settlements, lump-sum/pass-through, payments received after year end, etc.).
Only uninsured payments are to be on cash basis – all other payor payments must include all payments made for the dates of service as of the audit date.
Ambulance is not a hospital service (not billed under the hospital provider number) and cannot be included in the uninsured.
Myers and Stauffer
36

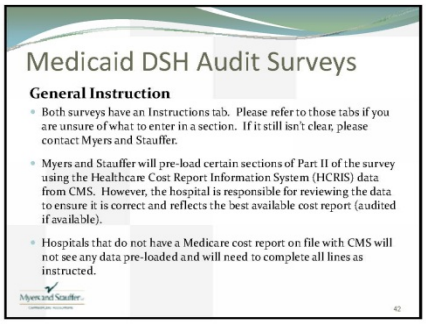

Changes from the Prior Year
Two-Part Survey
Claims based on Cost Reporting Periods spanning MSP rate year
Pre-populated from HCRIS database
Review of MMIS data from TMHP
TMHP data ran on adjudication date
Medicaid FFS Late Filings will be reportable in Survey
Uninsured data ran on admission date
Uninsured data testing differences
Myers and Stauffer
37

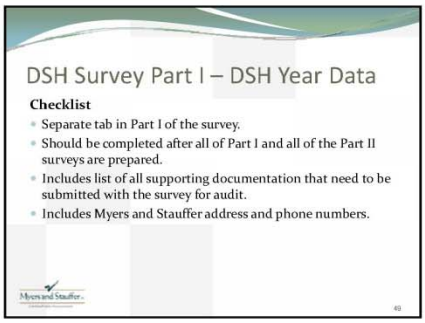

TMHP Claims Data
TMHP has been working on providing Medicaid Eligible claims
Medicaid fee-for-service paid claims data
Reported based on cost report year (using adjudication date).
Adjudication date – The date a hospital claim for payment for a covered Medicaid service is paid or adjusted.
At revenue code level.
Will include Medicaid Eligible claims that were denied or reduced because of exhaustion of spell of illness
Will include Late Filings (95 days to one year) on a separate report - Needs to be provided concurrently by provider (Exhibit C)
Myers and Stauffer
38

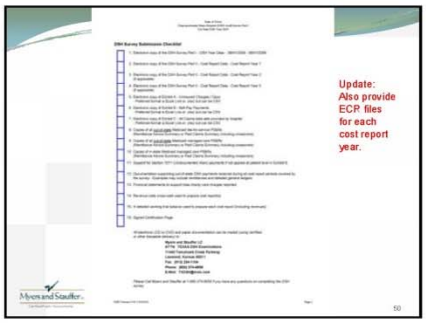

TMHP Claims Data
TMHP has been working on providing Medicaid Eligible claims
Medicare/Medicaid cross-over paid claims data
Reported based on cost report year (using adjudication date).
At revenue code level.
Hospital is responsible for ensuring all Medicare payments are included in the final survey even if the payments are not reflected on the state's paid claim totals.
Myers and Stauffer
39

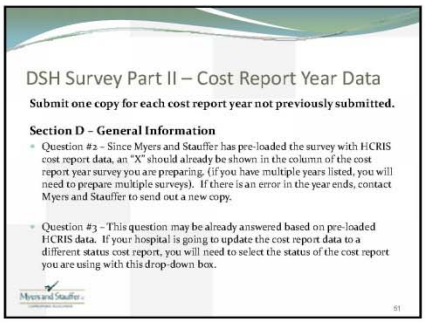

TMHP Claims Data
TMHP has been working on providing Medicaid Eligible claims
Medicaid managed care claims data
Should be concurrently generated by hospital
If the hospital cannot obtain a paid claims listing from the MCO, the hospital should send in detailed listing in Exhibit C format.
Should be reported based on cost report year (using adjudication date if possible, otherwise reported by admission date).
Myers and Stauffer
40

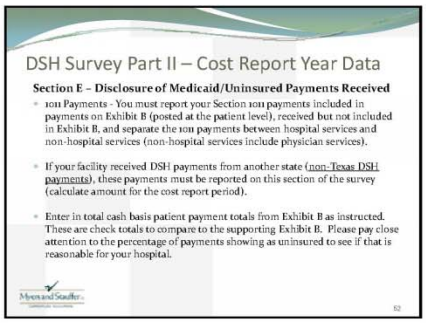

Medicaid DSH Audit Surveys
General Instruction
The survey is split into 2 separate Excel files:
DSH Survey Part I – DSH Year Data
Includes all DSH year -specific information
Always complete one copy
DSH Survey Part II – Cost Report Year Data
Includes all cost report year-specific information
Will have to complete a separate copy for each cost report year needed to cover the DSH year
Usually hospitals will have 1 year , but hospitals with year end changes or that are new to the DSH survey process may have to complete 2 or 3 year ends
Myers and Stauffer
41

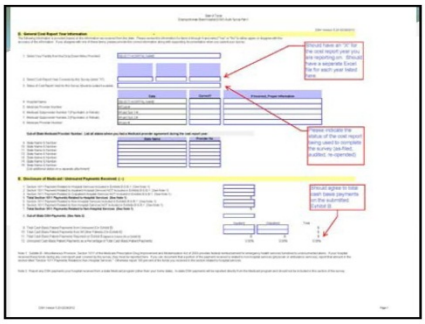

Medicaid DSH Audit Surveys
General Instruction
Both surveys have an Instructions tab. Please refer to those tabs if you are unsure of what to enter in a section. If it still isn't clear, please contact Myers and Stauffer.
Myers and Stauffer will pre-load certain sections of Part II of the survey using the Healthcare Cost Report Information System (HCRIS) data from CMS. However, the hospital is responsible for reviewing the data to ensure it is correct and reflects the best available cost report (audited if available).
Hospitals that do not have a Medicare cost report on file with CMS will not see any data pre-loaded and will need to complete all lines as instructed.
Myers and Stauffer
42

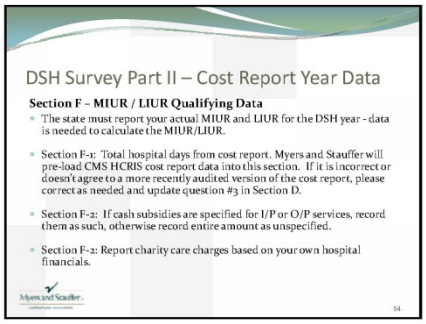

DSH Survey Part I – DSH Year Data
Checklist
Separate tab in Part I of the survey.
Should be completed after all of Part I and all of the Part II surveys are prepared.
Includes list of all supporting documentation that need to be submitted with the survey for audit.
Includes Myers and Stauffer address and phone numbers.
Myers and Stauffer
49

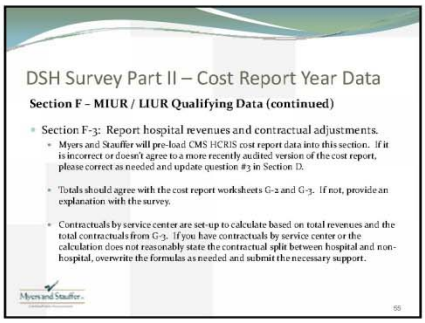

Update:
Also provide ECP files for each cost report year.
Myers and Stauffer
50

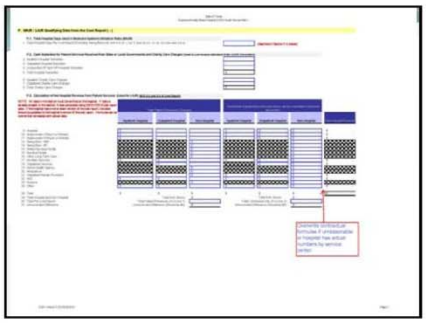

DSH Survey Part II – Cost Report Year Data
Submit one copy for each cost report year not previously submitted.
Section D – General Information
Question #2 – Since Myers and Stauffer has pre-loaded the survey with HCRIS cost report data, an "X" should already be shown in the column of the cost report year survey you are preparing. (If you have multiple years listed, you will need to prepare multiple surveys). If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.
Question #3 – This question may be already answered based on pre-loaded HCRIS data. If your hospital is going to update the cost report data to a different status cost report, you will need to select the status of the cost report you are using with this drop-down box.
Myers and Stauffer
51


DSH Survey Part II – Cost Report Year Data
Section E – Disclosure of Medicaid/Uninsured Payments Received
1011 Payments - You must report your Section 1011 payments included in payments on Exhibit B (posted at the patient level), received but not included in Exhibit B, 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 (non-Texas DSH payments), 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. Please pay close attention to the percentage of payments showing as uninsured to see if that is reasonable for your hospital.
Myers and Stauffer
52

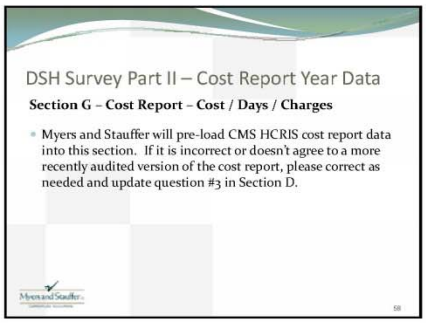


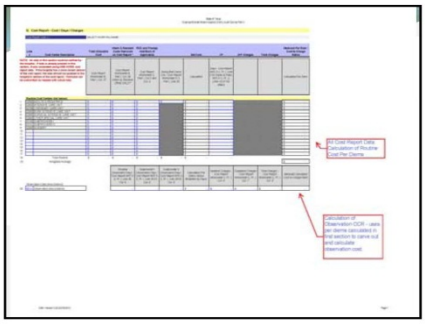

DSH Survey Part II – Cost Report Year Data
Section F – MIUR / LIUR Qualifying Data
The state must report your actual MIUR and LIUR for the DSH year - data is needed to calculate the MIUR/LIUR.
Section F-1: Total hospital days from cost report. Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
Section F-2: If cash subsidies are specified for I/P or O/P services, record them as such, otherwise record entire amount as unspecified.
Section F-2: Report charity care charges based on your own hospital financials.
Myers and Stauffer
54

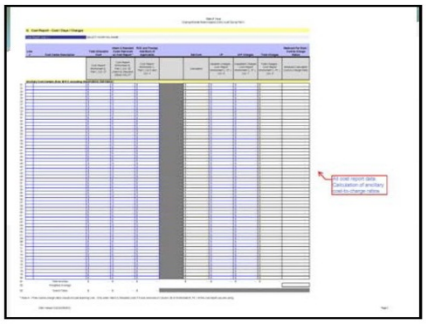

DSH Survey Part II – Cost Report Year Data
Section F – MIUR / LIUR Qualifying Data (continued)
Section F-3: Report hospital revenues and contractual adjustments.
Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
Totals should agree with the cost report worksheets G-2 and G-3. If not, provide an explanation with the survey.
Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If you have contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.
Myers and Stauffer
55

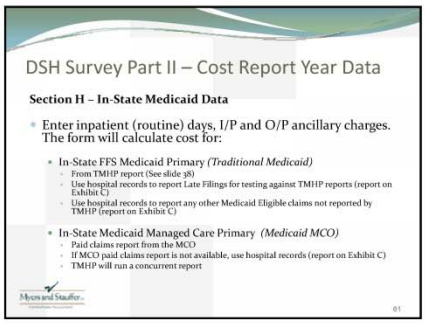


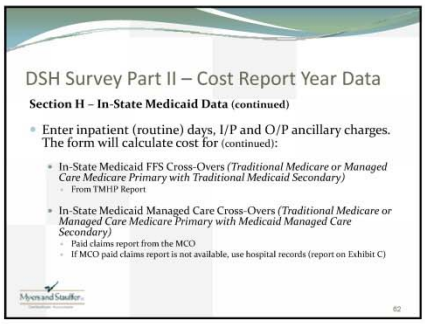

DSH Survey Part II – Cost Report Year Data
Section G – Cost Report – Cost / Days / Charges
Calculation of Routine Cost Per Diems
Calculation of Ancillary Cost-to-Charge Ratios
Myers and Stauffer
57

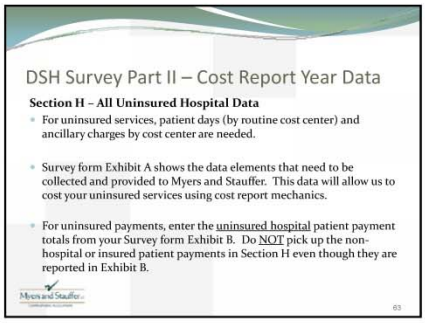

DSH Survey Part II – Cost Report Year Data
Section G – Cost Report – Cost / Days / Charges
Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
Myers and Stauffer
58

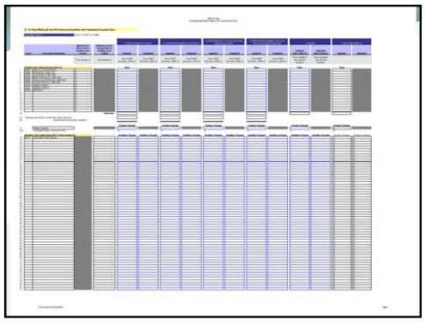


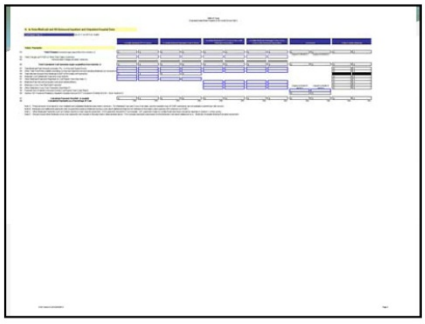


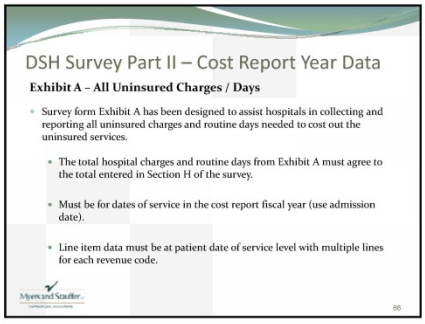

DSH Survey Part II – Cost Report Year Data
Section H – In-State Medicaid Data
Enter inpatient (routine) days, I/P and O/P ancillary charges. The form will calculate cost for:
In-State FFS Medicaid Primary (Traditional Medicaid)
From TMHP report (See slide 38)
Use hospital records to report Late Filings for testing against TMHP reports (report on Exhibit C)
Use hospital records to report any other Medicaid Eligible claims not reported by TMHP (report on Exhibit C)
In-State Medicaid Managed Care Primary (Medicaid MCO)
Paid claims report from the MCO
If MCO paid claims report is not available, use hospital records (report on Exhibit C)
TMHP will run a concurrent report
Myers and Stauffer
61

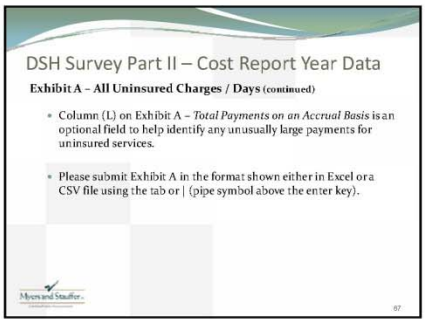

DSH Survey Part II – Cost Report Year Data
Section H – In-State Medicaid Data (continued)
Enter inpatient (routine) days, I/P and O/P ancillary charges. The form will calculate cost for (continued):
In-State Medicaid FFS Cross-Overs (Traditional Medicare or Managed Care Medicare Primary with Traditional Medicaid Secondary)
From TMHP Report
In-State Medicaid Managed Care Cross-Overs (Traditional Medicare or Managed Care Medicare Primary with Medicaid Managed Care Secondary)
Paid claims report from the MCO
If MCO paid claims report is not available, use hospital records (report on Exhibit C)
Myers and Stauffer
62

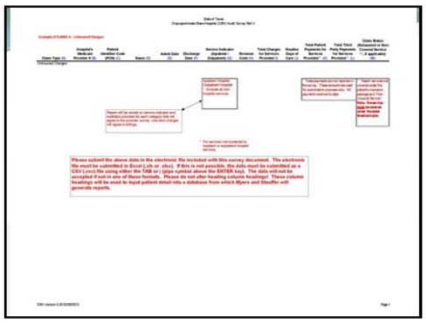

DSH Survey Part II – Cost Report Year Data
Section H – All Uninsured Hospital Data
For uninsured services, patient days (by routine cost center) and ancillary charges by cost center are needed.
Survey form Exhibit A shows the data elements that need to be collected and provided to Myers and Stauffer. This data will allow us to cost your uninsured services using cost report mechanics.
For uninsured payments, enter the uninsured hospital patient payment totals from your Survey form Exhibit B. Do NOT pick up the non-hospital or insured patient payments in Section H even though they are reported in Exhibit B.
Myers and Stauffer
63

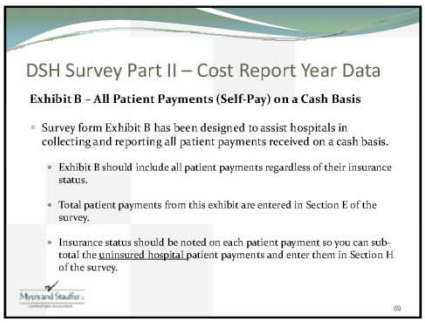


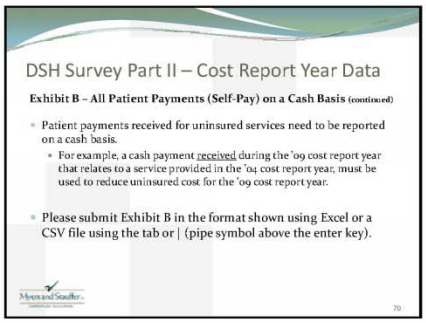


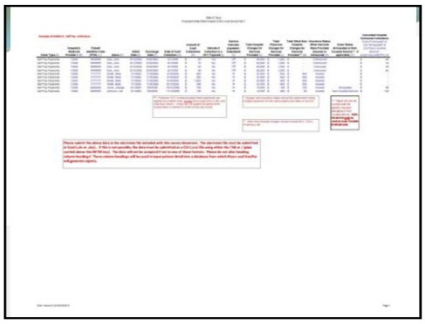

DSH Survey Part II – Cost Report Year Data
Exhibit A – All Uninsured Charges / Days
Survey form Exhibit A has been designed to assist hospitals in collecting and reporting all uninsured charges and routine days needed to cost out the uninsured services.
The total hospital charges and routine days from Exhibit A must agree to the total entered in Section H of the survey.
Must be for dates of service in the cost report fiscal year (use admission date).
Line item data must be at patient date of service level with multiple lines for each revenue code.
Myers and Stauffer
66

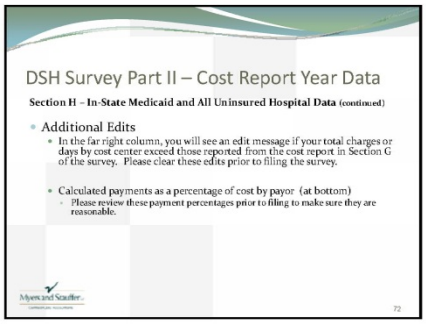

DSH Survey Part II – Cost Report Year Data
Exhibit A – All Uninsured Charges / Days (continued)
Column (L) on Exhibit A – Total Payments on an Accrual Basis is an optional field to help identify any unusually large payments for uninsured services.
Please submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).
Myers and Stauffer
67




DSH Survey Part II – Cost Report Year Data
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.
Myers and Stauffer
69


DSH Survey Part II – Cost Report Year Data
Exhibit B – All Patient Payments (Self-Pay) on a Cash Basis (continued)
Patient payments received for uninsured services need to be reported on a cash basis.
For example, a cash payment received during the '09 cost report year that relates to a service provided in the '04 cost report year, must be used to reduce uninsured cost for the '09 cost report year.
Please submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).
Myers and Stauffer
70




DSH Survey Part II – Cost Report Year Data
Section H – In-State Medicaid and All Uninsured Hospital Data (continued)
Additional Edits
In the far right column, you will see an edit message if your total charges or days by cost center exceed those reported from the cost report in Section G of the survey. Please clear these edits prior to filing the survey.
Calculated payments as a percentage of cost by payor (at bottom)
Please review these payment percentages prior to filing to make sure they are reasonable.
Myers and Stauffer
72

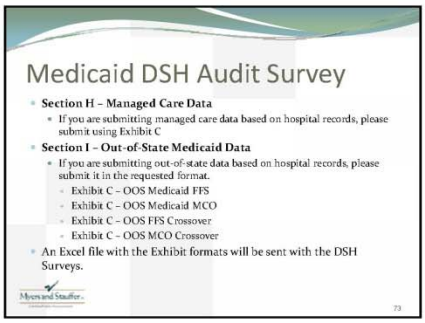
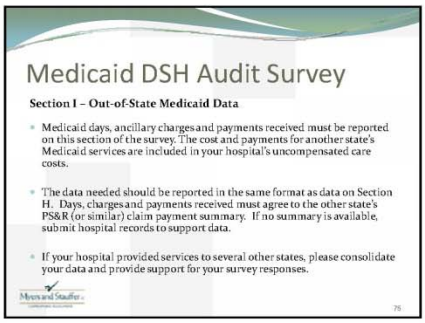
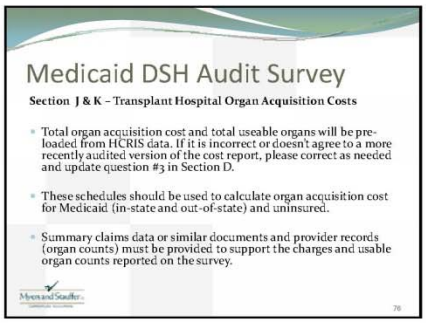
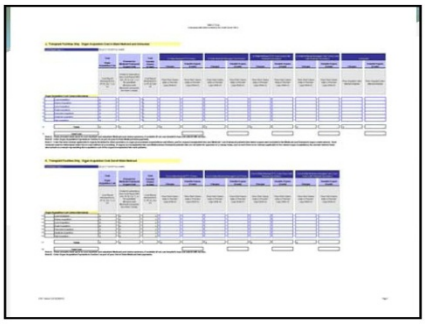
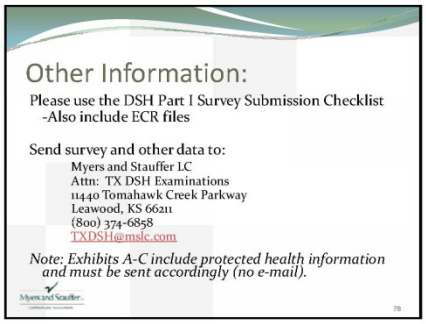

Medicaid DSH Audit Survey
Section H – Managed Care Data
If you are submitting managed care data based on hospital records, please submit using Exhibit C
Section I – Out-of-State Medicaid Data
If you are submitting out-of-state data based on hospital records, please submit it in the requested format.
Exhibit C – OOS Medicaid FFS
Exhibit C – OOS Medicaid MCO
Exhibit C – OOS FFS Crossover
Exhibit C – OOS MCO Crossover
An Excel file with the Exhibit formats will be sent with the DSH Surveys.
Myers and Stauffer
73


Exhibit C - OOS
Medicaid FFS


Medicaid DSH Audit Survey
Section I – Out-of-State Medicaid Data
Medicaid days, ancillary charges and payments received must be reported on this section of the survey. The cost and payments for another state's Medicaid services are included in your hospital's uncompensated care costs.
The data needed should be reported in the same format as data on 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 hospital records to support data.
If your hospital provided services to several other states, please consolidate your data and provide support for your survey responses.
Myers and Stauffer
75


Medicaid DSH Audit Survey
Section J & K – Transplant Hospital Organ Acquisition Costs
Total organ acquisition cost and total useable organs will be pre-loaded from HCRIS data. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured.
Summary claims data or similar documents and provider records (organ counts) must be provided to support the charges and usable organ counts reported on the survey.
Myers and Stauffer
76




Other Information:
Please use the DSH Part I Survey Submission Checklist
-Also include ECR files
Send survey and other data to:
Myers and Stauffer LC
Attn: TX DSH Examinations
11440 Tomahawk Creek Parkway
Leawood, KS 66211
(800) 374-6858
TXDSH@mslc.com
Note: Exhibits A-C include protected health information and must be sent accordingly (no e-mail).
Myers and Stauffer
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K: Required Forms

RFQ No. 13004

BUREAU FOR MEDICAL SERVICES

MED PURCHASING AFFIDAVIT

West Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owned is an amount greater than one thousand dollars in the aggregate

DEFINITIONS:
"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, Limited Liability Company or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing ***(West Virginia Code*** §61-5-3), it is hereby certified that the vendor affirms and acknowledges the information in this affidavit and is in compliance with the requirements as stated.

WITNESS THE FOLLOWING SIGNATURE

Vendor's Name: Myers and Stauffer LC

Authorized Signature: Michael K. Hoff Date: 2/18/13

State of MARYLAND

County of BALTIMORE, to-wit:

Taken, subscribed, and sworn to before me this 18 day of FEB., 20 13

My Commission expires MAR 10, 2016.

AFFIX SEAL HERE **NOTORY PUBLIC** Linda P. Kromm

LINDA P. KROMM NOTARY PUBLIC BALTIMORE COUNTY, MD

Purchasing Affidavit *(Revised 12/15/09)*

MED-96

AGREEMENT ADDENDUM

In the event of conflict between this addendum and the agreement, this addendum shall control:

1. **DISPUTES** - Any references in the agreement to arbitration or to the jurisdiction of any court are hereby deleted. Disputes arising out of the agreement shall be presented to the West Virginia Court of Claims.
2. **HOLD HARMLESS** - Any clause requiring the Agency to indemnify or hold harmless any party is hereby deleted in its entirety.
3. **GOVERNING LAW** - The agreement shall be governed by the laws of the State of West Virginia. This provision replaces any references to any other State's governing law.
4. **TAXES** - Provisions in the agreement requiring the Agency to pay taxes are deleted. As a State entity, the Agency is exempt from Federal, State, and local taxes and will not pay taxes for any Vendor including individuals, nor will the Agency file any tax returns or reports on behalf of Vendor or any other party.
5. **PAYMENT** - Any references to prepayment are deleted. Payment will be in arrears.
6. **INTEREST** - Should the agreement include a provision for interest on late payments, the Agency agrees to pay the maximum legal rate under West Virginia law. All other references to interest or late charges are deleted.
7. **RECOUPMENT** - Any language in the agreement waiving the Agency's right to set-off, counterclaim, recoupment, or other defense is hereby deleted.
8. **FISCAL YEAR FUNDING** - Service performed under the agreement may be continued in succeeding fiscal years for the term of the agreement, contingent upon funds being appropriated by the Legislature or otherwise being available for this service. In the event funds are not appropriated or otherwise available for this service, the agreement shall terminate without penalty on June 30. After that date, the agreement becomes of no effect and is null and void. However, the Agency agrees to use its best efforts to have the amounts contemplated under the agreement included in its budget. Non-appropriation or non-funding shall not be considered an event of default.
9. **STATUTE OF LIMITATION** - Any clauses limiting the time in which the Agency may bring suit against the Vendor, lessor, individual, or any other party are deleted.
10. **SIMILAR SERVICES** - Any provisions limiting the Agency's right to obtain similar services or equipment in the event of default or non-funding during the term of the agreement are hereby deleted.
11. **ATTORNEY FEES** - The Agency recognizes an obligation to pay attorney's fees or costs only when assessed by a court of competent jurisdiction. Any other provision is invalid and considered null and void.
12. **ASSIGNMENT** - Notwithstanding any clause to the contrary, the Agency reserves the right to assign the agreement to another State of West Virginia agency, board or commission upon thirty (30) days written notice to the Vendor and Vendor shall obtain the written consent of Agency prior to assigning the agreement.
13. **LIMITATION OF LIABILITY** - The Agency, as a State entity, cannot agree to assume the potential liability of a Vendor. Accordingly, any provision limiting the Vendor's liability for direct damages to a certain dollar amount or to the amount of the agreement is hereby deleted. Limitations on special, incidental or consequential damages are acceptable. In addition, any limitation is null and void to the extent that it precludes any action for injury to persons or for damages to personal property.
14. **RIGHT TO TERMINATE** - Agency shall have the right to terminate the agreement upon thirty (30) days written notice to Vendor. Agency agrees to pay Vendor for services rendered or goods received prior to the effective date of termination.
15. **TERMINATION CHARGES** - Any provision requiring the Agency to pay a fixed amount or liquidated damages upon termination of the agreement is hereby deleted. The Agency may only agree to reimburse a Vendor for actual costs incurred or losses sustained during the current fiscal year due to wrongful termination by the Agency prior to the end of any current agreement term.
16. **RENEWAL** - Any reference to automatic renewal is hereby deleted. The agreement may be renewed only upon mutual written agreement of the parties.
17. **INSURANCE** - Any provision requiring the Agency to insure equipment or property of any kind and name the Vendor as beneficiary or as an additional insured is hereby deleted.
18. **RIGHT TO NOTICE** - Any provision for repossession of equipment without notice is hereby deleted. However, the Agency does recognize a right of repossession with notice.
19. **ACCELERATION** - Any reference to acceleration of payments in the event of default or non-funding is hereby deleted.
20. **CONFIDENTIALITY:** -Any provision regarding confidentiality of the terms and conditions of the agreement is hereby deleted. State contracts are public records under the West Virginia Freedom of Information Act.
21. **AMENDMENTS** - All amendments, modifications, alterations or changes to the agreement shall be in writing and signed by both parties. No amendment, modification, alteration or change may be made to this addendum without the express written approval of the Purchasing Division and the Attorney General.

ACCEPTED BY DHHR OFFICE OF PURCHASING:

Spending Unit: _____

Signed: _____

Title: _____

Date: _____

VENDOR

Company Name: Myers and Stauffer LC

Signed: _____

Title: Member

Date: 2/18/13

Bureau for Medical Services

VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with ***West Virginia Code,*** §5A-3-37. (Does not apply to construction contracts). ***West Virginia Code,*** §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code.*** This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Resident Vendor Preference, if applicable.

1. **Application is made for 2.5% resident vendor preference for the reason checked:**
____ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. **Application is made for 2.5% resident vendor preference for the reason checked:**
____ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. **Application is made for 2.5% resident vendor preference for the reason checked:**
____ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. **Application is made for 5% resident vendor preference for the reason checked:**
__ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**
____ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**
__ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61 -5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: Myers and Stauffer LC **Signed:** Mark K Ma

Date: February 18, 2013 **Title:** Member

"Check any combination of preference consideration(s) indicated above, which you are entitled to receive

This form is not applicable to Myer and Stauffer.

Client#: 52154 MYERSTA

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 1/03/2013

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	
CBIZ Insurance Services 401 Plymouth Road, Suite 200 Plymouth Meeting, PA 19462	PHONE (A/C, No, Ext): 610-862-2249	FAX (A/C, No): 610-862-2500
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Hartford Casualty Insurance Co	29424
INSURED Myers and Stauffer, LC 4123 Southwest Gage Ctr. Dr. Topeka, KS 66604	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			42SBAFM9189	09/01/2012	09/01/2013	EACH OCCURRENCE	$1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$300,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$10,000
							PERSONAL & ADV INJURY	$1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$2,000,000
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$2,000,000
								$
A	AUTOMOBILE LIABILITY			42SBAFM9189	09/01/2012	09/01/2013	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS / X NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB X OCCUR			42SBAFM9189	09/01/2012	09/01/2013	EACH OCCURRENCE	$4,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$4,000,000
	DED X RETENTION $10000							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						WC STATU-TORY LIMITS / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N / A						E.L. EACH ACCIDENT	$
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
M & S Consulting

CERTIFICATE HOLDER

DHHR Office of Purchasing
Attn: Robert Price
One Davis Square, Suite 100
Charleston, WV 25301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

CBIZ Insurance Services, Inc.

ACORD 25 (2010/05) 1 of 1 #S689486/M657454 The ACORD name and logo are registered marks of ACORD PLC

Client#: 2372 CBIZINC

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 1/03/2013

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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PRODUCER	CONTACT NAME:	
CBIZ Insurance Services 401 Plymouth Road, Suite 200 Plymouth Meeting, PA 19462	PHONE (A/C, No, Ext): 610-862-2249	FAX (A/C, No): 610-862-2500
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Hartford Insurance- Comml Lines	
INSURED CBIZ, Inc. and subsidiaries 6050 Oak Tree Blvd., South, Suite 500 Cleveland, OH 44131	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	☐ CLAIMS-MADE ☐ OCCUR						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			42WNMF4640	09/30/2012	09/30/2013	X WC STATU-TORY LIMITS ☐ OTH-ER	
A	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [N] N/A (Mandatory in NH)			42WBRMF4641WI	09/30/2012	09/30/2013	E.L. EACH ACCIDENT	$1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

M & S Consulting

CERTIFICATE HOLDER	CANCELLATION
DHHR Office of Purchasing Attn: Robert Price One Davis Square, Suite 100 Charleston, WV 25301	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE CBIZ Insurance Services, Inc.

ACORD 25 (2010/05) 1 of 1 The ACORD name and logo are registered marks of ACORD
#S689487/M657563 PLC