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

Cost Report Year (07/01/2019-06/30/2020) ROOSEVELT WARM SPRGS REHAB HOSPITAL

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 Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 843.53		1,861		326		863		80		223		1,269		19.65%
2	03100 INTENSIVE CARE UNIT	$ -												-		
3	03200 CORONARY CARE UNIT	$ -												#REF!		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ -												-		
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	1,861		326		863		80		223		#REF!		
19	Total Days per PS&R or Exhibit Detail			1,861		326		863		80		223				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 2,588,067		$ 510,925		$ 1,382,659		$ 131,674		$ 357,685		$ 4,613,325		47.72%
21.01	Calculated Routine Charge Per Diem			$ 1,390.69		$ 1,567.25		$ 1,602.15		$ 1,645.93		$ 1,603.97		#REF!		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		-											$ -	$ -	
23	5400 RADIOLOGY-DIAGNOSTIC		0.461308	69,702		27,094		52,397		4,460		14,002		$ 153,653	$ -	56.94%
24	6000 LABORATORY		0.086889	519,289		50,040		238,528		17,079		43,668		$ 824,936	$ -	41.85%
25	6500 RESPIRATORY THERAPY		0.395118	192,926		8,083		140,246		1,850		13,824		$ 343,105	$ -	51.77%
26	6600 PHYSICAL THERAPY		0.190922	893,380		170,734		441,378		41,752		116,675		$ 1,547,244	$ -	44.58%
27	6700 OCCUPATIONAL THERAPY		0.187567	1,156,233		211,451		575,075		52,520		142,773		$ 1,995,279	$ -	44.30%
28	6800 SPEECH PATHOLOGY		0.149806	331,220		84,537		164,028		-		60,670		$ 579,785	$ -	40.43%
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.926463	40,831		4,901		19,228		7,116		3,923		$ 72,076	$ -	44.51%
30	7300 DRUGS CHARGED TO PATIENTS		0.224894	947,098		100,153		425,969		40,110		78,725		$ 1,513,330	$ -	44.43%
31			-											$ -	$ -	
32			-											$ -	$ -	
33			-											$ -	$ -	
34			-											$ -	$ -	
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41			-											$ -	$ -	
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59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (07/01/2019-06/30/2020) ROOSEVELT WARM SPRGS REHAB HOSPITAL

				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		%
61			-											$ -	$ -	-
62			-											$ -	$ -	
63			-											$ -	$ -	
64			-											$ -	$ -	
65			-											$ -	$ -	
66			-											$ -	$ -	
67			-											$ -	$ -	
68			-											$ -	$ -	
69			-											$ -	$ -	
70			-											$ -	$ -	
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123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 4,150,679	$ -	$ 656,993	$ -	$ 2,056,849	$ -	$ 164,887	$ -	$ 474,260	$ -			

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

Cost Report Year (07/01/2019-06/30/2020) ROOSEVELT WARM SPRGS REHAB HOSPITAL

	Totals / Payments	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		%
128	**Total Charges *(includes organ acquisition from Section J)***	$ 6,738,746	$ -	$ 1,167,918	$ -	$ 3,439,508	$ -	$ 296,561	$ -	$ 831,945 (Agrees to Exhibit A)	$ - (Agrees to Exhibit A)	$ 11,642,733	$ -	45.57%
129	Total Charges per PS&R or Exhibit Detail	$ 6,738,746	$ -	$ 1,167,918	$ -	$ 3,439,508	$ -	$ 296,561	$ -	$ 831,945	$ -			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 2,411,193	$ -	$ 407,018	$ -	$ 1,158,595	$ -	$ 105,190	$ -	$ 283,306	$ -	$ 4,081,996	$ -	44.49%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 2,911,788				$ 259,376		$ 28,028				$ 3,199,192	$ -	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 427,887								$ 427,887	$ -	
134	Private Insurance (including primary and third party liability)	$ 28,579						$ 89,914				$ 118,493	$ -	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 13		$ 28,665								$ 28,678	$ -	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 2,940,380	$ -	$ 456,552	$ -									
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 739,005		$ -				$ 739,005	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ 314,962						$ 314,962	$ -	
141	Medicare Cross-Over Bad Debt Payments											$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 35,106				
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ (529,187)	$ -	$ (49,534)	$ -	$ (154,748)	$ -	$ (12,752)	$ -	$ 248,200	$ -	$ (746,221)	$ -	
146	**Calculated Payments as a Percentage of Cost**	122%	0%	112%	0%	113%	0%	112%	0%	12%	0%	118%	0%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					2,985								
148	**Percent of cross-over days to total Medicare days from the cost report**					29%								

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

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2020

DSH Version 6.00 2/17/2021

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2019	06/30/2020

2. Select Your Facility from the Drop-Down Menu Provided: ROOSEVELT WARM SPRGS REHAB HOSPITAL

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	07/01/2019	06/30/2020	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	Data
6. Medicaid Provider Number:	000000778A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	113028

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 Examination Year:	DSH Examination Year (07/01/19 - 06/30/20)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	No
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
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?	Yes
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	1/1/1927

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020** $ -
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2019 - 06/30/2020** $ -
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2019 - 06/30/2020** $ -

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.**	Yes

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	CEO Title	10/19/2021 Date
David Mork Hospital CEO or CFO Printed Name	706-655-5461 Hospital CEO or CFO Telephone Number	Dmork@augusta.edu Hospital CEO or CFO E-Mail

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

Hospital Contact:	
Name	Bob McDowell
Title	Reimbursement Director
Telephone Number	706-721-4258
E-Mail Address	bmcdowell@augusta.edu
Mailing Street Address	1120 15th Street, Building O107, Suite 510
Mailing City, State, Zip	Augusta, GA 30912

Outside Preparer:	
Name	Laura Gillenwater, CPA
Title	Senior Manager
Firm Name	HORNE LLP
Telephone Number	601-326-1378
E-Mail Address	laura.gillenwater@hornellp.com

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2020

N/A

N/A

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 (if not already populated). 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 2020 DSH Survey, if your hospital completed the DSH survey for 2019, the first cost report year should follow the last cost report year reported on the 2019 DSH survey. The last cost report year on the 2020 survey must end on or after the end of the 2020 DSH year. If your hospital did not complete the 2019 survey, your cost reports for 2020 must cover the entire 2020 DSH year.

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

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 and Medicaid Managed Care supplemental payments should include all non-claims payments for hospital services paid on the state fiscal year. This includes, but is not limited to) UPL payments, Medicaid GME payments, bonus payments, incentive payments, full Medicaid pricing (FMP) payments, etc. 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.

N/A

N/A N/A

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.

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2020

DSH Version 6.00 2/17/2021

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2019	06/30/2020

2. Select Your Facility from the Drop-Down Menu Provided: ROOSEVELT WARM SPRGS REHAB HOSPITAL

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	07/01/2019	06/30/2020	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	Data
6. Medicaid Provider Number:	000000778A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	113028

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 Examination Year:

	DSH Examination Year (07/01/19 - 06/30/20)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	No
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
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?	Yes
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	1/1/1927

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2020

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020** — $ -
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2019 - 06/30/2020** — $ -
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2019 - 06/30/2020** — $ -

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.**	Yes

Explanation for "No" answers:

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

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

DocuSigned by:
David Mork
26CBC95C20984A8...

Hospital CEO or CFO Signature	Title	Date
	CEO	10/19/2021

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
David Mork	706-655-5461	Dmork@augusta.edu

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

Hospital Contact:	
Name	Bob McDowell
Title	Reimbursement Director
Telephone Number	706-721-4258
E-Mail Address	bmcdowell@augusta.edu
Mailing Street Address	1120 15th Street, Building O107, Suite 510
Mailing City, State, Zip	Augusta, GA 30912

Outside Preparer:	
Name	Laura Gillenwater, CPA
Title	Senior Manager
Firm Name	HORNE LLP
Telephone Number	601-326-1378
E-Mail Address	laura.gillenwater@hornellp.com

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.

X	1. Electronic copy of the DSH Survey Part I - DSH Year Data - 07/01/2019 - 06/30/2020
X	2. Electronic copy of the DSH Survey Part II - Cost Report Data - Cost Report Year 07/01/2019 - 06/30/2020
N/A	3. N/A
N/A	4. N/A
X	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)
X	5 (b). Description of logic used to compile Exhibit A. Include a copy of all financial classes and payer plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
X	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).
X	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.
X	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).
X	7 (b). Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payer plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
N/A	8. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	9. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	10. Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	11. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B
N/A	12. Documentation supporting out-of-state DSH payments received - Examples may include remittances, detailed general ledgers, or add-on rates.
N/A	13. Financial statements or other documentation to support total charity care charges and subsidies reported on Section F of DSH Survey Part II
N/A	14. Revenue code cross-walk used to prepare cost report, or supporting grouping schedules
X	15 (a). A detailed working trial balance used to prepare each cost report (including revenues)
N/A	15 (b). A detailed revenue working trial balance by payer/contract. The schedule should show charges, contractual adjustments, and revenues by payer plan and contract (e.g., Medicare, each Medicaid agency payer, each Medicaid Managed care contract)
X	16. Electronic copy of all cost reports used to prepare each DSH Survey Part II
N/A	17. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligible cost report payments)
N/A	18. Documentation supporting Medicaid Managed Care Quality Incentive Payments, or any other Medicaid Managed Care lump sum payments

Please upload all checklist items above to the Myers and Stauffer Web Portal. If you are unable to access the Web Portal, please call or email.
Web Portal Address:

https://dsh.mslc.com

All electronic (CD or DVD - CDs or DVDs must be encrypted and/or password protected) and paper documentation can be mailed (using certified or other traceable delivery) to:

Myers and Stauffer LC
ATTN: DSH Examinations
700 W. 47th Street, Suite 1100
Kansas City, Missouri 64112
Fax: (816) 945-5301
Phone: (800) 374-6858
E-Mail:

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