

Exhibit 3B -- Charity Care Listing Instructions and Form

Exhibit 3B presents the charity care listing information required to support the charity care amounts claimed on Worksheet S-10, line 20, and must be submitted with cost reports for cost reporting periods beginning on or after October 1, 2022. For each CCN in the hospital healthcare complex, submit a listing of patients, identified as uninsured or insured, that received charity care. Enter dates in the MM/DD/YYYY format.

If a SCH is eligible to receive a DSH payment adjustment but Worksheet E, Part A, line 48, is greater than line 47, do not complete an Exhibit 3B listing; however, if Worksheet E, Part A, line 47, is greater than line 48, the SCH must submit an Exhibit 3B listing.

The sum of column 20 amounts for uninsured patients (insurance status code 1 or 2) on charity care listings for all of the hospital and hospital healthcare complex CCNs must equal Worksheet S-10, Part I, line 20, column 1. The sum of column 20 amounts for insured patients (insurance status code 3) on charity care listings for all of the hospital and hospital healthcare complex CCNs must equal Worksheet S-10, Part I, line 20, column 2. The sum of column 20 amounts for uninsured patients on the charity care listing for the hospital CCN must equal Worksheet S-10, Part II, line 20, column 1; and the sum of column 20 amounts for insured patients must equal Worksheet S-10, Part II, line 20, column 2.

Enter the provider name, hospital CCN and component CCN (only if the listing presents the charity care for a component of the hospital), CRP beginning and ending dates, the name of the preparer and the date prepared. Also enter the sum of the uninsured amounts (insurance status 1 or 2) in column 20, and the sum of the insured amounts (insurance status 3) in column 20.

Columns 1, 2, 3, 4, and 5--From the patient's bill, enter the patient's last name, first name, dates of service, and patient account or identification number that correlate to the claimed charity care charges.

Column 6--Enter 1, 2, or 3, to indicate the patient's insurance status at the time services were provided, as follows:

- Enter 1 to indicate the patient was uninsured (did not have any insurance coverage).
- Enter 2 to indicate the patient was insured but not covered when the patient:
 - had insurance coverage through an insurance company with which you do not have a contractual relationship,
 - had insurance coverage and the services provided were medically necessary but not covered,
 - had insurance coverage and the patient had exhausted their benefits, or
 - had general coverage through Medicaid but was not covered for this particular stay due to exhausted benefits or noncoverage.
- Enter 3 to indicate the patient was insured.

Column 7--For insured patients, enter the name of the primary payor, e.g., Medicaid, HMO Medicaid, BCBS, Aetna, State Farm, etc., regardless of whether you have a contractual (or inferred contractual) relationship with the insurer.

Column 8--For insured patients, enter the name of the secondary payor (e.g., Medicaid, HMO Medicaid, BCBS, Aetna, State Farm, etc.), regardless of whether you have a contractual (or inferred contractual) relationship with the insurer.

Column 9--Enter the total charges (excluding physician/professional charges) for the claim that correlates to the claimed charity care charges.

Column 10--If the total charges in column 9 include amounts for physician/professional charges, enter those physician/professional charges in this column.

Column 11--Enter the amount of deductible, coinsurance, and copayment owed by the patient according to their medical insurance coverage, if applicable.

Column 12--Enter the total amounts received from third party payors (any entity paying medical claims on behalf of the insured such as government agencies, insurance companies, and HMOs).

Column 13--Complete this column only for insured patients; do not complete this column for uninsured patients. Enter the amount of the contractual allowance for the insured patient (i.e. the difference between the hospital's billed charges and the amount contractually paid by an insurer after deductible and coinsurance for an insured patient, if applicable). Report the sum of contractual allowance amounts for primary and secondary payors, if applicable.

Column 14--Enter the sum of other unpaid non-allowable amounts including:

- non-covered charges for medically necessary services not included in the hospital's written charity care policy or FAP
- non-covered charges for services not medically necessary
- courtesy discounts
- administrative adjustments
- denial adjustments

Column 15--Enter all payments received from patients (or individuals responsible for payment). (Charity care is determined as column 9 minus columns 10, 11, 12, 13, 14, 15, and 16, and is reported in column 17, 18, or 19).

Column 16--Enter the amounts written off as a patient bad debt (i.e., written off as a bad debt or implicit price concession) against the A/R (considered a reduction in revenue) in the provider's financial accounting system, regardless of the date, for this claim.

Column 17--Complete this column only for uninsured patients; do not complete this column for insured patients. Enter the amount of the uninsured discount given to the uninsured patient pursuant to the hospital's written charity care policy or FAP.

Column 18--For insured patients, enter the portion of the medically necessary non-covered charges considered for charity care, if such inclusion is specified in the hospital's written charity care policy or FAP and the patient meets the hospital's policy criteria, as follows:

- enter the charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs.
- enter the charges for non-covered days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs.
- enter the portion of charges where the patient has exhausted their benefits.

Column 19--Enter any other allowable charges (not reported in column 17 or column 18) and written off as charity care pursuant to the provider's written charity care policy or FAP.

Column 20--Enter the sum of the amounts in columns 17, 18, and 19.

Column 21-- Enter the date the charity care amount or uninsured discount was written off.

EXHIBIT 3B

<i>TITLE</i>	<i>CHARITY CARE CHARGES</i>
<i>PROVIDER NAME</i>	
<i>HOSPITAL CCN</i>	
<i>COMPONENT CCN</i>	
<i>CRP BEGINNING DATE</i>	
<i>CRP ENDING DATE</i>	
<i>PREPARED BY</i>	
<i>DATE PREPARED</i>	
<i>UNINSURED COLUMN 20</i>	
<i>INSURED COLUMN 20</i>	

<i>PATIENT CLAIM INFORMATION</i>					<i>INSURANCE STATUS</i>	<i>PRIMARY PAYOR</i>	<i>SECONDARY PAYOR</i>	<i>TOTAL CHARGES FOR CLAIM</i>	<i>PHYSICIAN / PROFESSIONAL CHARGES</i>	<i>DEDUCTIBLE / COINSUR / COPAY AMOUNTS</i>
<i>PATIENT NAME - LAST</i>	<i>PATIENT NAME - FIRST</i>	<i>DATE OF SERVICE - FROM</i>	<i>DATE OF SERVICE - TO</i>	<i>PATIENT ACCOUNT NUMBER</i>						
<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>	<i>10</i>	<i>11</i>

<i>TOTAL THIRD PARTY PAYMENTS</i>	<i>INSURED CONTRACTUAL ALLOWANCE AMOUNT</i>	<i>OTHER NON-ALLOWABLE AMOUNTS</i>	<i>TOTAL PATIENT PAYMENTS</i>	<i>AMOUNTS WRITTEN OFF AS BAD DEBT</i>	<i>UNINSURED DISCOUNT AMOUNTS</i>	<i>CHARITY CARE NON-COVERED CHARGES</i>	<i>OTHER CHARITY CARE CHARGES</i>	<i>AMOUNTS WRITTEN OFF TO CHARITY CARE AND UNINSURED DISCOUNTS</i>	<i>WRITE OFF DATE</i>
<i>12</i>	<i>13</i>	<i>14</i>	<i>15</i>	<i>16</i>	<i>17</i>	<i>18</i>	<i>19</i>	<i>20</i>	<i>21</i>

Exhibit 3C -- Listing of Total Bad Debts Instructions and Form

For cost reporting periods beginning on or after October 1, 2022, IPPS hospitals eligible for DSH and UCC must complete an Exhibit 3C listing to support the amount of Medicare and non-Medicare bad debts, or implicit price concessions, reported on Worksheet S-10, line 26.

If a SCH is eligible to receive a DSH payment adjustment but Worksheet E, Part A, line 48, is greater than line 47, do not complete an Exhibit 3C listing; however, if Worksheet E, Part A, line 47, is greater than line 48, the SCH must submit an Exhibit 3C listing.

Complete a separate exhibit for the hospital and each component of the hospital complex (each CCN) and, on each listing, report only the data related to inpatient and outpatient services billed under that CCN. The sum of the amounts in column 17 for all the CCNs of the hospital complex bad debt listings must correspond to the amount reported on Worksheet S-10, Part I, line 26. The sum of the amounts in column 17 for the hospital CCN bad debt listing must correspond to the amount reported on Worksheet S-10, Part II, line 26. The bad debt of a Medicare beneficiary may be included on this listing even when their unpaid deductible and coinsurance amounts do not meet the Medicare bad debt criteria for inclusion on the Medicare bad debt listing (not included on Worksheet E, Parts A or B) for this cost reporting period.

Enter dates in the MM/DD/YYYY format.

Exhibit 3C requires the following information:

Enter the provider name, hospital CCN (even when the listing presents the bad debts for a component of the hospital), component CCN (only if the listing presents the bad debts for the component of the hospital), CRP beginning and ending dates, name of the preparer, date prepared, and sum of the amounts in column 17.

Columns 1, 2, 3, 4, and 5--From the patient's bill, enter the patient's last name, first name, dates of service, and patient account or identification number that correlate to the claimed bad debt.

Column 6--Enter 1, 2, or 3, to indicate the patient's insurance status at the time services were provided, as follows:

- Enter 1 to indicate the patient was uninsured (did not have any insurance coverage).
- Enter 2 to indicate the patient was insured but not covered when the patient:
 - had insurance coverage through an insurance company with which you do not have a contractual relationship,
 - had insurance coverage and the services provided were medically necessary but not covered, or
 - had insurance coverage and the patient had exhausted their benefits.
- Enter 3 to indicate the patient was insured.

Column 7--Enter the patient's primary payor at the time services were provided, e.g., BCBS, AARP, or Medicare.

Column 8--Enter the patient's secondary payor at the time services were provided, e.g., BCBS, AARP, or Medicare.

Column 9--Enter IP for inpatient or OP for outpatient to indicate the type of service provided to the patient.

Column 10--Enter the total charges for services provided to the patient.

Column 11---If the total charges in column 10 include amounts for physician/professional charges, enter those physician/professional charges in this column.

Column 12-- Enter all payments received from patients (or individuals responsible for payment), for amounts currently or previously written off to bad debt.

Column 13--Enter the total amounts received from third party payors, including amounts for Medicare cross-over claims for dual eligible beneficiaries.

Columns 14--Enter the portion of the patient's charges written off to charity care. For charity care determined in a year prior to the bad debt determination, ensure that the amount reported in this column relates to the charges reported in column 10, regardless of the charity care write off date.

Column 15--Enter contractual allowances, and other amounts such as insurance write-offs, courtesy discounts, and employee discounts. These amounts are not charity care or bad debt but must be included in determining the amount of allowable bad debt.

Column 16--Enter the date the amounts were written off as a bad debt (i.e., written off as a bad debt or implicit price concession) against the A/R (reduction in revenue) in the provider's financial accounting system.

Column 17--Calculate the net patient bad debt amount by computing the ratio of total charges to total charges plus physician/professional charges (column 10 divided by the sum of columns 10 and 11). Apply the ratio to the total payments, discounts, and allowances (columns 12 through 15) and subtract the resulting amount from total charges (column 10).

EXHIBIT 3C

<i>TITLE</i>	<i>TOTAL BAD DEBTS</i>
<i>PROVIDER NAME</i>	
<i>HOSPITAL CCN</i>	
<i>COMPONENT CCN</i>	
<i>CRP BEGINNING DATE</i>	
<i>CRP ENDING DATE</i>	
<i>PREPARED BY</i>	
<i>DATE PREPARED</i>	
<i>TOTAL COLUMN 17</i>	

<i>PATIENT CLAIM INFORMATION</i>					<i>INSURANCE STATUS</i>	<i>PRIMARY PAYOR</i>	<i>SECONDARY PAYOR</i>
<i>PATIENT LAST NAME</i>	<i>PATIENT FIRST NAME</i>	<i>DATE OF SERVICE - FROM</i>	<i>DATE OF SERVICE -TO</i>	<i>PATIENT ACCT NUMBER</i>			
<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>

<i>SERVICE INDICATOR (IP / OP)</i>	<i>TOTAL CHARGES</i>	<i>TOTAL PHYSICIAN / PROFESSIONAL CHGS</i>	<i>TOTAL PATIENT PAYMENTS</i>	<i>TOTAL THIRD PARTY PAYMENTS</i>	<i>PATIENT CHARITY CARE AMOUNT</i>	<i>CONTRACTUAL ALLOWANCE / OTHER AMOUNT</i>	<i>A/R WRITE OFF DATE</i>	<i>PATIENT BAD DEBT WRITE OFF AMOUNT</i>
<i>9</i>	<i>10</i>	<i>11</i>	<i>12</i>	<i>13</i>	<i>14</i>	<i>15</i>	<i>16</i>	<i>17</i>