4012.2 Part II - Hospital.--This part provides for the collection of uncompensated and indigent care data only for inpatient and outpatient services billable under the *1886(d)* hospital CCN. The data reported on this part is a subset of the data reported on Part I. For a cost reporting period beginning on or after October 1, 2022, an §1886(d) hospital, including a subsection (d) Puerto Rico hospital under §1886(n)(6)(B), reports uncompensated and indigent care data for the hospital CCN only. Do not include data for services provided by any other part of the hospital complex, e.g., psychiatric unit, SNF, HHA, ESRD, etc. *Do not complete this Part II if the hospital is a CAH*.

Uncompensated and Indigent Care Cost-to-Charge Ratio--

Line 1--Enter the CCR resulting from Worksheet C, Part I, line 202, column 3, minus lines 40, 41, 42, 44, 45, 46, 88, 89, 94, 99, 101, 115, and 116, column 3; divided by Worksheet C, Part I, line 202, column 8, minus lines 40, 41, 42, 44, 45, 46, 88, 89, 94, 99, 101,115, and 116, column 8.

For all inclusive rate no-charge-structure providers, enter your ratio as calculated in accordance with CMS Pub. 15-1, chapter 22, §2208.

Lines 2 through 19--Do not complete.

Uncompensated care cost--

Line 20--Enter, in columns 1 and 2, the portion of the charity care charges and uninsured discount amounts reported on Worksheet S-10, Part I, line 20, for the general short-term hospital inpatient and outpatient services billed under the hospital CCN. In column 3, enter the sum of columns 1 and 2.

Line 21--Calculate the cost for charity care and uninsured discounts. In column 1, calculate the cost of uninsured patients approved for charity care and uninsured discounts by multiplying line 20, column 1, by the CCR on line 1. In column 2, enter the cost of insured patients approved for charity care calculated as the sum of the deductibles and coinsurance not subject to the CCR on line 1 for insured patients approved for charity care (line 20, column 2, minus lines 25 and 25.01) plus the non-covered charges for insured patients for days exceeding a length-of-stay limit and charges for insured patients' liability that are subject to the CCR on line 1 (lines 25 and 25.01, multiplied by line 1). In column 3, enter the sum of columns 1 and 2.

Line 22--Enter, in columns 1 and 2, the portion of the payments reported on Worksheet S-10, Part I, line 22, for the general short-term hospital inpatient and outpatient services billed under the hospital CCN. In column 3, enter the sum of columns 1 and 2.

Line 23--Calculate the cost of charity care for columns 1 and 2 by subtracting line 22 from line 21. For columns 1 and 2, if the amount on line 22 is greater than line 21, enter zero. In column 3, enter the sum of columns 1 and 2.

Line 24--Enter "Y" for yes if any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported on line 20, column 2, and complete line 25. Otherwise, enter "N" for no.

Line 25--If you answered yes to question 24, enter the portion of the charges reported on Worksheet S-10, Part I, line 25, for the general short-term hospital inpatient and outpatient services billed under the hospital CCN. The charges entered on this line are subject to the CCR and must also be reported in the amount on line 20, column 2.

Line 25.01--Enter the portion of the charges reported on Worksheet S-10, Part I, line 25.01, for the general short-term hospital inpatient and outpatient services billed under the hospital CCN. The charges entered on this line are subject to the CCR and must also be reported in the amount on line 20, column 2.

Line 26--Enter the portion of the charges reported on Worksheet S-10, Part I, line 26, for the general short-term hospital inpatient and outpatient services billed under the hospital CCN.

Line 27--Enter the Medicare reimbursable (also referred to as adjusted) bad debts, including PARHM demonstration, pursuant to 42 CFR 413.89(h). The amount reported must be the sum of the amounts reported on the hospital Worksheet E, Part A, line 65; PARHM demonstration Worksheet E, Part A, line 65; the hospital Worksheet E, Part B, line 35; and PARHM demonstration Worksheet E, Part B, line 35.

Line 27.01--Enter the Medicare allowable bad debts, including PARHM demonstration. The amount reported must be the sum of the amounts reported on the hospital Worksheet E, Part A, line 64; the PARHM demonstration Worksheet E, Part A, line 64; the hospital Worksheet E, Part B, line 34; and the PARHM demonstration Worksheet E, Part B, line 34.

Line 28--Calculate the non-Medicare bad debt amount by subtracting line 27.01 from line 26.

Line 29--Calculate the non-Medicare and nonreimbursable Medicare bad debt amount as the sum of:

- non-Medicare bad debt amount on line 28 multiplied by the CCR on line 1, plus
- nonreimbursable Medicare bad debt amount calculated by subtracting line 27 from line 27.01 (this amount is not multiplied by the CCR on line 1).

Line 30--Calculate the cost of uncompensated care by entering the sum of line 23, column 3, and line 29.

Line 31--Calculate the cost of unreimbursed and uncompensated care as the sum of line 19 and line 30.

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, Part I, 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 hospitals 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, 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

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

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

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

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, Part I, 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

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

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

SERVICE INDICATOR (IP / OP)	TOTAL CHARGES	TOTAL PHYS-ICIAN / PROFES-SIONAL CHGS	TOTAL PATIENT PAYMENTS	TOTAL THIRD PARTY PAYMENTS	PATIENT CHARITY CARE AMOUNT	CONTRACTUAL ALLOWANCE / OTHER AMOUNT	A/R WRITE OFF DATE	PATIENT BAD DEBT WRITE OFF AMOUNT
9	10	11	12	13	14	15	16	17