UTAH DEPARTMENT OF HEALTH

REVIEW OF THE UTAH DEPARTMENT OF HEALTH'S MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS PROGRAM

Independent Accountants' Report on
Applying Agreed Upon Procedures

Medicaid State Plan Rate Year
Ending September 30, 2006

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Independent Accountants' Report on Applying Agreed-Upon Procedures

To Michael Hales – Director, Division of Medicaid and Health Financing:

We have performed the procedures enumerated in the attached schedule, which were agreed to by the Utah Department of Health (UDOH or the State), solely to assist in evaluating the State of Utah's compliance with the six verifications outlined in the *Medicaid Program; Disproportionate Share Hospital (DSH) Payments; Final Rule - 42 CFR Parts 447 and 455* (Final Rule) during the Medicaid State Plan rate year ending September 30, 2006. Management is responsible for the State'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. The sufficiency of these procedures is solely the responsibility of those parties specified in this report.

The procedures we performed and the results of those procedures are outlined in the attached *Schedule of Agreed-Upon Procedures.*

We were not engaged to and did not conduct an examination, the objective of which would be an expression of an opinion on compliance. 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 UDOH, the Centers for Medicare and Medicaid Services, and the Utah hospitals which received DSH payments, and is not intended to be and should not be used by anyone other than these specified parties.

Carver Florek & James, CPA's

September 30, 2010

UTAH DEPARTMENT OF HEALTH
Schedule of Agreed-Upon Procedures
Medicaid State Plan Year Ended September 30, 2006

VERIFICATION 1 – DSH Payment Retention

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.

BACKGROUND

DSH payment eligibility is established under *Section 1923 of the Social Security Act* and *Attachment 4.19-A* of the *Utah State Plan under Title XIX of the Social Security Act Medical Assistance Program* (State Plan). Generally, in order to qualify for DSH payments, hospitals must have a Medicaid inpatient utilization rate (MIUR) of at least one percent and have at least two obstetricians (OB) who have staff privileges and agree to provide such services to individuals entitled to medical assistance. In addition, hospitals must have either a MIUR of at least 14 percent or a low income utilization rate (LIUR) of at least 25 percent to qualify. However, certain rural hospitals need only have a MIUR of at least one percent and provide OB services in order to qualify.

PROCEDURES AND RESULTS

We examined the survey obtained from each hospital, which documented the DSH eligibility requirements. We traced the MIUR and LIUR calculations reported in the survey to supporting documentation provided by the hospitals. We also verified that each hospital provided the names of the obstetricians, or other qualified physicians who provided obstetric services in rural communities, as required under the Final Rule and the State Plan.

Results:
All hospitals receiving DSH payments qualified for the payments during the Medicaid State Plan rate year ended September 30, 2006.

We determined the total state-wide DSH allotment as reported in the *Federal Register Vol. 72, No. 248* and quantified actual DSH expenditures reported by the State in the CMS 64 reports for the period.

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Schedule of Agreed-Upon Procedures

Medicaid State Plan Year Ended September 30, 2006

We compared DSH funds received by the State to DSH payments made to the various hospitals. We also reconciled DSH payments reported by the hospitals to the State's records, and resolved differences where differences were initially reported. In addition, we obtained written representation from hospital management in the survey verifying that each hospital retained its full DSH payment. We also examined documentation supporting any out-of-state DSH payments reported by the hospitals.

Results:

We noted that total DSH payments as reported on the CMS 64 reports agreed to the allowable state-wide DSH allotment per the Federal Register Vol. 72, No. 248, and that the DSH payments per the CMS 64 reports agreed with the actual payments to the states, with the exception of the IMD hospital. For the State's IMD hospital, the DSH payment in the CMS 64 report totaled $934,583, while the actual payment to the hospital amounted to $758,670.

As part of the survey, all of the hospitals confirmed that they were allowed to retain 100 percent of the DSH payments received to offset their uncompensated care cost for providing hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage.

Exhibit 1 (column 17) presents verified DSH payments by hospital for the Medicaid State Plan rate year ended September 30, 2006.

VERIFICATION 2 – Uncompensated Care vs. DSH Payments

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 that audited Medicaid State Plan rate year must be measured against the actual uncompensated care cost in that same audited Medicaid State Plan rate year.

PROCEDURES AND RESULTS

We compared the DSH payments with the uncompensated care costs for the Medicaid State Plan rate year ended September 30, 2006, and noted any hospitals where DSH payments exceeded the hospital-specific uncompensated care costs. We compared DSH payments for the period with the hospital-specific DSH payments against limits set forth in the State Plan.

Results:
We noted that 18 of the 34 eligible hospitals reported DSH payments that exceeded the hospital's reported uncompensated care costs for the period. Excess DSH payments aggregated approximately $15.5 million. The State-owned teaching hospital totaled $13.2 million. With the exception of the State-owned teaching hospital, excess DSH payments ranged by hospital from approximately $1,000 to $1.0 million. For the remaining 15 hospitals, excluding the IMD for which the DSH payment is limited under the Federal Register, aggregate uncompensated costs exceeded DSH payments by approximately $26.5 million.

The hospital DSH survey required each provider to report uncompensated care costs for the Medicaid State Plan rate year ending September 30, 2006. In order to report uncompensated care costs for the period, charge and payment information was determined for the Medicaid State Plan rate year and hospitals used two or more *Medicare 2552-96 hospital cost reports* (MCR) when their reporting periods did not correspond with the Medicaid State Plan rate year. We compiled DSH payments for the year ended September 30, 2006, and measured against uncompensated care costs for that same period.

Results:
The DSH survey completed by each hospital verified DSH payments were measured against actual uncompensated care costs for that same Medicaid State Plan year ended September 30, 2006.

Exhibit 1 (columns 16 and 17) presents verified total uncompensated care costs and total DSH payments, by hospital, for the Medicaid State Plan year ended September 30, 2006.

VERIFICATION 3 – Qualifying Uncompensated Care and the DSH Payment

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.

BACKGROUND

For purposes of the DSH review, hospitals were required to report uncompensated care costs for patients eligible for Medicaid benefits and other uninsured individuals using a comprehensive survey, developed jointly by Carver Florek & James, CPA's and the State, following the cost principles outlined in the Final Rule and the *General DSH Audit and Reporting Protocol - CMS-2198-F*. All hospitals that received DSH monies prepared and submitted a survey to document their hospital-specific DSH limit. The survey included discrete sections to report uncompensated costs for furnishing inpatient and outpatient hospital services to in-state Medicaid-funded patients, out-of-state Medicaid-funded patients, and other patients with no source of third-party coverage. The primary source documents used to develop cost and payment information for the DSH survey included Medicaid Management Information System (MMIS) data provided by the State, hospital billing records and other hospital accounting information for the uninsured and Medicaid out-of-state, and the MCR.

Our verification procedures were tailored based on the type of hospital and the nature and availability of hospital records as well as the magnitude of DSH payments received during the year. For verification purposes, hospitals were broken out into the following five categories: (1) State-owned teaching hospital, (2) State-owned Institution for Mental Diseases (IMD), (3) Other government-owned rural hospitals, (4) Urban and rural privately owned hospitals that received DSH payments in excess of $100,000 via an add-on to their normal Diagnostic Related Group (DRG) payment, and (5) Urban and rural privately owned hospitals that received DSH payments in amounts less than $100,000 via an add-on to their normal DRG payment.

Exhibit 1 (column 16) presents verified total uncompensated care costs, by hospital, for the Medicaid State Plan year ended September 30, 2006.

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Schedule of Agreed-Upon Procedures

Medicaid State Plan Year Ended September 30, 2006

PROCEDURES AND RESULTS

State-owned teaching hospital

Utah has one state-owned teaching hospital that received DSH funds during the year. The hospital utilized internal hospital billing records for Medicaid in-state and out-of-state claims and payments. This was necessary primarily in order to present charges on a basis consistent with the manner in which cost-to-charge ratios were developed in the MCR.

We obtained and reviewed the hospital's DSH survey for the Medicaid State Plan rate year ended September 30, 2006, which reported uncompensated care costs for the period. We traced charge and payment information in the survey to detail data files maintained by the hospital that supported charges for Medicaid in-state, Medicaid out-of-state, and uninsured patients. We examined a selection of claims from detail charge data for each of the three categories of patients. We verified days and charge information by examining billing and other hospital accounting records. We verified Medicaid eligibility for Medicaid patients and reconciled Medicaid claims to the State's MMIS for consistency with the State data. We confirmed Medicaid out-of-state eligibility, charges and payments with the other states.

For uninsured patients, we examined the claims' financial class and reviewed other billing records searching for evidence of third-party insurance to verify the "uninsured" status of the claim.

Due to data limitations, stemming from the passage of time, charges by cost center location were not available prior to the hospital's fiscal year ended 2008. Accordingly, charges for purposes of the 2006 survey were mapped to the respective cost centers using service patterns from the hospital's fiscal year ended 2008. We examined the allocation of charges among cost centers by verifying the source of a sample of charges by cost center from the fiscal 2008 data and tested the integrity of the allocation formulas.

We traced per diems and cost-to-charge ratios (used in the survey to quantify cost) to the applicable MCRs. Organ acquisition costs were verified using hospital records and other cost data from the MCRs. IME and DGME costs were traced to an analysis prepared by the hospital and source MCR data.

Results:

We noted that the survey submitted by the hospital initially included Medicaid claims with no payment in both the Medicaid in-state and uninsured uncompensated care calculations. In addition, a certain number of uninsured claims reported under the excepted benefits described in 45 CFR §146.145 had already been included in the uninsured calculation. We also noted that uncompensated care costs for some prisoners and other ineligible patients were initially included in the charges and payments used to develop uncompensated care. We verified that the hospital revised the survey and that these items were excluded from uncompensated care costs reported on Exhibit 1 (column 16).

No other significant exceptions were noted that represented departures from the approved methodology for calculating uncompensated care costs.

State-owned IMD hospital

Utah has one state-owned IMD hospital that received DSH payments during the period. The IMD hospital has little, if any, in-state Medicaid uncompensated care costs as the hospital undergoes an annual Medicaid cost settlement with the State of Utah. Further, the hospital did not provide services to any out-of-state Medicaid patients during the period. Accordingly, only individuals with no third-party coverage were included in the determination of the hospital-specific DSH limit.

We obtained and reviewed the hospital's DSH survey for the Medicaid State Plan rate year ended September 30, 2006, which reported uncompensated costs for the period. Uninsured days were determined by the hospital by taking total days, as reported in the hospital's accounting records, and removing any days related to Medicaid, Medicare, or forensic (prison) patients. We traced the total days to the hospital's accounting records. We traced Medicare and Medicaid days to the MCR and forensic patients' days to supporting documents provided by the hospital. The uninsured days were reduced by a factor representing an estimate of days with some form of third-party liability (TPL) insurance. The TPL factor was conservatively estimated by calculating the ratio of days with any form of payment (TPL, self-pay, or otherwise), and dividing it by the total days for the period. Days with any form of payment were traced to reports from the hospital's billing system.

Uninsured ancillary charges were determined by taking the ratio of uninsured days to total days and applying this ratio to the cost center specific ancillary charges in the MCR. We traced total charges to the MCRs and the uninsured ratio to supporting documents provided by the hospital. The ancillary charges were also reduced by the TPL factor.

We traced per diems and cost-to-charge ratios (used to quantify cost in the survey) to the applicable MCR amounts.

Results:
We noted claims with third-party coverage were initially included in the uninsured uncompensated care costs reported in the survey. We verified that the hospital revised the survey and that these items were excluded from uncompensated care costs reported on Exhibit 1 (column 16).

No other significant exceptions were noted that represented departures from the approved methodology for calculating uncompensated care costs.

Other government-owned rural hospitals

We obtained and reviewed the hospital's DSH survey for the Medicaid State Plan rate year ended September 30, 2006, which reported uncompensated care costs for the period.

We traced day, charge and payment data stemming from claims for Medicaid patients to data derived from the State's MMIS, where applicable.

We examined days and charges summarized by revenue code from the MMIS for consistency with the mapping of days and charges to cost centers in the survey.

We examined a selection of claims for Medicaid out-of-state and uninsured patients and traced the claims to hospital billing and other accounting records to verify that only eligible days and charges were included in the hospital-specific DSH limit.

We traced per diems and cost-to-charge ratios (used to quantify cost in the survey) to the applicable MCR amounts.

Results:
We noted that for some hospitals, uncompensated care costs initially included disallowed physician costs, bad debt and clinic and finance charges. In addition, we discovered claims with third-party coverage in the uninsured uncompensated care costs calculation. We verified that the hospitals revised the surveys, and that these items were excluded from uncompensated care costs reported on Exhibit 1 (column 16).

We noted that one of the seven hospitals was unable to determine the Medicaid out-of-state and uninsured uncompensated care costs as the files had been purged from the hospital's system. Attempts to restore the charge and payment detail were ineffective as the data files were unrecoverable. Therefore, uncompensated care costs for that hospital was limited to Medicaid eligible patients based on the information available. See Exhibit 1 (footnote 6).

No other significant exceptions were noted that represented departures from the approved methodology for calculating uncompensated care costs.

Urban and rural private hospitals that received DSH payments in excess of $100,000 via an add-on to their normal DRG payment

We obtained and reviewed the hospitals' DSH survey for the Medicaid State Plan rate year ended September 30, 2006, which reported uncompensated costs for the period.

We traced day, charge and payment data stemming from claims for Medicaid patients to data derived from the State's MMIS, where applicable. In additon, some hospitals reported Medicaid Managed Care (MCO) and Primary Care Network (PCN) days from their internal accounting systems, as the information was not available from MMIS. Inpatient days were traced to hospitals' accounting records.

We examined days and charges summarized by revenue code from the MMIS for consistency with the mapping of days and charges in the survey.

We examined a selection of claims for uninsured patients and traced the claims to hospital billing and other accounting records to verify that only eligible days and charges were included in the hospital-specific DSH limit.

We traced per diems and cost-to-charge ratios (used to quantify cost in the survey) to the applicable MCR amounts. We traced organ acquisition and IME/DGME costs and related payments to supporting documentation provided by the hospitals and MCRs, as applicable.

Results:

We noted one hospital where non-hospital-based service costs not covered under the State Plan were included in uncompensated care costs reported in the survey. We verified that the hospital revised the survey and that these items were excluded from uncompensated care costs reported on Exhibit 1 (column 16).

No other significant exceptions were noted that represented departures from the approved methodology for calculating uncompensated care costs.

Urban and rural privately owned hospitals that received DSH payments in amounts less than $100,000 via an add-on to their normal DRG payment

We obtained and reviewed the hospitals' DSH survey for the Medicaid State Plan rate year ended September 30, 2006, which reported uncompensated care costs for the period.

We traced day, charge and payment data stemming from claims for Medicaid patients to data derived from the State's MMIS, where applicable. Some hospitals reported MCO and PCN days from their internal accounting systems. Inpatient days were traced to hospital accounting records.

We examined days and charges summarized by revenue code from the MMIS for consistency with the mapping of days and charges in the survey.

We traced per diems and cost-to-charge ratios (used to quantify cost in the survey) to the applicable MCR amounts.

Results:

We noted that, in some instances, the hospitals' data contained charges and payments that did not reconcile to the supporting documents provided by the hospitals. We verified that the hospitals revised the survey and that these items were excluded from uncompensated care costs reported on Exhibit 1 (column 16).

In addition, four privately owned hospitals relied upon their internal records to report Medicaid charges and payments, rather than the State's MMIS. The providers noted that by using their records, hospitals were able to consistently report FFS, MCO and PCN charges and payments, correct any payments relating to unknown contractual adjustments and spendown estimates, and reconcile any unknown revenue code classifications. The charge and payment information provided was traced to each hospital's applicable accounting records.

No other significant exceptions were noted that represented departures from the approved methodology for calculating uncompensated care costs.

We noted that one of the 25 hospitals was unable to determine any of the Medicaid out-of-state and uninsured uncompensated care costs as the data files had been purged from their system. See Exhibit 1 (footnote 6).

VERIFICATION 4 – Application of Payments

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.

BACKGROUND

For hospitals in the State of Utah, payments offset against hospital service costs for purposes of the hospital-specific limit included: Medicaid claims payments, Medicaid managed-care payments, Medicaid supplemental payments (UPL, IME, DGME, etc.), third-party payments (including patient co-pays), Medicare regular rate payments, Medicare cross-over (including any patient co-pays, coinsurance and deductibles), Medicare cross-over allowable bad debt payments, and supplemental and enhanced Medicare payments attributable to dual eligible patients (including Medicare DSH, IME and DGME payments).

The State provided the hospitals the fee-for-service (FFS) regular Medicaid rate claims payments made to each DSH hospital from MMIS for the period covering the Medicaid State Plan rate year under review. Using their accounting records, hospitals reported all MCO and PCN information associated with the Section 1115 waiver program including supplemental and enhanced payments applicable to patients eligible for both Medicare and Medicaid.

PROCEDURES AND RESULTS

We examined the surveys obtained from each hospital to verify that all Medicaid payments were reported by the hospitals for the Medicaid State Plan rate year ended September 30, 2006, regardless of the related service cost. Regular FFS Medicaid payments were traced to the MMIS data provided by the State and to each hospital's accounting books and records. MCO and PCN payments were reconciled to the hospitals' accounting books and records. We also confirmed supplemental payments with the State.

Results:
The FFS Medicaid claims payments reported in the survey reconciled to the State's MMIS without exception. In addition, supplemental IME and DGME payments were traced to the State's records without exception.

Many hospitals initially omitted supplemental Medicare payments as they were not aware of the requirement to include such payments. Adjustments were made to each applicable DSH survey to include the Medicare DSH, IME, DGME and allowable bad debt payments applicable to dual eligibles, as required. Accordingly, all available Medicaid payments, including supplemental payments, were included in the revised calculation of the hospital-specific DSH payment limit, or uncompensated care costs outlined in the survey.

Due to the manner in which cost-to-charge ratios are established, *the government-owned teaching hospital relied upon its internal records to report Medicaid charges and payments, rather than the State's MMIS. The charge and payment information provided was traced to applicable accounting records and reconciled to the MMIS, without significant exception.*

In addition, four privately owned hospitals relied upon their internal records to report Medicaid charges and payments, rather than the State's MMIS. The providers noted that by using their records, hospitals were able to correct any payments relating to unknown contractual adjustments and spendown estimates. The charge and payment information provided was traced to each hospital's applicable accounting records.

See Exhibit 1 (columns 6-10) for the verified Medicaid payments by hospital for the Medicaid State Plan rate year ended September 30, 2006.

VERIFICATION 5 – Information and Record Retention

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 42 CFR Section 455.304; and any payments made on behalf of the uninsured from payment adjustments under that Section has been separately documented and retained by the State.

PROCEDURES AND RESULTS

We examined the State's practices regarding document retention in connection with information and records pertaining to regular claimed expenditures (and related payments) by providers under the Medicaid program. Supplemental Medicaid payments including DSH, IME and DGME made to qualifying hospitals, hospital service costs and related payments made on behalf of the uninsured were also evaluated.

Results:
All pertinent records and documentation required to support payment adjustments, as described in 42 CFR §455.304, were available for our review. The primary record documenting uncompensated care costs for Medicaid and uninsured patients was a comprehensive survey developed jointly with the State for the DSH audit, which was submitted by each hospital that received DSH payments during the fiscal year ended September 30, 2006.

The State maintains archived records from the MMIS. The MMIS documents inpatient and outpatient hospital service costs and payments made under the FFS Medicaid in-state program, which supports Medicaid charge and payment information included in the surveys.

The State also retains records of the claims add-on and supplemental DSH payments made by the State, quarterly CMS 64 reports (which contain total DSH expenditures for the period), and copies of the approved State Plan outlining the methodology used by the State to make DSH payments.

VERIFICATION 6 – DSH Payment Limit Methodology

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. 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 hospital service they received.

BACKGROUND

The primary documents which set forth the methodology for calculating each hospital's payment limit under *Section 1923(g)(1) of the Act* include the State Plan and the State's revised hospital survey document, which includes detailed instructions to hospitals and a spreadsheet model based on the approved methodology used to calculate uncompensated care costs.

PROCEDURES AND RESULTS

We reviewed the State Plan for provisions related to the definition of uncompensated care costs. We reviewed *42 CFR - Part 447 and 455, Medicaid Program; Disproportionate Share Hospital Payments; Final Rule,* (Final Rule) and CMS's *General DSH Audit and Reporting Protocol* - CMS-2198-F for rules on quantifying uncompensated costs.

We worked directly with State personnel to develop a comprehensive hospital survey that quantifies uncompensated care costs for hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage using the principles set forth in the Final Rule and CMS's *General DSH Audit and Reporting Protocol (CMS 2198-F).*

Results:
The State Plan defines uncompensated care costs as "the amount of non-reimbursed costs written off as non-recoverable for services rendered to the uninsured, i.e., indigent, and includes the difference between cost of providing services to those eligible for medical assistance under the State Plan and the payment for those services by the State by Medicaid or any other payer."

The instructions which accompany the hospital survey for quantifying uncompensated care costs further clarifies that "uncompensated services for the uninsured include costs incurred for inpatient and outpatient hospital services to individuals with no source of third-party coverage for the hospital services they receive, including all Section 1011 charges for undocumented aliens. The uninsured uncompensated amount cannot include amounts associated with unpaid co-pays or deductibles for individuals with third-party insurance or any other unreimbursed costs associated with inpatient or outpatient services provided to individuals with third-party coverage, but for which such third-party benefit package excludes such services. Nor does uncompensated care cost include bad debt or payer discounts related to services furnished to individuals who have any form of insurance coverage. The total uncompensated care cost for the uninsured includes the cost of furnishing inpatient and outpatient services less any direct or indirect payments from or on behalf of such uninsured individuals." The instructions further specify that prisoners or other wards of the State are not considered uninsured.

The hospital survey includes a methodology for calculating 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 service they received as follows:

1. *Medicaid FFS days and ancillary charges were derived from the State's MMIS and hospital accounting records and assigned to the applicable routine or nonroutine cost centers based on corresponding revenue code data.*

2. *Medicaid managed care days and ancillary charges were derived from hospital accounting records and assigned to the applicable routine or nonroutine cost centers based on corresponding revenue code data.*

3. *Uninsured days and charges were derived from hospital accounting and billing systems and allocated to routine and nonroutine cost centers using allocation methodologies based on service patterns for similar services or other means.*

4. *Total costs were determined by applying cost center days and charges to the respective routine per diems or nonroutine cost-to-charge ratios derived directly from the hospitals' 2552-96 MCRs.*

5. *All regular claims payments, managed care payments or other supplemental Medicaid or Medicare (dual eligible) payments, as well as any uninsured payments, were offset against total costs to determine the amount of total uncompensated care cost.*

UTAH DEPARTMENT OF HEALTH
HOSPITAL DATA SUMMARY SCHEDULE
FOR MEDICAID STATE PLAN RATE YEAR ENDED SEPTEMBER 30, 2006

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
Hospital Name	Estimate of Hospital-Specific DSH Limit (Footnote 2)	Medicaid Inpatient Utilization Rate (MIUR)	Low Income Utilization Rate (LIUR)	State Defined DSH Qualification Criteria	IP/OP Medicaid Fee-For-Service (FFS) Basic Rate Payments	IP/OP Medicaid Managed Care Organization Payments	Supplemental /Enhanced Medicaid IP/OP Payments	Medicare Supplemental Settlements	Total Medicaid IP/OP Payments	Total Cost of Care for Medicaid IP/OP Services	Total Medicaid In-State & Out-Of-State Uncompensated Care	Uninsured IP/OP Revenues (Footnote 3)	Total Cost of IP/OP Care for the Uninsured	Total Uninsured IP/OP Uncompensated Care Costs	Total Annual Uncompensated Care Costs (Footnote 4 & 5)	Medicaid Disproportionate Share Hospital Payments
Allen Memorial Hospital	$ 469,949	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	$ 1,719,481	$ -	$ -	$ -	$ 1,719,481	$ 1,801,147	$ 81,666	$ 60,245	$ 480,506	$ 420,261	$ 501,927	$ 469,950
American Fork Hospital	20,651	16.15%	12.60%	Qualifies. See Footnote (1)(b).	6,832,050	477,336	-	552	7,309,938	6,109,120	(1,200,818)	1,029,027	2,067,399	1,038,372	(162,446)	20,651
Ashley Regional Medical Center	25,995	17.66%	14.35%	Qualifies. See Footnote (1)(b).	2,985,999	-	-	(3,168)	2,982,831	2,229,694	(753,137)	627,705	1,197,052	569,347	(183,790)	25,995
Bear River Valley Hospital	1,666	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	470,067	-	-	1,014	471,081	467,878	(3,203)	301,611	411,543	109,932	106,729	1,666
Beaver Valley Hospital	458,531	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	876,764	20,085	-	(494)	896,354	1,317,494	421,140	-	290,921	290,921	712,061	458,532
Brigham City Hospital	19,088	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	2,767,810	260,715	-	1,330	3,029,855	2,735,679	(294,176)	122,694	700,175	577,481	283,305	19,088
Castleview Hospital	58,958	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	7,078,205	-	-	(13,519)	7,064,686	4,563,927	(2,500,759)	380,173	563,353	183,180	(2,317,579)	58,958
Central Valley Medical Center	29,895	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	2,353,183	-	-	-	2,353,183	1,923,697	(429,486)	169,173	748,917	579,744	150,257	29,895
Delta Community Medical Center	12,812	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	846,036	-	-	-	846,036	736,869	(109,167)	87,903	199,536	111,633	2,465	12,812
Dixie Medical Center	66,418	17.72%	13.91%	Qualifies. See Footnote (1)(b).	19,225,053	1,766,136	-	20,729	21,011,918	21,296,230	284,311	2,585,678	8,429,172	5,843,495	6,127,806	66,418
Fillmore Hospital	10,059	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	671,820	-	-	-	671,820	595,083	(76,737)	60,387	212,905	152,518	75,781	10,059
Garfield Memorial Hospital	410,481	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	405,735	6,074	-	(18,448)	393,362	485,947	92,586	99,610	231,231	131,621	224,207	410,481
Gunnison Valley Hospital	438,102	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	1,389,440	-	-	163	1,389,603	1,251,031	(138,571)	194,520	259,950	65,430	(73,142)	438,102
Heber Valley Medical Center	22,797	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	1,192,868	25	-	(1,415)	1,191,478	980,438	(211,040)	286,897	519,506	232,609	21,569	22,797
Intermountain Medical Center	148,654	14.86%	15.85%	Qualifies. See Footnote (1)(b).	38,787,229	2,997,481	1,340,511	36,333	43,161,554	37,179,695	(5,981,859)	2,786,061	19,904,640	17,118,579	11,136,720	148,654
Kane County Hospital	454,131	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	661,559	-	-	220	661,779	905,947	244,168	44,021	343,278	299,257	543,425	454,132
Logan Regional Medical Center	37,693	26.26%	16.32%	Qualifies. See Footnote (1)(b).	11,164,918	514,071	-	25,202	11,704,191	10,278,290	(1,425,901)	1,204,875	2,722,180	1,517,305	91,404	37,693
McKay Dee Hospital	97,070	23.71%	18.70%	Qualifies. See Footnote (1)(b).	28,846,958	4,607,051	629,830	42,998	34,126,837	29,345,313	(4,781,525)	1,508,264	10,015,606	8,507,342	3,725,817	97,070
Milford Valley Memorial Hospital	225,104	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	25,013	-	-	-	25,013	38,271	13,258	-	24,912	24,912	38,170	225,104
Mountain View (Columbia) Hospital	8,433	24.88%	12.71%	Qualifies. See Footnote (1)(b).	4,006,442	3,452,261	-	(1,654)	7,457,049	6,781,735	(675,315)	562,938	1,779,621	1,216,683	541,369	8,433
Mountain West Medical Center	52,818	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	5,417,573	-	-	1,958	5,419,532	3,270,595	(2,148,937)	359,739	1,402,203	1,042,464	(1,106,473)	52,818
Orem Community Hospital	8,591	31.60%	18.41%	Qualifies. See Footnote (1)(b).	3,332,719	133,563	-	-	3,466,282	3,416,573	(49,709)	349,630	836,369	486,738	437,029	8,591
Pioneer Valley Hospital	22,474	42.35%	0.00%	Qualifies. See Footnote (1)(b).	17,367,571	-	-	(19,322)	17,348,249	13,032,127	(4,316,122)	-	1,303,120	1,303,120	(3,013,002)	22,474
Primary Childrens Medical Center	685,046	36.92%	28.78%	Qualifies. See Footnote (1)(b).	48,115,964	25,778,819	2,435,948	-	76,330,732	76,845,899	515,168	998,265	4,744,092	3,745,827	4,260,995	813,906
Salt Lake Regional Medical Center	17,732	24.12%	0.00%	Qualifies. See Footnote (1)(b).	9,637,760	-	-	(14,310)	9,623,450	7,263,618	(2,359,832)	-	1,603,356	1,603,356	(756,475)	17,732
San Juan Hospital	1,036,694	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	1,637,871	-	-	(2,121)	1,635,750	1,572,062	(63,688)	See Footnote (6).	See Footnote (6).	See Footnote (6).	(63,688)	1,036,694
Sanpete Valley Hospital	39,640	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	2,058,909	-	-	-	2,058,909	1,518,584	(540,325)	223,780	392,273	168,493	(371,832)	39,640
Sevier Valley Medical Center	16,925	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	3,174,670	-	-	(20,868)	3,153,802	2,506,384	(647,419)	305,334	545,387	240,053	(407,366)	16,925
St Mark's Hospital	30,663	20.90%	9.43%	Qualifies. See Footnote (1)(b).	13,177,944	15,199,044	317,975	92,540	28,787,503	21,979,831	(6,807,672)	2,478,306	7,312,520	4,834,214	(1,973,458)	30,663
Uintah Basin Medical Center	90,745	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	4,374,499	-	-	10,144	4,384,643	3,616,554	(768,089)	See Footnote (6).	See Footnote (6).	See Footnote (6).	(768,089)	90,745
University Of Utah Hospital	13,193,582	29.90%	19.16%	Qualifies. See Footnote (1)(b).	87,951,458	-	72,711,915	2,160,885	162,824,258	121,183,517	(41,640,741)	15,834,343	50,908,076	35,073,733	(6,567,008)	13,193,582
Utah Valley Regional Medical Center	151,601	23.75%	19.09%	Qualifies. See Footnote (1)(b).	37,566,703	4,686,541	814,159	2,474	43,069,876	37,358,427	(5,711,449)	2,009,114	8,350,709	6,341,595	630,146	151,601
Valley View Medical Center	84,914	N/A. See Footnote (1)(a).	N/A. See Footnote (1)(a).	Qualifies. See Footnote (1)(a).	6,133,137	938,717	-	(21,147)	7,050,708	5,530,203	(1,520,505)	639,958	1,658,405	1,018,446	(502,059)	84,914
Utah State Hospital (IMD)	934,586	19.17%	105.01%	Qualifies. See Footnote (1)(b).								581,395	17,597,799	17,016,403	17,016,403	758,670

Footnotes:

(1). Utah State Plan DSH qualification criteria: (a). Rural Hospitals- All rural hospitals qualify automatically for DSH. (b). Urban, Teaching & State Hospitals- Must have met I and II and either III or IV. I. Have a MIUR of at least 1%. II. Have at least 2 obstetricians who have staff privileges & agree to provide these services to individuals entitled to "medical assistance". III. Have a MIUR of at least 14%. IV. Have a LIUR of at least 25%.

(2). The hospital-specific DSH limit is the lower of the cap set forth in the State Plan or the actual DSH payment for the hospital's estimated uncompensated care costs less any out-of-state DSH monies paid for the Medicaid State Plan rate year ended September 30, 2006. The State IMD DSH limit is set under Federal Register Vol. 72, No. 248.

(3). No applicable Section 1011 payments were reported by the hospitals.

(4). Uncompensated care is defined as the amount of non-reimbursed costs written off as non-recoverable for services rendered to the uninsured, i.e., indigent, and includes the difference between cost of providing services to those eligible for medical assistance under the State Plan and the payment for those service by the State by Medicaid or any other payer. Uncompensated care also includes, costs incurred for inpatient and outpatient hospital services to individuals with no source of third-party coverage for the hospital services they receive, including all Section 1011 charges for undocumented aliens. The uninsured uncompensated amount cannot include amounts associated with unpaid co-pays or deductibles for individuals with third-party insurance or any other unreimbursed costs associated with inpatient or outpatient services provided to individuals with third-party coverage, but for which such third-party benefit package excludes such services. Nor does uncompensated care cost include bad debt or payer discounts related to services furnished to individuals who have any form of insurance coverage. The total uncompensated care costs for the uninsured includes the cost of furnishing inpatient and outpatient services less any direct or indirect payments from or on behalf of such uninsured individuals. Prisoners or other wards of the State are not considered uninsured.

(5). Negative uncompensated care amounts represent total payments in excess of total hospital service costs for Medicaid eligible and uninsured patients.

(6). Uncompensated care costs were limited to Medicaid in-state eligible patients. The hospital was unable to identify specific Medicaid out-of-state and uninsured charges and payments.

EXHIBIT 1