Myers and Stauffer LC

Certified Public Accountants
9265 Counselors Row, Suite 200
Indianapolis, Indiana 46240-6419

June 14, 2007

«provname»
Attn: «pcontact»
«paddress1»
«pcity», «pstate» «pzip»

Article Number: «DHL»
Return Receipt Requested

Provider Number: «medicaid»

Dear _____:

Please find the enclosed survey form that must be completed in order to determine Indiana Medicaid Disproportionate Share Hospital (DSH) eligibility for the State Fiscal Years ended June 30, 2006 and June 30, 2007.

The DSH Survey Section must be completed and postmarked no later than August 14, 2007. Please compare information already entered into the survey for accuracy and provide support for any changes or additions. Please note that timely and accurate completion of the enclosed survey will expedite the completion of DSH eligibility and payment distributions.

Please complete and return the attached survey to the address below. Surveys must be postmarked no later than August 14, 2007. This will be the only notification sent concerning the deadline. No second notifications will be sent. If the response to the survey is not received by the deadline, your facility will be deemed ineligible for DSH payments for SFY 2006 and 2007.

A diskette containing claims data may accompany this letter. If this letter does not contain a claims disk, Myers and Stauffer has identified your facility as having a change in ownership since the time the claims were incurred. As such, we are in need of additional information from your facility before we can release claims data to you. Please call Roger Sell or Melenie Burns by telephone at (800) 877-6927 or (317) 846-9521.

For those hospitals receiving a diskette with this letter, please note that the claims data has been encrypted and the files are password protected. Please e-mail Myers and Stauffer at claimsrequest@mslc.com to receive your password. To ensure that only authorized users obtain

access to your claims data, the password request must be sent by the addressee of this letter and it must be sent from your facility's e-mail domain. Your hospital's password will be e-mailed to you once your identity has been confirmed. Once your password is obtained, WinZip software is required to access and decrypt the claims data. A free evaluation version of the software may be downloaded from the WinZip website at http://www.winzip.com/downwz.htm. This site provides installation information, or you may contact Myers and Stauffer at claimsrequest@mslc.com for additional assistance.

Should you have any questions related to the survey, please do not hesitate to contact Melenie Burns or Roger Sell by telephone at (800) 877-6927 or (317) 846-9521.

Sincerely,

Myers and Stauffer

OFFICE OF MEDICAID POLICY AND PLANNING
DISPROPORTIONATE SHARE (DSH) ELIGIBILITY SURVEY
June 12, 2007

The enclosed survey is designed to collect the information necessary to administer the Indiana Medicaid Disproportionate Share program. This survey will be used to determine ***DSH eligibility and payment for State Fiscal Years (SFY) 2006 and 2007. Your facility must have been in operation and participating in the Medicaid program during the SFY for which payment is being made in order to be eligible for DSH participation.*** According to our records, your survey information should be taken from the Medicaid cost report for your facility's fiscal year ended during SFY 2004, which is July 1, 2003 to June 30, 2004.

This survey is **mandatory** and must be completed by each facility in its entirety. As a condition of participation in the Medicaid program, you are required, pursuant to Paragraph 24 of your provider agreement, to submit to the Office of Medicaid Policy and Planning (OMPP) any information it deems necessary for the program. Please be advised the OMPP considers completion of this survey essential for the efficient operation and proper administration of the Medicaid program. In order to properly evaluate statewide participation and eligibility for DSH in accordance with State and Federal regulations, survey information is required from all Indiana hospitals, even from those ineligible for DSH in the past.

Please complete and return the attached survey to the address postmarked no later than August 14, 2007. This will be the only notification sent concerning the deadline. No second notifications will be sent. If the response to the survey is not postmarked by the deadline, your facility will be deemed ineligible for DSH payments for SFYs 2006 and 2007. The only information submitted by your facility which will be included in your facility's DSH eligibility calculation, is on a survey submitted by August 14, 2007. Information received from your facility that is postmarked after the due date will not result in increased Medicaid days, payments, or charges, etc. being included in the facility's Medicaid inpatient utilization rate or Low income utilization rate (the ratios used to determine DSH eligibility.) In addition, failure to complete the survey may be considered a breach of the Medicaid provider agreement. If extenuating circumstances will prevent you from meeting the filing deadline, please contact Myers and Stauffer immediately at (317) 846-9521 or (800) 877-6927. You may also contact us at the following address:

Myers and Stauffer LC
Attention: Melenie Burns or Roger Sell
9265 Counselors Row, Suite 200
Indianapolis, Indiana 46240-6419

For survey questions that ask for summary and/or supporting documentation, attach the required information. **This information must be provided in the form of an Excel spreadsheet submitted on disk, in the format presented in Exhibit A.** All documentation should be referenced back to the pertaining survey question. **Please maintain all source documentation used to complete the survey, as additional information (i.e., remittance advices, patient listings, etc.) may be requested to verify your numbers.** All providers are asked to compare the information already completed on the survey for accuracy. Please make any needed corrections and submit

documentation to support the correction. Please be advised that any questions that require support but do not have the required documentation **will not be used in the calculations** for DSH eligibility or payment.

Thank you for your cooperation in completing this survey.

General Instruction

1. The requested data should be provided for the same period as your facility's cost reporting period that ends in State Fiscal Year 2004 (July 1, 2003 - June 30, 2004.)

2. Payments received should represent those payments that are received for dates of service within the reporting period. Therefore uninsured, out-of-state, and other data will match the service period of the Medicaid data from the Medicaid Claims Report.

3. This survey requires support for several items listed. Such reports should include the patient name, Medicaid number, and dates of service, as well as any additional information requested. If any of the information included in the form is incorrect, provide the correct number as well as information to support the corrected amount. All support must be submitted in the form of an Excel document on disk, using the format in Exhibit A.

   Please provide a patient listing for any additional Medicaid eligible services provided in addition to those included in the claims report received from Myers and Stauffer. The patient listing should include patient names, Medicaid numbers, dates of services, and patient days. The report should not include any Medicaid days already included in the paid days report. This report should be submitted in the form of an Excel document on disk, using the format in Exhibit A.

   Unsupported days and payments will not be used. Additional documentation to support a sample from this patient listing for Medicaid eligible services may be requested.

4. Supporting documentation for all data elements must be maintained. This supporting documentation does not need to be remitted with your survey form, but must be available immediately upon request by the Office of Medicaid Policy and Planning.

Section A

1. Section A of the survey document is used to collect Medicaid eligible days and any payments received (Inpatient and Outpatient) for services provided to Indiana and any other state's Medicaid patients. Include routine, newborn, subprovider, special units (ICU, CCU, etc.) and out-of-state services. Include patient services, even if reimbursed by Indiana Medicaid as an outpatient visit due to the stay being less than twenty-four (24) hours. These services should be identified on your patient listing as falling under the twenty-four (24) hour rule, or a separate listing of these services should be included as support.

   Do not include services for patients in LTC (long-term care), SNF (skilled nursing facility), ICF/MR (intermediate care facility/mentally retarded), RTC (residential treatment care), Swing beds, non-hospital service areas or HCI (hospital care for the indigent) days. **Do not** include services attributable to Medicaid patients between the

ages of 21 and 65 in Institutions for Mental Disease with 17 or more licensed beds. **Do not** include any crossover services or services for a patient that was eligible for both Medicaid and Medicare Part A. Do not include Title XXI CHIP.

2. Any out-of-state services reported must be supported, upon request, by an Excel report using the format in Exhibit A. Verification of supporting documentation (such as paid claims summaries, EOB's, or RIA's) may occur. Reports or supporting documentation from the State Agency (or their fiscal agent) is preferred.

3. Out-of-State data collected or summarized must be for the same cost reporting period as is being used for the cost report data and in-state payment information.

4. Information provided for inpatient services to Indiana Medicaid eligible patients not included in claims reports received from Myers and Stauffer must be supported by a patient listing. This listing must be provided in Excel, using the format in Exhibit A.

Section B

1. Total number of hospital's inpatient days as reported on your cost report. Include routine, newborn, subprovider, special wards, and out-of-state days. Do not include LTC (long-term care), SNF (skilled nursing facility), ICF/MR (intermediate care facility/mentally retarded), RTC (residential treatment care), Swing Beds, or non-hospital services.

   If the facility netted any of the following days from total hospital inpatient days as reported on your cost report, list how many fall into each of the following categories:

   - Days for which a patient was eligible for Medicare Part A and Medicaid.
   - Self-insured days (These are days for which hospitals provide inpatient services to their employees in lieu of providing health insurance as an employee benefit.)
   - "Leave of absence" days (These are typically days for which patients receiving psychiatric care leave for holidays or special occasions, and their room is held for them with the expectation that they will be returning.)
   - Labor and delivery days that were billed on an inpatient claim (provide support for this calculation).

Section C

1. For purposes of the Low-Income Utilization Rate (LIUR) calculation it is necessary to calculate net hospital revenue for patient services. This will be accomplished with information from your cost report along with the information reported in section C. Section C of the survey is requesting a breakdown of the patient revenue and contractual adjustments reported on Schedule G-3 Lines 1 & 2 of the cost report. Please provide the total patient revenue and contractual adjustments applicable to each of the lines listed for hospital and non-hospital services. The total patient revenue should agree to Schedule G-3 Line 1 and the total contractual adjustments should agree to G-3 Line 2. Note that

ICF/MR (intermediate care facility/mentally retarded) and RTC (residential treatment care) are non-hospital services.

Total patient revenues less total contractual adjustments and discounts should equal Net Patient Revenue on your facility's audited financial statements. If these amounts are not the same, please provide information to reconcile these amounts at the bottom of Section C.

Section D

1. Report all state or local government cash subsidies received for patient care services. State and local subsidies should not include Supplemental Medicaid payments or Medicaid/Medicare DSH payments. Each cash subsidy should be able to be supported by a copy of notice of grant award and verification of the amount actually received, e.g. as shown on the audited financial statements, upon request.

   In general, funds received from a trust, grant, out-of-state government, etc. that are intended to support direct patient care services should be included in Section D of the survey document. If the funds are designated for capital expenditures or other services such as retail-like pharmacy, the funds should not be included in Section D of the survey.

Section E

1. Section E. of the Survey form is to collect information on services provided to the uninsured. **The information for this section should represent the services provided to patients with no third party coverage (uninsured), regardless of definitions of charity care, indigent care, etc**. **Do not include any coinsurance, co-payment, or deductible amounts unless the deductible caused a situation in which the insurance provider made no payment for that particular service**.

2. Uninsured services should also include services provided to patients with third party insurance if the third party insurer did not cover the service(s) provided, or when the patient's insurance limits were reached resulting in non-insurance coverage of patient care services provided by the hospital.

3. See Exhibit A for an example format of the information that needs to be available to support the data reported in section E. The supporting documentation should be maintained by the facility in accordance with the documentation retention requirements outlined above.

Exhibit A

1. This exhibit was prepared to share with hospitals an acceptable format for the information that should be maintained to support answers provided in Sections A, C and E of the hospital's survey.

2. Dates of Service. All dates of service must fall within the facility's cost reporting period ending in 2004.

3. Payments received information should include all payments received for services provided during the hospital's cost report year ended during SFY 2004.