State of Indiana
Disproportionate Share Hospital (DSH) Eligibility Survey
For State DSH Years Ending 06/30/2012 and 06/30/2013

Please read the Instructions carefully, and make sure to submit proper supporting documents required;
Any unsupported days/payments may be adjusted without notice.
If an updated Cost Report was used, please submit the updated Cost Report in PDF version. Please note that this must also be submitted as an amended cost report with Indiana Medicaid (using the same process in which you submitted the original cost report) in order to be used in your hospital's MIUR or LIUR calculation.

General Instructions

1. Select the "Survey" tab in the Excel workbook. Choose "Agree or Disagree" or "Yes or No", where applicable. Provide additional information, if needed.
2. The requested data should be provided for the same period as your facility's cost reporting period that ends in State Fiscal Year 2011 (July 1, 2010 - June 30, 2011).
3. Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years.

Identification of Cost Report Needed and General Information:

1. Answer questions 6, 7, and 8 to determine if your hospital is eligible to receive DSH payments.
2. If the answer is "yes" to question 6b, provide Exhibit E in the format as tab "Ex.E OB".

Section A - Out-of-State Medicaid Provider Agreements (Numbers):

1. Provide the name and Medicaid provider number for any state (other than Indiana) where you had a current Medicaid provider agreement and received claims payments during the term of the DSH year. Per federal regulation, Medicaid DSH calculations must include both in-state Medicaid services as well as out-of-state Medicaid services.

Section B - Summary of Inpatient Days and Payments:

1. This section of the survey is used to collect information to calculate the Medicaid Inpatient Utilization Rate (MIUR) and Low Income Utilization Rate (LIUR). **Please note that the numerator of the Medicaid Inpatient Utilization Rate (Medicaid-eligible days) does not include days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMDs).**

2. In Column one (Eligible Days), record your routine days of care provided to patients eligible for Medicaid. On lines 1,3,5 and 7, days can be found in Column Q of the Paid Claims Summary, "Days Patient was Medicaid-Eligible". In Column two (Payments Received From Medicaid), record your inpatient and outpatient payments received from Medicaid. Payments received should represent those payments that were received for dates of service within the reporting period. In other words, data will match the service period represented by the Paid Claims Summary.

3. Report in this section (lines 12-28), services provided to Medicaid-eligible patients. Include both Indiana and any other state's Medicaid patients (for out of state claims, Lines 23-28, include both paid and unpaid claims), including routine, newborn, subprovider, and special units (ICU, CCU, etc.). Include days for inpatient 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 the patient listing you submit as falling under the twenty-four (24) hour rule, or a separate listing of these services should be included as support. Please note that if the payment for such a claim was included as an outpatient payment in the paid claims summary (and therefore included in the column "Payments Received from Medicaid" for lines 2, 4, 6, or 8, do not include the payment again on lines 13, 15, 17, 19, or 20.)

4. **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, or non-hospital service areas. Do not include HCI or indigent care days, as they are not considered Medicaid 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 Title XXI CHIP or services for patients eligible under the ARCH program.

5. 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.

6. This section requires supporting documents for additional information submitted (See Exhibits Instructions below in details).

For days and payments reported on survey lines 12-20, Exhibit A is required for supporting the additional services provided to Indiana Medicaid-eligible patients, that are not already included in the paid claims summary, or reported on lines 1-8.

For days and payments reported on survey lines 21, Exhibit B is required for supporting the additional days/payments for claims already included in the Paid Claims Summary.

For days and payments reported on survey lines 22, Exhibit C is required for supporting the deduction of days/payments for claims already included in the Paid Claims Summary.

For days and payments reported on survey lines 23-28, Exhibit D is required for supporting the services provided to patients eligible for Medicaid in states other than Indiana, both paid and unpaid. Provide support for paid out-of-state claims (such as paid claims summaries, EOBs, or RAs). Reports or supporting documentation from the State Agency (or their fiscal agent) is preferred. Unpaid OOS services must be supported by a Benefits Eligibility Verification that shows the patient's state Medicaid eligibility during the time of service.

All exhibits must be submitted electronically on CD, using the format in the Exhibits Templates.

Unsupported days and payments will not be included in the hospitals Medicaid Inpatient Utilization Rate (MIUR) or Low-Income Utilization Rate (LIUR) calculations. Additional documentation to support a sample from this patient listing for Medicaid eligible services may be requested.

Section C - MIUR / LIUR Qualifying Data from the Cost Report

Section C-1 Total Hospital Days Used in Medicaid Inpatient Utilization Ration (MIUR)

1. Section C-1 is required to calculate the Medicaid Inpatient Utilization Rate (MIUR). The MIUR is a federal DSH eligibility criteria that must be met in order to receive DSH payments.

2. Line 1 total number of hospital's inpatient days as reported on your cost report: This amount should include routine, newborn, subprovider, special wards, employee discount days, labor and deliver days and out-of-state days. It should 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 C/R Form 2552-96: W/S S-3, Pt. I, Col. 6, Sum of Lns. 12, 14, 14.x, 28, 28.x, 29, less lines 3 & 4.
   If C/R Form 2552-10: W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 16.x, 17, 17.x, 18, 18.x, 30, 31, 32, less lines 5 & 6.

3. If any of the following days are not included in the amount listed in line 1, include them in line 2 and provide a schedule showing how many fall into each of the following categories:

   1). Self-insured days (These are days for which hospitals provide inpatient services to their employees) Any days reported in Worksheet S-3 (Line 28, 28.x on Form 2552-96 or Line 30,31 on Form 2552-10) have been included in the amount listed in survey Line 1.

   2). "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.)

   3). Labor and delivery days: Any days reported in Worksheet S-3 (Line 29 on Form 2552-96 or Line 32 on Form 2552-10) have been included in the amount listed in survey Line 1.

4. If the amount listed in survey line 1 is an overstatement of allowable days, enter a negative amount in line 2, so that the final amount listed in total line accurately represents your hospital's total allowable inpatient hospital days for purposes of calculating your MIUR. Provide a separate schedule to provide the detail of any changes, by category of day.

Section C-2 Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges

1. State and local subsidies do not include regular Medicaid payments, supplemental (UPL) Medicaid payments or Medicaid/Medicare DSH payments. Subsidies are funds the hospital received from state or local government sources to assist hospitals to provide care to uninsured or underinsured patients.

2. On lines 3a - 3c, report all state or local government cash subsidies received for patient care services. If the subsidies are directed specifically for inpatient or outpatient services, record the subsidies in the appropriate box. If the subsidies do not specify inpatient or outpatient services, record the subsidies in line 3c.
3. The unspecified subsidies will be allocated between inpatient and outpatient using your total hospital revenue reported in Section C-3.
4. Provide documentation to support the cash subsidies reported.
5. On lines 4a and 4b, report the applicable charity care charges. Report the hospital's inpatient and outpatient charity care charges for the applicable cost reporting period in the DSH year. These charges must reconcile to the charity care charges reported in your financial statements and/or annual audit. Cash subsidies are used to calculate Medicaid DSH eligibility under the federal low income utilization rate formula. They are **NOT** used to reduce your net uninsured cost for DSH payment programs.
6. Provide the financial statement page that supports the reported charity care charges, and if necessary, provide a reconciliation schedule.
7. Other uninsured inpatient charges not included in the charity care charges should be reported on line 5. Support for the other uninsured inpatient charges must be submitted electronically on CD with the eligibility survey. Include patient name, Social Security number and dates of service. Use Exhibit A as the format template for reporting this information.

Section C-3 Calculation of Net Hospital Revenue from Patient Services (Used for LIUR)

1. For purposes of the low-income utilization rate (LIUR) calculation, it is necessary to calculate net hospital revenue from patient services. This section of the survey requests a breakdown of charges reported on cost report Worksheet G-2 between hospital and non-hospital services. The form directs you to allocate your total contractual adjustments, as reported on cost report Worksheet G-3, Line 2, between hospital and non-hospital services. The form provides space for an allocation of contractual allowances among service types. If contractual adjustment amounts are not maintained by service type in your accounting system, a reasonable allocation method must be used. This will allow for the calculation of net "hospital" revenue. Total charges and contractual adjustments must agree to your cost report.

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.
2. The Certification page must be signed and printed out, and submitted as a hardcopy (or scanned as PDF) together with the finished survey CD.

Exhibit A - Indiana Medicaid-Eligible Not on Paid Claims Summary

1. Use Exhibit A to provide the information that needs to be available to support the data reported in Section B Lines 12 through 20 of the survey related to services for Indiana Medicaid-Eligible Not on Paid Claims Summary. Failure to include all the information requested in Exhibit A may result in the days and/or payments being excluded from the calculation of your hospital's MIUR and/or LIUR.
2. Refer to the "Acceptable claim types" at the bottom of the Exhibit A to finish "Claim Type" column.
3. Complete Exhibit A based on Indiana Medicaid hospital reimbursement methodology (only include the inpatient services that were discharged, or the outpatient services provided, during the cost reporting period covered by the survey). State-Operated Facilities and long term acute care (LTAC) hospitals should include all Medicaid inpatient days of care provided during the cost reporting period, and payments received for those days.
4. Indicate if the patient is a newborn. In cases where the newborn's RID and/or SSN is unavailable, provide the mother's RID and/or SSN in the indicated columns as shown in the Ex. A .

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Exhibit B - Additional Indiana Medicaid-Eligible Days for Claims on the Paid Claims Summary

1. Use Exhibit B to provide the information that needs to be available to support the data reported in Section B Line 21 of the survey related to claims already included in the Paid Claims Summary, but for which you wish to include additional Medicaid-eligible days, or payments. Failure to include all the information requested in Exhibit B may result in the days and/or payments being excluded from the calculation of your hospital's MIUR and/or LIUR.
2. Provide the original Medicaid Eligible Days/ Medicaid Payments in Paid Claims Summary in columns J and M; provide the correct Medicaid Eligible Days/ Medicaid Payments in columns L and O; put the sum of columns K and N in survey.
3. Include only the additional Medicaid-eligible days or payments in the survey.

Exhibit C - Reduction in Indiana Medicaid-Eligible Days or Payments for Claims on the Paid Claims Summary

1. Use Exhibit C to provide the information that needs to be available to support the data reported in Section B Line 22 of the survey related to claims already included in the Paid Claims Summary, but for which you wish to deduct Medicaid-eligible days, or payments.
2. Provide the original Medicaid Eligible Days/ Medicaid Payments in Paid Claims Summary in columns J and M; provide the correct Medicaid Eligible Days/ Medicaid Payments in columns L and O; put the sum of columns K and N in survey.
3. Include only the reducted Medicaid-eligible days or payments in the survey (Use minus mark).

Exhibit D - Out-Of-State Supplemental Medicaid-Eligible Claims Summary

1. Use Exhibit D to report the information that needs to be available to support the data reported in Section B Lines 23 through 28 of the survey related to services for Out-Of-State Medicaid-Eligible patients. Failure to include all the information requested in Exhibit D may result in the days and/or payments being excluded from the calculation of your hospital's MIUR and/or LIUR.
2. Refer to the "Acceptable claim types" at the bottom of the Exhibit D to finish "Claim Type" column.

Exhibit E - Names of Current Obstetricians on Staff

1. Use Exhibit E for submitting the names of your hospital's current obstetricians.

Please submit your completed survey, along with your additional Medicaid data analyses (exhibits A, B, C , D and E) electronically to Myers and Stauffer LC. Exhibits A, B, C, D and E may be submitted in Excel (.xls), Access (.mdb), Dbase or FoxPro (.dbf), or comma separated values (.csv). This information contains protected health information (PHI), and as such, should be properly encrypted and sent on CD or DVD via U.S. mail, or via other carrier authorized to transfer PHI.

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DSH Survey Submission Checklist

Please check the items below are included in your survey submission packet and PRINT this page to attach with your submission.
Please make sure to submit all the proper supporting documents required;
Any unsupported days/payments might be adjusted out of the hospital's MIUR or LIUR without notice.

☐ 1. Electronic copy of the Excel Survey

☐ 2. Electronic copy of Exhibit A - Indiana Medicaid-Eligible Not on Paid Claims Summary
- Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)

☐ 3. Electronic copy of Exhibit B - Additional Indiana Medicaid-Eligible Days for Claims on the Paid Claims Summary
- Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)

☐ 4. Electronic copy of Exhibit C - Reduction in Indiana Medicaid-Eligible Days or Payments for Claims on the Paid Claims Summary
- Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)

☐ 5. Electronic copy of Exhibit D - Out-Of-State Supplemental Medicaid-Eligible Claims Summary
- Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)

*Provide support for paid out-of-state claims (such as paid claims summaries, EOBs, or RAs). Reports or supporting documentation from the State Agency (or their fiscal agent) is preferred. Unpaid OOS services must be supported by a Benefits Eligibility Verification that shows the patient's state Medicaid eligibility during the time of service.

☐ 6. Electronic copy of Exhibit E - Names of Current Obstetricians on Staff
- Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)

7. Other supporting documents:

☐ Updated Cost Report used; please note that this must be submitted as an amended cost report with Indiana Medicaid
(using the process in which you submitted the original cost report) in order to be used in your hospital's MIUR or LIUR calculation.

☐ Documents to support Survey Section C-1, Line 2: Adjustments to total hospital inpatient days

☐ Documents to support Survey Section C-2, Line 3: Hospital Cash Subsidies

☐ Documents to support Survey Section C-2, Line 4: Charity Care Charges

☐ Documents to support Survey Section C-2, Line 5: Additional Uninsured Inpatient Charges Not Included in Charity Care Charges

All electronic (CD or DVD) and paper documentation can be mailed (using certified or other traceable delivery) to:

Myers and Stauffer
ATTN: DSH Eligibility
9265 Counselors Row, Suite 200
Indianapolis, Indiana 46240-6419
Phone: 1-800-877-6927
Fax: (317) 571-8481

Please call Myers and Stauffer at 1-800-877-6927 if you have any questions on completing the DSH survey.

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Facility Name:

For State Fiscal years 2012 and 2013

Identification of Cost Report Needed:

	Cost Report Begin Date		Cost Report End Date
Cost Report Begin Date		**Cost Report End Date**	

The Medicare cost report information contained within this survey is obtained from the cost report on file with Indiana Medicaid as of 6/26/2012.

Medicaid Claims Data Cut-Off Dates:		
	FFS/MC -	5/29/2012
	HIP -	12/30/2011

General Information:

The following information is provided based on the information we received from the state. Please review this information for items 1 through 5 and select either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey. Select Yes or No to questions 6 through 8.

		Data		If Disagree Proper Information
1.	Hospital Name: (Hospital Name)			
2.	Medicaid Provider Number: (Medicaid Number)			
	Medicaid Subprovider Number 1 (Psychiatric or Rehab):			
	Medicaid Subprovider Number 2 (Psychiatric or Rehab):			
3.	Medicare Provider Number: (Medicare Number)			
4.	Type of Hospital: (Acute, LTC, Psych, Teaching, Children's, other)			
5.	Type of Ownership: (Private, State Govt, Non-State Govt, IHS/Tribal)			

Obstetrician Requirement:

6a.	During the cost report ended within SFY 2011, did the hospital have at least two obstetricians who had staff privileges at the hospital and who agreed to provide obstetric services to Medicaid-eligible individuals through the cost reporting period listed at the top of this survey? (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 obstetric procedures.)	
6b.	Does the hospital currently have at least two obstetricians who have staff privileges at the hospital and who agree to provide obstetric services to Medicaid-eligible individuals? (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 obstetric procedures.) Provide names of hospital's current obstetricians in **Exhibit E**.	
7.	Was the hospital exempt from the requirement listed under #6 above because the hospital's inpatients are predominantly under 18 years of age?	
8.	Was the hospital exempt from the requirement listed under #6 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? (This exception does not apply to facilities that opened after 12/22/87.)	

A. Out-of-State Medicaid Provider Number. List all states with which your hospital had a Medicaid provider agreement during the DSH year if related data for that state is also included:

	State	Provider No.
1.	State Name & Number	
2.	State Name & Number	
3.	State Name & Number	
4.	State Name & Number	
5.	State Name & Number	
6.	State Name & Number	
7.	State Name & Number	
8.	State Name & Number	
9.	State Name & Number	

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Facility Name:

For State Fiscal years 2012 and 2013

B. Summary of Inpatient Days, and Payments, Attributable to Patients Eligible for Medical Assistance

	Patient Type	Eligible Days	Payments Received From Medicaid
1.	Medicaid Indiana FFS - Inpatient Claims		
2.	Medicaid Indiana FFS - Outpatient Claims		
3.	Medicaid Indiana MCO - Inpatient Claims		
4.	Medicaid Indiana MCO - Outpatient Claims		
5.	Medicaid Crossover - Inpatient Claims [1]		
6.	Medicaid Crossover - Outpatient Claims [1]		
7.	Healthy Indiana Plan (HIP) - Inpatient Claims		
8.	Healthy Indiana Plan (HIP) - Outpatient Claims		
9.	SFY2011 Supplemental Payment to Privately Owned Hospitals		
10.	SFY2011 Indiana Medicaid Municipal Hospital Payment		
11.	SFY2011 Safety Net Payment		
12.	Medicaid - Indiana - eligible not included in Claims Reports (**Exhibit A needed**) FFS - Inpatient Claims		
13.	Medicaid - Indiana - eligible not included in Claims Reports (Exhibit A needed) FFS - Outpatient Claims		
14.	Medicaid - Indiana - eligible not included in Claims Reports (**Exhibit A needed**) MCO - Inpatient Claims		
15.	Medicaid - Indiana - eligible not included in Claims Reports (Exhibit A needed) MCO - Outpatient Claims		
16.	Medicaid - Indiana - eligible not included in Claims Reports (**Exhibit A needed**) Dually-Eligible [1] - Inpatient Claims		
17.	Medicaid - Indiana - eligible not included in Claims Reports (Exhibit A needed) Dually-Eligible [1] - Outpatient Claims		
18.	Medicaid - Indiana - eligible not included in Claims Reports (**Exhibit A needed**) HIP - Inpatient Claims		
19.	Medicaid - Indiana - eligible not included in Claims Reports (Exhibit A needed) HIP - Outpatient Claims		
20.	Medicaid - Indiana - eligible not included in Claims Reports (Exhibit A needed) New Born Claims		
21.	Medicaid - Indiana - Additional Medicaid Eligible Days/Payments on a Claim Included in the Paid Claims Summary (**Exhibit B needed**)		
22.	Medicaid - Indiana - Reduction in Medicaid Eligible Days/Payments on a Claim Included in the Paid Claims Summary (**Exhibit C needed**)		
23.	Medicaid Out-of-State FFS - Inpatient (paid and unpaid [2]) (**Exhibit D needed**)		
24.	Medicaid Out-of-State FFS - Outpatient (paid and unpaid [2]) (**Exhibit D needed**)		
25.	Medicaid Out-of-State MCO - Inpatient (paid and unpaid [2]) (**Exhibit D needed**)		
26.	Medicaid Out-of-State MCO - Outpatient (paid and unpaid [2]) (**Exhibit D needed**)		
27.	Medicaid Out-of-State Dually-Eligible [1] - Inpatient (paid and unpaid [2]) (**Exhibit D needed**)		
28.	Medicaid Out-of-State Dually-Eligible [1] - Outpatient (paid and unpaid [2]) (**Exhibit D needed**)		
	Total	0	0

1. Episodes of care during which the patient was eligible for both Medicaid and Medicare Part A.
For paid claims, these are referred to as "crossover" since the paid claim has crossed over from the Medicare payment system to the Indiana Medicaid payment system.

2. Provide support for paid out-of-state claims (such as paid claims summaries, EOBs, or RAs). Reports or supporting documentation from the State Agency (or their fiscal agent) is preferred. Unpaid OOS services must be supported by a Benefits Eligibility Verification that shows the patient's state Medicaid eligibility during the time of service.

C. MIUR / LIUR Qualifying Data from the Cost Report

C-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR) **(See Note in Section C-3, below)**

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed If C/R Form 2552-96: W/S S-3, Pt. I, Col. 6, Sum of Lns. 12, 14, 14.x, 28, 28.x, 29, less lines 3 & 4. If C/R Form 2552-10: W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 16.x, 17, 17.x, 18, 18.x, 30, 31, 32, less lines 5 & 6.	
2.	Adjustments to total hospital inpatient days from the cost report for purposes of calculating the MIUR (Supporting documents must be provided)	
	Total	-

C-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care and Additional Uninsured Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

3a.	Inpatient Hospital Cash Subsidies (Supporting documents must be provided)	
3b.	Outpatient Hospital Cash Subsidies (Supporting documents must be provided)	
3c.	Unspecified I/P and O/P Hospital Cash Subsidies (Supporting documents must be provided)	
	Total Hospital Cash Subsidies	$ -
4a.	Inpatient Charity Care Charges	
4b.	Outpatient Charity Care Charges	
	Charity Care Charges Reported on Financial Statements (Please provide the financial statement page that supports the reported amount, and if necessary, a reconciliation schedule.)	$ -
5.	Additional Uninsured Inpatient Charges Not Included in Charity Care Charges (Documents to support this amount must be submitted - see Exhibit A as a template to report this information)	
	Total Charity Care Charges	$ -

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For State Fiscal years 2012 and 2013

C-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using Medicare cost report on file with Indiana Medicaid as of xx/xx/xxxx data. If the hospital has a more recent version of the cost report, the hospital should amend the report filed with Indiana Medicaid. The data on this survey can then be updated to use the data from the amended cost report. Formulas can be overwritten as needed with actual data.

From Cost Report		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
Line#	Cost Center	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
9.	Hospital							$ -
10.	Subprovider I (Psych or Rehab)							$ -
11.	Subprovider II (Psych or Rehab)							$ -
12.	Swing Bed - SNF							
13.	Swing Bed - NF							
14.	Skilled Nursing Facility							
15.	Nursing Facility							
16.	Other Long-Term Care							
17.	Ancillary Services							$ -
18.	Outpatient Services							$ -
19.	Home Health Agency							
20.	Ambulance							
21.	Outpatient Rehab Providers							$ -
22.	ASC							$ -
23.	Hospice							
24.	Other							$ -
28.	Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -
29.	Total Hospital and Non Hospital		Total from Above	$ -		Total from Above	$ -	
30.	Total Per Cost Report		Total Patient Revenues (G-3 Line 1)			Total Contractual Adj. (G-3 Line 2)		
31.	Unreconciled Difference		Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -	

Certification:

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 of the DSH Eligibility Survey are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. 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

Date

Hospital CEO or CFO Printed Name, Title

Hospital CEO or CFO Telephone Number

Hospital CEO or CFO E-mail

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

Hospital Contact:		**Outside Preparer:**	
Name		Name	
Title		Title:	
Telephone Number		Firm Name:	
E-Mail Address		Telephone Number	
Mailing Street Address		E-Mail Address	
Mailing City, State, Zip			

EXHIBIT A

Indiana Medicaid-Eligible Not on Paid Claims Summary

Provider Identifier		Claim Type[1]	Patient Identifier			If Patient is a Newborn - Mother's Information			Date(s) of Service		Inpatient XIX-Eligible Days	Medicaid Payments
Hospital Name	Indiana Medicaid Provider Number		Indiana Medicaid Recipient Number	Social Security Number (XXX-XX-XXXX)	Name	Indiana Medicaid Recipient Number	Social Security Number (XXX-XX-XXXX)	Name	From	To		

[1] **Please enter the following acceptable claim types in this field:**

Indiana FFS - Inpatient	Section B, Line 12
Indiana FFS - Outpatient	Section B, Line 13
Indiana MCO - Inpatient	Section B, Line 14
Indiana MCO - Outpatient	Section B, Line 15
Indiana Dually-Eligible - Inpatient	Section B, Line 16
Indiana Dually-Eligible- Outpatient	Section B, Line 17
HIP - Inpatient	Section B, Line 18
HIP - Outpatient	Section B, Line 19
Newborn claim	Section B, Line 20

Please submit the above data in an electronic file included with this survey document. The electronic file can be in several formats including Excel (.xls), Access (.mdb), Dbase (.dbf), and Comma Separated Values (CSV).

EXHIBIT B

Additional Indiana Medicaid-Eligible Days or Payments for Claims on the Paid Claims Summary

Provider Identifier		Claim Type[1]	ICN	Patient Identifier			Date(s) of Service		Days in Paid Claims Summary	ADDITIONAL Inpatient XIX-Eligible Days[1]	Correct Medicaid-Eligible Days	Medicaid Payments in Paid Claims Summary	ADDITIONAL Medicaid Payments[1]	Correct Medicaid-Eligible Days
Hospital Name	Indiana Medicaid Provider Number			Indiana Medicaid Recipient Number	Social Security Number (XXX-XX-XXXX)	Name	From	To						
		Additional Days for Paid Claim												

[1] include only the **additional** Medicaid-eligible days or payments. Do not include the Medicaid-eligible days or payments that have already been included on the Paid Claims Summary.

Section B, Line 21

For services not incidental to inpatient or outpatient hospital services.

Please submit the above data in an electronic file included with this survey document. The electronic file can be in several formats including Excel (.xls), Access (.mdb), Dbase (.dbf), and Comma Separated Values (CSV).

EXHIBIT C

Reduction in Indiana Medicaid-Eligible Days or Payments for Claims on the Paid Claims Summary

Provider Identifier		Claim Type[1]	ICN	Patient Identifier			Date(s) of Service		Days in Paid Claims Summary	Reducted Inpatient XIX-Eligible Days[1]	Correct Medicaid-Eligible Days	Medicaid Payments in Paid Claims Summary	Reducted Medicaid Payments[1]	Correct Medicaid Payments
Hospital Name	Indiana Medicaid Provider Number			Indiana Medicaid Recipient Number	Social Security Number (XXX-XX-XXXX)	Name	From	To						
		Reduction to Paid Claim												

[1] include only the reducted Medicaid-eligible days or payments. Do not include the Medicaid-eligible days or payments that have already been included on the Paid Claims Summary.
Section B, Line 22

Please submit the above data in an electronic file included with this survey document. The electronic file can be in several formats including Excel (.xls), Access (.mdb), Dbase (.dbf), and Comma Separated Values (CSV).

EXHIBIT D

Out-Of-State Supplemental Medicaid-Eligible Claims Summary

Provider Identifier		Claim Type[1]	Patient Identifier			If Patient is a Newborn - Mother's Information			Date(s) of Service		Inpatient XIX-Eligible Days	Medicaid Payments
Hospital Name	Other States Medicaid Provider Number		Other States Medicaid Recipient Number	Social Security Number (XXX-XX-XXXX)	Name	Other States Medicaid Recipient Number	Social Security Number (XXX-XX-XXXX)	Name	From	To		

[1] **Please enter the following acceptable claim types in this field:**

OOS FFS - Inpatient	Section B, Line 23
OOS FFS - Outpatient	Section B, Line 24
OOS MCO - Inpatient	Section B, Line 25
OOS MCO - Outpatient	Section B, Line 26
OOS Dually-Eligible - Inpatient	Section B, Line 27
OOS Dually-Eligible - Outpatient	Section B, Line 28

Provide support for paid out-of-state claims (such as paid claims summaries, EOBs, or RAs). Reports or supporting documentation from the State Agency (or their fiscal agent) is preferred. Unpaid OOS services must be supported by a Benefits Eligibility Verification that shows the patient's state Medicaid eligibility during the time of service.

Please submit the above data in an electronic file included with this survey document. The electronic file can be in several formats including Excel (.xls), Access (.mdb), Dbase (.dbf), and Comma Separated Values (CSV).

EXHIBIT E

Names of Current Obstetricians on Staff

Last name	First Name

Please submit the above data in an electronic file included with this survey document. The electronic file can be in several formats including Excel (.xls), Access (.mdb), Dbase (.dbf), and Comma Separated Values (CSV).