Myers and Stauffer LC

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

July 2, 2012

«Provider_Name»
Attn: «Contact»
«ContactTitle»
«Chain_Name»
«Address_1»
«Address_2»
«City», «State» «Zip»

UPS Tracking Number: «UPS_Number»

Return Receipt Requested

Provider Number: «Medicaid»

Dear Mr./Ms. «LastName»::

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 ending June 30, 2012 and June 30, 2013. Detailed instructions have been included within this letter and in the "Instructions" tab of the survey workbook in the enclosed CD. Please read and follow these instructions in order to prepare and submit an accurate and complete survey in accordance with the program requirements.

You are required to submit the survey response in Excel format on a CD. Hard copies will not be accepted, with the exception of the checklist and a signed certification page, which is required to be submitted in hard copy format.

The survey must be completed and postmarked no later than **August 30, 2012**. **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 the DSH eligibility determination and payment distributions.

Please complete and return the enclosed survey to the address below. Surveys must be postmarked no later than August 30, 2012. 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, only information included in the survey mailed to you will be included in your hospital's eligibility calculation for SFY 2012 and 2013.**

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.

Upon opening your CD, you will find one file, a SecureZip application. You will need to open this file and select the location to which you want your survey files extracted. After selecting the location, the program will request your password. Enter your password to decrypt the files and extract them to the desired location. Please note that decryption software (e.g., WinZIP) is no longer required to open and extract your files. The files on your CD are compressed and encrypted using PKWARE, and are sent to you in a self-extracting file.

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

Sincerely,

Myers and Stauffer

OFFICE OF MEDICAID POLICY AND PLANNING
DISPROPORTIONATE SHARE HOSPITAL (DSH) ELIGIBILITY SURVEY
July 1, 2012

The enclosed survey is designed to collect the information necessary to administer the Indiana Medicaid Disproportionate Share Hospital program. This survey will be used to determine DSH eligibility for State Fiscal Years (SFY) 2012 and 2013. ***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.*** Your survey information should be taken from the Medicaid cost report for your facility's fiscal year ended during SFY 2011, which is July 1, 2010 to June 30, 2011.

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 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 enclosed survey to the address below postmarked no later than August 30, 2012. This will be the only notification sent concerning the deadline.

- If the response to the survey is not postmarked by the deadline, only information included in the survey sent to you will be included in your hospital's calculation to determine eligibility for DSH payments for SFY 2012 and 2013.

- Only information submitted by your facility on a survey postmarked by August 30, 2012 will be included in your facility's DSH eligibility calculation. Information included on surveys received from your facility 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).

- You may be contacted to provide additional information, clarification, or support for information reported on your survey response.

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: 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 electronically on CD, in the format presented in Exhibits A, B, C, D and E.** 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 review the information already completed on the survey for accuracy – and to correct it, if necessary. Please provide any additional information and submit documentation to support the changes. If there is any incorrect information included in the survey, please provide corrected amounts. You may do so in any format you would like (you may not be able to change the amounts in locked cells in the workbook). Please clearly indicate the changes needed and corrected information in a document entitled "Correction to Survey Amounts" to ensure that the information is identified and incorporated into the eligibility calculation. Please note that any additional days or payments must be supported by detail reported in the formats illustrated by Exhibits A, B, C and D and submitted electronically. Please be advised that any questions that require support but do not have the required documentation **may not be used in the calculations** for DSH eligibility.

Thank you for your cooperation in completing this survey.