State of Indiana
Disproportionate Share Hospital (DSH) Eligibility Survey
For State Fiscal Years 2006 and 2007

Reporting Period Begin Date: _____ **End Date:** _____

Medicaid Claims Data Cut-Off Dates:
Inpatient FFS - 4/10/2007
Inpatient MC - 4/19/2007
Outpatient FFS - 4/24/2007
Outpatient MC - 4/19/2007

General Information

The following information is provided based on the information available to the state. Please review this information and check the box to either agree with the accuracy of the information or disagree. If you disagree with one of these items please provide the correct information along with supporting documentation when you submit your survey.

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

		Agree	Disagree
6.	The hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed 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.)	☐	☐
6a.	The hospital is exempt from the requirement listed under #6 above because the hospital's inpatients are predominantly under 18 years of age.	☐	☐
6b.	The hospital is 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.	☐	☐

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

	Patient Type	Eligible Days	Payments Received From Medicaid
1.	Medicaid - Indiana Inpatient Claims		
2.	Medicaid - Indiana Outpatient Claims		
3.	Medicaid MCO - Indiana Inpatient Claims		
4.	Medicaid MCO - Indiana Outpatient Claims		
5.	Medicaid Rehabilitation Option (Psych Only)		
6.	SFY 2004 Hospital Care for the Indigent Payment		
7.	SFY 2004 Supplemental Payment to Privately Owned Hospitals		
8.	SFY 2004 Indiana Medicaid Municipal Hospital Payment		
9.	SFY 2004 Safety Net Payment		
10.	Medicaid - Indiana - Inpatient - eligible not included in Claims Reports		
11.	Medicaid FFS Out-of-State - Inpatient		
12.	Medicaid FFS Out-of-State - Outpatient		
13.	Medicaid MCO Out-of-State - Inpatient		
14.	Medicaid MCO Out-of-State - Outpatient		
15.	$0 Paid Medicaid Out-of-State		
16.	Out -of-State DSH Payments Received		

B. Total Hospital Inpatient Days

1.	Total number of hospital's inpatient days as reported on the cost report.	
2.	Hospital inpatient days deducted from total for cost reporting purposes (See Instructions)	

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C. Calculation of Net Hospital Revenue for Patient Services

	Total Patient Revenues			Contractual Adjustments	
	Hospital In Patient	Hospital Out Patient	Non-Hospital	Hospital	Non-Hospital
1. Hospital					
2. Psych Subprovider					
3. Rehab. Subprovider					
4. Swing Bed - SNF					
5. Swing Bed - NF					
6. Skilled Nursing Facility					
7. Nursing Facility					
8. Other Long-Term Care					
10. Intensive Care Unit					
11. Coronary Care Unit					
12. Burn Intensive Care Unit					
13. Surgical Intensive Care Unit					
14. Other Special Care					
17. Ancillary Services					
18. Outpatient Services					
19. Home Health Agency					
20. Ambulance					
21. Outpatient Rehab Providers					
22. ASC					
23. Hospice					
24. Other					
Total					
Total Hospital + Non Hospital					

Less: Total Patient Revenues (G-3 Line 1) _____ Less: Total Cont Allow (G-3 Line 2) _____

Unreconciled Difference (Should be $0) _____ _____

Total Net Patient Revenue _____

Less: Total Net Patient Revenue per Audited Financial Statement _____

Difference _____

Explanation: _____

D. Cash Subsidies for Patient Services Received Directly from State/Local Government

	Inpatient	Outpatient	Unspecified
1. Cash Subsidies from State/Local Government			

Total Subsidies _____

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E. Charges and Payments Received from the Uninsured

Data to be summarized from those individuals who received services and no payment from a third party payer. See Exhibit A for an example of the format of documentation that should be available to support these reported numbers.	**Charges Attributable to Uninsured**	**Payments Received for those Services**
1. Inpatient (Excluding Physician Charges)		
2. Amount of payments reported in line 1 that were also included in cash susidies reported in Section D		

Certification

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the above information is 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 Medicaid Disproportionate Share Hospital (DSH) payment eligibility. Detailed support exists for all amounts reported in this survey. We have made our best faith effort at gathering the information requested in this survey, including any exhibits, schedules, and explanations. I understand that no additional days, payments or charges will be included that will increase the hospital's Medicaid Inpatient or Low Income Utilization Rate if submitted after the survey deadline. I understand that any false information provided may result in a demand for repayment of amounts calculated based on the faulty information.

_____ _____
Hospital CEO or CFO Date

_____
Title

Please provide the following contact information for the individual in your hospital authorized to respond to inquiries about the responses to this survey.

Name _____

Title _____

Telephone Number _____

E-Mail Address _____

Additional Notes: _____