State of Indiana
Hospital Specific Limit (HSL) Survey
For State DSH Year Ending 6/30/2010

DSH Survey Submission Checklist

- ☐ **1. Electronic copy of the Excel Survey (Sections A-B)**
  - CD
- ☐ **2. Signature on Certification (hand-written) (Survey-Sec.A-B, Page 2)**
  - Hardcopy or PDF in CD
- ☐ **3. Electronic copy of Exhibit A - Support of In-State FFS Medicaid-Eligible Not on Medicaid Paid Claims Data**
  - CD, Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)
- ☐ **4. Electronic copy of Exhibit B - Support of In-State MCO Medicaid-Eligible Not on Medicaid Paid Claims Data**
  - CD, Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)
- ☐ **5. Electronic copy of Exhibit C - Support of Uninsured I/P and O/P Hospital Services**
  - CD, Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)
- ☐ **6. Electronic copy of all out-of-state Medicaid fee-for-service Medicaid Paid Claims Data (Remittance Advice Summary or Paid Claims Summary)**
  - CD
- ☐ **7. Electronic copy of all out-of-state Medicaid managed care Medicaid Paid Claims Data (Remittance Advice Summary or Paid Claims Summary)**
  - CD
- ☐ **8. Electronic copy of supporting documentation used to complete Medicare Allowed Amount on Cross-Overs Payments**
  - CD
- ☐ **9. Electronic copy of Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit C**
  - CD
- ☐ **10 Electronic copy of documentation supporting out-of-state DSH payments received during all cost report period covered by the survey**
  - CD; Examples may include remittances and detailed general ledgers
- ☐ **11 Electronic copy of Medicare-adjusted cost report; if adjustments impacted amounts used to complete DSH HSL survey.**
  - CD

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

Myers and Stauffer
ATTN: HSL Survey
9265 Counselors Row, Suite 200
Indianapolis, IN 46240

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

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Do NOT add/delete rows/columns in the survey.

If no data is provided in any of the survey section(s), please indicate with "N/A".

For any note(s) added, please indicate clearly which row(s)/column(s) are reflected.

The cost report year ended within SFY 2009 will be used to calculate the DSH Hospital Specific Limit for SFY 2010 DSH payments. Use the best Medicare cost report available.

CLAIMS REPORTS HAVE BEEN PROVIDED TO ASSIST YOU IN COMPLETING THIS SURVEY. THE ACCURACY AND COMPLETENESS OF THESE REPORTS HAS NOT BEEN VERIFIED. YOU ARE RESPONSIBLE FOR THE ACCURACY AND COMPLETENESS OF THE INFORMATION REPORTED ON THE SURVEY YOU SUBMIT.

General Instructions and Identification of Medicare Audited Cost Reports:

1. Select the "Survey-Sec.A-B" tab in Excel workbook. In row 2, enter your facility name.
   Provide your cost reporting period that ended within SFY 2009 (July 1,2008 - June 30, 2009). The cost report period must begin on or before the start of SFY 2009 (July 1, 2008).
2. Enter your facility's Indiana Medicaid provider number and Medicare provider number.
3. Answer questions 4, 5 and 6 which are required to determine if your hospital is eligible to receive DSH payments. The time period for this response is SFY 2010 (July 1,2009 - June 30, 2010).
4. Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years.

Section A - Cost Report Information:

1. Use **Worksheet S-3, Part I** and **Worksheet E-3, Part IV**. If the Medicare intermediary has made adjustments to your submitted cost report which affect these lines, use the Medicare-adjusted cost report. Please submit a copy of this cost report with your DSH HSL survey.

Section B - Disclosure of 1011 and Out-of-State DSH Payments:

1. If your hospital received Section 1011 payments (reimbursement for services provided to undocumented aliens) as authorized by Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act during any of the cost report years needed to cover the DSH year, these payments must be disclosed in this section of the survey. Since these payments may be made to cover non-hospital services, if you can document the non-hospital portion of these services, they should be reported as such. Otherwise, all 1011 payments must be reported as related to hospital services. Separate out the 1011 payments included on a patient basis in Exhibit B from those not included in Exhibit B.
2. Out-of-State DSH payments. If your hospital received DSH payments from another state, these payments must be reported in this section.
3. Out-of-State supplemental payments. If your hospital received supplemental payments from another state, these payments must be reported in this section of the survey.

Section C - Calculation of In-State Medicaid and Uninsured I/P and O/P Costs:

1. This section of the survey is used to collect information to calculate the hospital's Medicaid and Uninsured shortfall or longfall. By federal Medicaid DSH regulations, the shortfall/longfall must be calculated using Medicare cost report costing methodologies. Please utilize the best available Medicare cost report. **Please note that the services provided to Medicaid patients between 21 and 65 years of age in Institution for Mental Disease (IMDs) should be included in the uninsured columns of the survey. As an alternative to this form, you could choose to prepare a Medicaid DSH Cost Report to perform these calculations. If this option is chosen, please provide totals on this survey, and submit the ECR. Submit any variances between the Medicaid DSH Cost Report and the Medicare Cost Report previously submitted to Myers & Stauffer.**

2. Record the routine per diem cost per day for each hospital routine cost center present on your audited Medicare cost report. These amounts are calculated on **Worksheet D-I, Part II** of the cost report. Record each ancillary cost-to-charge ratio for each ancillary cost center on your cost report. These amounts are calculated on **Worksheet C, Part 1, Column 11 (for Critical Access Hospitals, Column 9)** of the Medicare cost report. If the Medicare intermediary has made adjustments to your submitted cost report which affect these lines, use the Medicare-adjusted cost report. Please submit a copy of this cost report with your DSH HSL survey.
   Teaching Hospitals: Use the Medicaid version of the Worksheet C, so your Direct Medical Education costs are included in the cost per diems and ancillary cost-to-charge ratios.
3. Record your routine days of care, routine charges and I/P and O/P ancillary charges in the next several columns. This information, when combined with cost information from the Medicare audited cost report, will calculate the total cost of hospital services provided to Medicaid and uninsured individuals. The reports generated by Myers & Stauffer that provide revenue code detail were pulled from the detailed claims information (rather than the header). In order to include the full charges from the claim (and therefore the full cost), we also provided a report with any detail lines that were denied (for claims that were otherwise paid). In other words, the denied report does not include those claims that were denied entirely. You should include charges from both reports in the schedules to arrive at the cost of care.
   Record your payments in the next several columns. This information, when combined with the calculated cost of hospital services provided to Medicaid and Uninsured individuals, will calculate the total payment shortfall (longfall).

a) ***In-State FFS Medicaid Primary:** In these two columns, record your in-state Medicaid fee-for-services days, charges and payments. The total days, charges and payments should reconcile to the **Medicaid Paid Claims Data**. Provide an explanation for any unreconciled amounts.

***In-State Managed Care Medicaid Primary:** Same requirements as above. If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient).

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b) ***In-State FFS Cross-Over:** Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's Medicare audited cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments. Payments should be calculated and reported using the accrual method. The total days, charges and payments should reconcile to the **Medicaid Paid Claims Data**. Provide an explanation for any unreconciled amounts.

***In-State Managed Care Cross-Over:** Same requirements as above. If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient).

c) ***Validated Paid Claims – Not Duplicates**: Using the criteria listed below, we identified several sets of Medicaid claims that may pertain to the same service; which may indicate a possible duplicate claim for which no adjustment was made by Indiana AIM. Accordingly, we have removed these claims from the paid claims report, and included them in a separate report entitled "Possible Duplicate Claims Report".

Criteria for including inpatient claims in Possible Duplicate Claims Report: Claims, including managed care and crossovers, were identified as possible duplicate records if they that had different ICNs, but identical recipient ID, provider ID, admission date and discharge date.

Criteria for including outpatient claims in Possible Duplicate Claims Report: Claims, including managed care and crossovers, were identified as possible duplicate records if they that had different ICNs, but identical recipient ID, provider ID, detail first date of service, detail revenue code, detail procedure code and header admit hour. This process reviewed detail records that had a claim status of P (paid). The process did not search for possible duplicate details within the same claim.

Please review these claims against your records and respond as follows:

1) For valid claims that are for separate services and are not duplicates of other reported services, please include in the section, **Validated Paid Claims – Not Duplicates**. Please provide an explanation as to why these claims do not represent duplicate claims. Supporting documentation for these explanations to verify that they are separate services, and are not duplicate claims, should be prepared and retained in your records, and made available upon request by OMPP.

2) For claims you identify as a duplicate reporting of a service already included in the survey, do not include in your survey response. Please note in your response which claim is a duplicate claim.

d) Report services provided to all Indiana Medicaid-eligible patients regardless of payment status or if covered under other insurance.
***In-State FFS Medicaid-Eligible Not on Medicaid Paid Claims Data:** In these two columns, record your in-state Medicaid fee-for-service days, charges and payments for services not included on the Medicaid Paid Claims Data. **Exhibit A needed as supporting documentation.**

***In-State Managed Care Medicaid-Eligible Not on Medicaid Paid Claims Data:** Same requirements as above. If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient). **Exhibit B needed as supporting documentation.**

e) *** Uninsured:**

Federal requirements mandate the uninsured services must be costed using Medicare cost reporting methodologies. As such, a hospital will need to report the uninsured days of care they provided during the cost reporting period, by routine cost center, as well as inpatient and outpatient ancillary service revenue by cost report cost center. **Exhibit C** has been prepared to assist hospitals develop the data needed to support responses on the survey. It must also only include charges for inpatient and outpatient hospital services, excluding physician charges and other non-hospital charges. **Per federal guidelines uninsured patients are individuals with no source of third party healthcare coverage (insurance). If the patient had health insurance, even if the third party insurer did not pay, those services are insured and cannot be reported as uninsured on the survey.**

Section D - Calculation of Out-of-State Medicaid Costs:

***Out-of-State Medicaid-Eligible:** This schedule is formatted similar to Schedule C. It should be prepared to capture all out-of-state Medicaid FFS, managed care, FFS cross-over and managed care cross-over services the hospital provided during the cost reporting year. Amounts reported on this schedule should reconcile to the out-of-state Medicaid Paid Claims Data (or equivalent schedule) produced by the Medicaid program or managed care entity. **Supporting documentation for this data must be submitted for review.**

Section E - Calculation of In-State Medicaid and Uninsured Organ Acquisition Costs:

1. **This section is to be completed by hospitals that have incurred in-state Medicaid or uninsured organ acquisition costs only.** Information is collected in a format similar to Section C.
2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.

Section F - Calculation of Out-of-State Medicaid Organ Acquisition Costs:

1. **This section is to be completed by hospitals that have incurred out-of-state Medicaid organ acquisition costs only.** Information is collected in a format similar to Section D.

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. Submit a signed, hard copy of the certification page with your survey.

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Exhibits - General

We prefer you complete the exhibit based on Indiana Medicaid hospital reimbursement methodology (only include the claims that were discharged during the cost reporting period covered). However, if the data cannot be easily reported using the Medicaid methodology, report it based on your own methodology in a consistent manner from year to year (e.g., discharge, admit, or dates of service).

Exhibit A - Support of In-State FFS Medicaid-Eligible Not on Medicaid Paid Claims Data:

1. See Exhibit A for an example format of the information that needs to be available to support the data reported in Section C of the survey related to services for In-State FFS Medicaid-Eligible Not on Medicaid Paid Claims Data provided for the cost report year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section.

Exhibit B - Support of In-State MCO Medicaid-Eligible Not on Medicaid Paid Claims Data:

1. See Exhibit B for an example format of the information that needs to be available to support the data reported in Section C of the survey related to services provided for In-State MCO Medicaid-Eligible Individuals Not on Medicaid Paid Claims Data for the cost report year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section.

Exhibit C - Support of Uninsured I/P and O/P Hospital Services:

1. See Exhibit C for an example format of the information that needs to be available to support the data reported in Section C of the survey related to uninsured services provided for the cost report year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section.

Please submit your completed survey, along with the supporting documentation (exhibits A, B, C and others) electronically to Myers and Stauffer LC. The data 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 sent on CD or DVD via U.S. mail, or via other carrier authorized to transfer PHI.

Please complete and print the Checklist with your submission. For item(s) not applicable, please mark "NA".

The following services are not permitted to be included in the DSH Hospital Specific Limit calculation:

- Exclude professional fees for hospital services to patients, such as Emergency Room (ER) physician charges and provider-based outpatient services. Exclude all physician professional services fees and CRNA charges. (42 CFR 447.299 (15) / 73 FR dated 12/19/08, pages 77924-77926)
- Exclude charges for services that are not medically necessary (including elective procedures), under applicable Medicaid standards (if the service does not meet definition of a hospital service covered under the Medicaid state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77930)*
- Exclude charges for services to prisoners (wards of the state). *(73 FR dated 12/19/08, page 77915 / State Medicaid Director letter dated August 16, 2002)*
- Exclude charges associated with the provision of durable medical equipment (DME) or prescribed drugs that are for "at home use", because the goods or services upon which these charges are based are not hospital services. *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude charges associated with services not billed under the hospital's provider numbers, as identified on the facility cost report, Worksheet S-2, Lines 2 and 3. These include non-hospital services offered by provider owned or provider based nursing facilities (SNF) and home health agencies (HHA). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude facility fees generated in provider based rural health clinic outpatient facilities (not a hospital service in state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77926)*
- Exclude charges for provider's swing bed SNF services (not a hospital service in state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude charges for Medicaid Rehabilitation Option (MRO) services (not a hospital service in state plan).
- Exclude charges for ambulance services (not a hospital service in state plan).
- Exclude charges for services when the patient's eligibility category is MCHIP (category 9) or the ARCH (Assistance to Residents in County Homes) program (not a hospital service in state plan).
- Exclude Independent Clinical ("Reference") Laboratory Charges (not a hospital service). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

Paid Claims Reports

CLAIMS REPORTS HAVE BEEN PROVIDED TO ASSIST YOU IN COMPLETING THIS SURVEY. THE ACCURACY AND COMPLETENESS OF THESE REPORTS HAS NOT BEEN VERIFIED. YOU ARE

Several paid claims reports accompany this survey on the CD sent to your facility. Below is a description of the reports, as well as the purpose. Please note, depending upon the claims submitted by your facility, the CD may not include all of these reports.

As noted above, the accuracy and completeness of this information has not been verified. There are likely inaccuracies or missing information, particularly with respect to managed care claims. For example, the Medicaid payment amount listed for managed care claims may not be the actual payment made to your hospital by the Managed Care Organization. This field is completed by HP when processing the claim as if it were fee-for-service.

File Name	Description	Purpose
aMedicaid#_CRYE	Header Level Information for Paid Claims - FFS, MC, HIP, Crossover	The survey allows you to report services provided to Medicaid-eligible patients that are not included on the paid claims report. This report provides you patient level detail in order to identify which services have not been included.
aMedicaid#_Paiddetail_CRYE	Paid Detail Level Information for Paid Claims - FFS, MC, HIP, Crossover	A revenue code summary has been provided to assist with completing Survey Section C (Medicaid costs).
aMedicaid#_denieddetail_CRYE	Denied Detail Level Information for Paid Claims - FFS, MC, HIP, Crossover	A revenue code summary has been provided to assist with completing Survey Section C (Medicaid costs). Even though these were denied at the detail level, costs of hospital services provided to Medicaid-eligible patients are permitted in the Hospital Specific Limit (HSL).
aMedicaid#_Disalloweddetail_CRYE	Disallowed Detail Level Information for Paid Claims - FFS, MC, HIP, Crossover	Costs for these detail lines are for services not permitted by federal rule to be included in the HSL. These are included so that you can identify these charges - do not include them in your survey response. If your paid claims include charges for these services, do not include an apportionment of header level charges, if they include charges for these disallowed services.
aMedicaid#_PossibleDuplicatesHeader_CRYE	Possible Duplicates - Header Level Information for Paid Claims - FFS, MC, HIP, Crossover	Our review of paid claims data indicated several claims that could be duplicates. Please review and determine which, if any services, are not duplicates and are eligible to be included in the HSL.
aMedicaid#_PossibleDuplicatePaiddetail_CRYE	Possible Duplicates - Paid Detail Level Information for Paid Claims - FFS, MC, HIP, Crossover	A revenue code summary has been provided to assist with completing Survey Section C (Medicaid costs).
aMedicaid#_PossibleDuplicatedenieddetail_CRYE	Possible Duplicates - Denied Detail Level Information for Paid Claims - FFS, MC, HIP, Crossover	A revenue code summary has been provided to assist with completing Survey Section C (Medicaid costs). Even though these were denied at the detail level, costs of hospital services provided to Medicaid-eligible patients are permitted in the Hospital Specific Limit (HSL).
aMedicaid#_PossibleDuplicateDisalloweddetail_CRYE	Possible Duplicates - Disallowed Detail Level Information for Paid Claims - FFS, MC, HIP, Crossover	Costs for these detail lines are for services not permitted by federal rule to be included in the HSL. These are included so that you can identify these charges - do not include them in your survey response. If your paid claims include charges for these services, do not include an apportionment of header level charges, if they include charges for these disallowed services.
aMedicaid#_CRYEMCHIP_ARCH	MCHIP/ARCH Claims	Exclude charges for services when the patient's eligibility category is MCHIP (category 9) or the ARCH (Assistance to Residents in County Homes) program (not a hospital service in state plan). These are provided so that you may identify these claims so that you do not include in the HSL survey.

CRYE: Cost Report Year End Date

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Include In Hospital Uninsured Charges for purposes of calculating Hospital-Specific DSH Limit:

To the extent hospital charges pertain to services that are medically necessary under applicable Medicaid standards and the services are defined as inpatient or outpatient hospital services under the Medicaid state plan the following charges are generally considered to be "uninsured":

Hospital inpatient and outpatient charges for services to patients who did not have any hospital health insurance or other legally liable third party coverage in effect at the time the services were rendered (reported based on date of service). (*42 CFR 447.299 (14) / Creditable coverage is further defined in the 45 CFR 146.113)*

- For the costs of services provided to patients in an IMD between the ages of 22 and 64 who are otherwise eligible for Medicaid, the costs should be reported as uncompensated care for the uninsured.
- Include facility fee charges generated for hospital provider based sub-provider services to uninsured patients. Such services are identified as psychiatric or rehabilitation services, as identified on the facility cost report, Worksheet S-2, Line 3. The costs of these services are included on the provider's cost report.
- Include hospital charges for undocumented aliens with no source of third party coverage for hospital services. (73 FR dated 12/19/08, page 77916 / 42 CFR 447.299 (13))
- Include charges related to patients who have met the lifetime maximum for all medical coverage under their insurance provider.
- Include lab and therapy outpatient hospital services.
- Include services paid for by religious charities with no legal obligation to pay.

Include In Hospital Uninsured Payments for purposes of calculating Hospital-Specific DSH Limit:

Include all payments received for hospital patients that met the uninsured definition at the time of the service. The payments must be reported on a cash basis (report in the year received, regardless of the year of service). *(73 FR dated 12/19/08, pages 77913 & 77927)*

- Include uninsured liens and uninsured accounts sold, when the cash is collected. (73 FR dated 12/19/08, pages 77942 & 77927)
- Include Section 1011 payments for hospital services without insurance or other third party coverage (undocumented aliens). (42 CFR 447.299 (13))
- Include other waiver payments for uninsured such as Hurricane Katrina/Rita payments. (73 FR dated 12/19/08, pages 77942 & 77927)

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Do NOT Include In Hospital Uninsured Charges for purposes of calculating Hospital-Specific DSH Limit:

Exclude charges for patients who had hospital health insurance or other legally liable third party coverage in effect at the time the services were rendered. Exclude charges for all non-hospital services. *(42 CFR 447.299 (14) / Creditable coverage is further defined in the 45 CFR Section 146.113)*

- Exclude professional fees for hospital services to uninsured patients, such as Emergency Room (ER) physician charges and provider-based outpatient services. Exclude all physician professional services fees and CRNA charges. (42 CFR 447.299 (15) / 73 FR dated 12/19/08, pages 77924-77926)
- Exclude bad debts and charity care associated with patients that have insurance or other third party coverage (have coverage). *(42 CFR 447.299 (15))*
- Exclude claims denied by an active health insurance carrier (have coverage). *(73 FR dated 12/19/08, pages 77910-77911, 77913)*
- Exclude uninsured charges for services that are not medically necessary (including elective procedures), under applicable Medicaid standards (if the service does not meet definition of a hospital service covered under the Medicaid state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77930)*
- Exclude charges for services to prisoners (wards of the state). *(73 FR dated 12/19/08, page 77915 / State Medicaid Director letter dated August 16, 2002)*
- Exclude Medicaid eligible patient charges (even if claim was not paid or denied), except for patients in an IMD between the ages of 22 and 64. *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77916)*
- Exclude charges for services rendered after benefits under the applicable coverage have been exhausted (still insured even if underinsured). *(73 FR dated 12/19/08, page 77913)*
- Exclude patient charges covered under an automobile or liability policy that actually covers the hospital service (insured). *(45 CFR 146.113, 45 CFR 146.145, 73 FR dated 12/19/08, pages 77911 & 77916)*
- Exclude charges for individuals with insurance that provides only an ambulatory benefit unless the benefit is further limited so that it is considered an excepted benefit (for example, restricted to onsite ambulatory medical clinics, limited to a particular diagnosis, or restricted to an indemnity benefit).
- Exclude charges for individuals with a "high-deductible" health insurance plan.
- Exclude charges related to patients who have met the lifetime maximum for a particular medical service, but still maintain medical coverage under their insurance provider for other services.
- Exclude contractual adjustments required by law or contract with respect to services provided to patients covered by Medicare, Medicaid or other government or private third party payers (insured). (*42 CFR 447.299 (15), 73 FR dated 12/19/08, page 77922)*
- Exclude charges for services to patients where coverage has been denied by the patient's public or private payer on the basis of lack of medical necessity, regardless as to whether they met Medicaid's medical necessity and coverage criteria (still insured). *(73 FR dated 12/19/08, page 77916)*
- Exclude unpaid Medicaid or Medicare deductible or co-payment amounts (patient has coverage). *(42 CFR 447.299 (15))*
- Exclude charges associated with the provision of durable medical equipment (DME) or prescribed drugs that are for "at home use", because the goods or services upon which these charges are based are not hospital services. *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude charges associated with services not billed under the hospital's provider numbers, as identified on the facility cost report, Worksheet S-2, Lines 2 and 3. These include non-hospital services offered by provider owned or provider based nursing facilities (SNF) and home health agencies (HHA). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude facility fees generated in provider based rural health clinic outpatient facilities (not a hospital service in state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77926)*
- Exclude charges for provider's swing bed SNF services (not a hospital service in state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude Independent Clinical ("Reference") Laboratory Charges (not a hospital service). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

Do NOT Include In Hospital Uninsured Payments for purposes of calculating Hospital-Specific DSH Limit:

- Exclude State, county or other municipal subsidy payments made to hospitals for indigent care. *(42 CFR 447.299 (12))*
- Exclude any individual payments or third party payments on deductibles and co-insurance on Commercial and Medicare accounts (cost not included so neither is payment). *(42 CFR 447.299 (15))*
- Exclude collections for non-hospital services: Skilled Nursing Facility, Nursing Facility, Rural Health Clinic, Federally Qualified Health Clinic, and non-hospital clinics (i.e. clinics not reported on Worksheet "C" Part I) (not hospital services). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

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Facility Name: ABC

DSH Year Basis Begin Date 7/1/2008 **DSH Year Basis End Date** 6/30/2009

Identification of Medicare audited cost report period for cost reporting:

	Cost Report Begin Date		Cost Report End Date
Cost Report Begin Date (The begin date must be on or before the DSH year begin date)		**Cost Report 1 End Date**	

General Information

Please provide the correct information, and choose Yes or No to questions 4 through 6.

1. Hospital Name: (Hospital Name) — ABC
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)

Please check the "Yes" or "No" Box in below:

	During SFY 2010 (July 1, 2009 - June 30, 2010):	Yes	No
4.	Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (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.)		
5.	Was the hospital exempt from the requirement listed under #4 above because the hospital's inpatients are predominantly under 18 years of age?		
6.	Was the hospital exempt from the requirement listed under #4 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. Cost Report Information:

		Cost Report Year
1.	Total Medicare Days (WS S-3 Pt I, Col.4. Sum of Lns.12.14.14.x, less Lns.3&4)	
2.	Medicare Allowable GME Payment (from W/S E-3, Part IV, Lines 24 plus 25)	

B. Disclosure of payments the hospital received:

		Cost Report Year	SFY 2010
1.	a. Section 1011 Payment Related to Hospital Services Included in Exhibit D & D-1 (See Note 1)		
	b. Section 1011 Payment Related to Hospital Services NOT Included in Exhibit D & D-1 (See Note 1)		
	Total Section 1011 Payments Related to Hospital Services (See Note 1)	$ -	
	c. Section 1011 Payment Related to Non-Hospital Services Included in Exhibit D & D-1 (See Note 1)		
	d. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibit D & D-1 (See Note 1)		
	Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)	$ -	
2.	**Out-of-State DSH Payments (See Note 2)**		
3.	a. Indiana Hospital Care for the Indigent Supplemental Payment		
	b. Indiana Medicaid Municipal Hospital Payment		
	c. Indiana Supplemental Payment to Privately Owned Hospitals		
	Total Indiana Supplemental Payments (See Note 3)		$ -
4.	**Out of State Supplemental Medicaid Payments made on a SFY basis**		

Note 1:
Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2:
Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

Note 3:
Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.

State of Indiana
Hospital Specific Limit (HSL) Survey
For State DSH Year Ending 6/30/2010

Facility Name: ABC

DSH Year Basis Begin Date 7/1/2008 **DSH Year Basis End Date** 6/30/2009

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, D, E, F, G, & H of the DSH 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

Date

Title

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

Hospital Contact:	
Name	
Title	
Telephone Number	
E-Mail Address	
Mailing Address	
City	
State	
Zip	

Outside Preparer:	
Name	
Title:	
Firm Name:	
Telephone Number	
E-Mail Address	

Please print a hard copy, sign, and submit with your survey.

State of Indiana
Hospital Specific Limit (HSL) Survey
For State DSH Year Ending 6/30/2010

ABC

C. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Medicare Audited Cost Report Year ending within SFY 2009

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers (Note A)	In-State FFS Medicaid Primary		In-State Managed Care Medicaid Primary		In-State FFS Cross-Over		In-State Managed Care Cross-Over		Validated Paid Claims – Not Duplicates		In-State FFS Medicaid-Eligible Not on Medicaid Paid Claims Data Exhibit A needed		In-State Managed Care Medicaid-Eligible Not on Medicaid Paid Claims Data Exhibit B needed		Total In-State Medicaid Data		Uninsured Exhibits C&D needed	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Data Sources:		Cost Report Worksheet D-1, Part II	Cost Report Worksheet C, Part 1	From Medicaid Paid Claims Data Summary (Note B)								From Possible Duplicate Claims Report		From Hospital's Own Internal Analysis				Calculation		From Hospital's Own Internal Analysis	
Routine Cost Centers (from W/S D-1) (list below):				Days		Days		Days		Days		Days		Days		Days		Days		Days	
																		-			
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			Total Days	-		-		-		-		-		-		-		-		-	
														(Agree to Exhibit A)		(Agree to Exhibit B)				(Agree to Exhibit C)	
			Total Days per Medicaid Paid Claims Data																		
			Unreconciled Days (Note C)	-		-		-		-											
			Explanations																		
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
	Routine Charges																	$ -			
Ancillary Cost Centers (from W/S C) (list below):				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges	
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State of Indiana
Hospital Specific Limit (HSL) Survey
For State DSH Year Ending 6/30/2010

ABC

C. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Medicare Audited Cost Report Year ending within SFY 2009

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers (Note A)	In-State FFS Medicaid Primary		In-State Managed Care Medicaid Primary		In-State FFS Cross-Over		In-State Managed Care Cross-Over		Validated Paid Claims – Not Duplicates		In-State FFS Medicaid-Eligible Not on Medicaid Paid Claims Data Exhibit A needed		In-State Managed Care Medicaid-Eligible Not on Medicaid Paid Claims Data Exhibit B needed		Total In-State Medicaid Data		Uninsured Exhibits C&D needed	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Data Sources:		Cost Report Worksheet D-1, Part II	Cost Report Worksheet C, Part 1	From Medicaid Paid Claims Data Summary (Note B)								From Possible Duplicate Claims Report		From Hospital's Own Internal Analysis				Calculation		From Hospital's Own Internal Analysis	
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	Total Charges			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
														(Agree to Exhibit A)		(Agree to Exhibit B)				(Agree to Exhibit C)	
	Total Charges per Medicaid Paid Claims Data																				
	Unreconciled Charges (Note C)			-	-	-	-	-	-	-	-										
	Explanations																				
	Total Calculated Cost			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)																	$ -	$ -		
	Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare)																	$ -	$ -		
	Total Allowed Amount from Medicaid Paid Claim Data (Payments)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -					$ -	$ -		
	Other Medicaid Payments Reported on Cost Report Year (See Note D)																	$ -	$ -		
	Medicare Paid Amount (excludes coinsurance/deductibles)																	$ -	$ -		
	Medicare Cross-Over Bad Debt Payments																	$ -	$ -		
	Other Medicare Cross-Over Payments (See Note E)																	$ -	$ -		
	Payments Received by Hospital for Medicaid-Eligible Services not included on Medicaid Paid Claims Data																	$ -	$ -		
	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)																				
																				(Agree to Exhibit C)	
	Calculated Payment Shortfall / (Longfall) for cost report year			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Note A - Use the Medicaid cost-to-charge ratios which may include teaching costs that were excluded for Medicare cost report purposes.
Note B - These amounts must agree to your inpatient and outpatient Medicaid paid claims data summary. For Managed Care and Cross-Over data, use the hospital's logs if paid claims data summaries are not available (submit logs with survey).
Note C - Please explain any difference.
Note D - Other Medicaid Payments such as Non-Claim Specific payments. DSH payments should NOT be included. Supplemental payments made on a state fiscal year basis should be reported in Section E of the survey.
Note E - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).

State of Indiana
Hospital Specific Limit (HSL) Survey
For State DSH Year Ending 6/30/2010

ABC

D. Out-of-State Medicaid Inpatient and Outpatient Hospital Data:

If this Section does not apply to your facility, please type "N/A" here.

Medicare Audited Cost Report Year ending within SFY 2009

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers (Note A)	Out-of-State FFS Medicaid Primary: Inpatient	Out-of-State FFS Medicaid Primary: Outpatient	Out-of-State Managed Care Medicaid Primary: Inpatient	Out-of-State Managed Care Medicaid Primary: Outpatient	Out-of-State FFS Cross-Over: Inpatient	Out-of-State FFS Cross-Over: Outpatient	Out-of-State Managed Care Cross-Over: Inpatient	Out-of-State Managed Care Cross-Over: Outpatient	Total Out-Of-State Medicaid: Inpatient	Total Out-Of-State Medicaid: Outpatient
Data Sources:		Cost Report Worksheet D-1, Part II	Cost Report Worksheet C, Part 1	From Medicaid Paid Claims Data Summary - submitted by provider (Note B)								Calculation	
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
												-	
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			Total Days	-		-		-		-		-	
			Total Days per Medicaid Paid Claims Data										
			Unreconciled Days (Note C)	-		-		-		-		-	
			Explanations										
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
	Routine Charges											$ -	
Ancillary Cost Centers (list below):				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges	
												-	-
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State of Indiana
Hospital Specific Limit (HSL) Survey
For State DSH Year Ending 6/30/2010

ABC

D. Out-of-State Medicaid Inpatient and Outpatient Hospital Data:

If this Section does not apply to your facility, please type "N/A" here.

Medicare Audited Cost Report Year ending within SFY 2009

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers (Note A)	Out-of-State FFS Medicaid Primary		Out-of-State Managed Care Medicaid Primary		Out-of-State FFS Cross-Over		Out-of-State Managed Care Cross-Over		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Data Sources:		Cost Report Worksheet D-1, Part II	Cost Report Worksheet C, Part 1	From Medicaid Paid Claims Data Summary - submitted by provider (Note B)								Calculation	
												-	-
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			Total Charges	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
			Total Charges per Medicaid Paid Claims Data										
			Unreconciled Charges (Note C)	-	-	-	-	-	-	-	-		
			Explanations										
			Total Calculated Cost	-	-	-	-	-	-	-	-	-	-
			Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)									$ -	$ -
			Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare)									$ -	$ -
			Total Payments per Medicaid Paid Claims Data	$ -	$ -	$ -	$ -					$ -	$ -
			Medicaid Cost Settlement Payments (See Note D)									$ -	$ -
			Other Medicaid Payments Reported on Cost Report Year (See Note E)									$ -	$ -
			Medicare Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
			Medicare Cross-Over Bad Debt Payments									$ -	$ -
			Other Medicare Cross-Over Payments (See Note F)									$ -	$ -
			Calculated Payment Shortfall / (Longfall)	-	-	-	-	-	-	-	-	-	-

Note A - Use the Medicaid cost-to-charge ratios which may include teaching costs that were excluded for Medicare cost report purposes.
Note B - These amounts must agree to your OOS inpatient and outpatient Medicaid paid claims data summary. For Managed Care and Cross-Over data, use the hospital's logs if paid claims data summaries are not available (submit logs with survey).
Note C - Please explain any difference.
Note D - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the Medicaid paid claims data summary.
Note E - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section E of the survey.
Note F - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).

State of Indiana
Hospital Specific Limit (HSL) Survey
For State DSH Year Ending 6/30/2010

ABC

E. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

If this Section does not apply to your facility, please type "N/A" here.

Medicare Audited Cost Report Year ending within SFY 2009

	Total Organ Acquisition Cost	Revenue for Medicaid/ Uninsured Organs Sold	Total Useable Organs (Count)	In-State FFS Medicaid Primary		In-State Managed Care Medicaid Primary		In-State FFS Cross-Over		In-State Managed Care Cross-Over		Uninsured	
				Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet B, Pt. I, Col. 27	Use Instructions from Cost Report W/S D-6, Pt. III, Col. 1, Ln 58 (substitute Medicare with Medicaid/ uninsured)	Cost Report Worksheet D-6, Pt. III, Line 54	From Medicaid Paid Claims Data Summary - submitted by provider (Note A)									
Organ Acquisition Cost Centers (list below):													
	Lung Acquisition												
	Kidney Acquisition												
	Liver Acquisition												
	Heart Acquisition												
	Pancreas Acquisition												
	Intestinal Acquisition												
	Totals			$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
	Total Cost				$ -		$ -		$ -		$ -		$ -

Note A - These amounts must agree to your Indiana inpatient and outpatient Medicaid paid claims summary, if available. If not, use hospital's logs and submit with survey.
Note B - Enter Organ Acquisition Payments in Section C as part of your In-State Medicaid total payments.

F. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

If this Section does not apply to your facility, please type "N/A" here.

Medicare Audited Cost Report Year ending within SFY 2009

	Total Organ Acquisition Cost	Revenue for Medicaid/ Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State FFS Medicaid Primary		Out-of-State Managed Care Medicaid Primary		Out-of-State FFS Cross-Over		Out-of-State Managed Care Cross-Over	
				Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet B, Pt. I, Col. 27	Use Instructions from Cost Report W/S D-6, Pt. III, Col. 1, Ln 58 (substitute Medicare with Medicaid/ uninsured)	Cost Report Worksheet D-6, Pt. III, Line 54	From Medicaid Paid Claims Data Summary - submitted by provider (Note A)							
Organ Acquisition Cost Centers (list below):											
	Lung Acquisition	$ -	$ -	-							
	Kidney Acquisition	$ -	$ -	-							
	Liver Acquisition	$ -	$ -	-							
	Heart Acquisition	$ -	$ -	-							
	Pancreas Acquisition	$ -	$ -	-							
	Intestinal Acquisition	$ -	$ -	-							
		$ -	$ -	-							
	Totals			$ -	-	$ -	-	$ -	-	$ -	-
	Total Cost				$ -		$ -		$ -		$ -

Note A - These amounts must agree to your OOS inpatient and outpatient Medicaid paid claims summary, , if available. If not, use hospital's logs and submit with survey.
Note B - Enter Organ Acquisition Payments in Section D as part of your Out-Of-State Medicaid total payments.

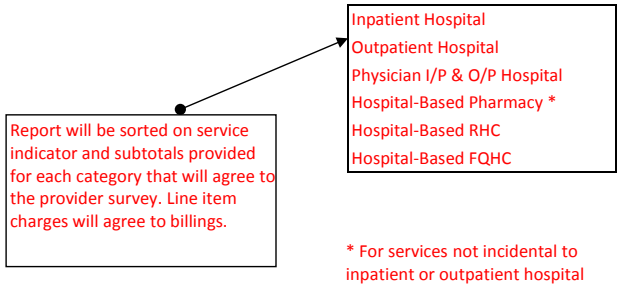
EXHIBIT A

State of Indiana
Hospital Specific Limit (HSL) Survey
For State DSH Year Ending 6/30/2010

ABC

Summary of In-State FFS Medicaid-Eligible Not on Medicaid Paid Claims Data

Provider ID	Patient Identifier				Date(s) of Service		Routine Days of Care [1]	Service Indicator	Revenue Code	Total Charges for Services Provided	Total Payments for Services Provided (Accrual Basis)
	Indiana Medicaid Recipient ID	Patient A/C ID	F Name	FDOS	LDOS						



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).

Note 1: Include only days for which patient was eligible for Indiana Medicaid.

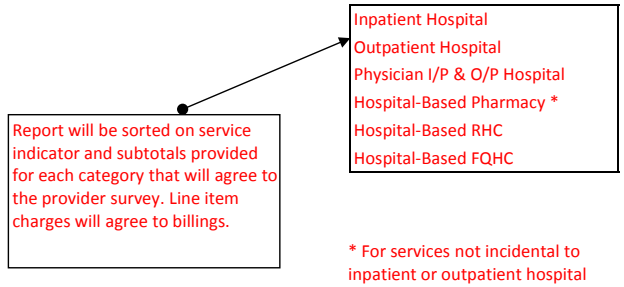
EXHIBIT B

ABC

State of Indiana
Hospital Specific Limit (HSL) Survey
For State DSH Year Ending 6/30/2010

Summary of In-State MCO Medicaid-Eligible Not on Medicaid Paid Claims Data

Provider ID	Patient Identifier					Date(s) of Service		Routine Days of Care [1]	Service Indicator	Revenue Code	Total Charges for Services Provided	Total Payments for Services Provided (Accrual Basis)
	Indiana Medicaid Recipient ID	Patient A/C ID	Claim ID	L Name	F Name	FDOS	LDOS					



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).

Note 1: Include only days for which patient was eligible for Indiana Medicaid.

EXHIBIT C

ABC

State of Indiana
Hospital Specific Limit (HSL) Survey
For State DSH Year Ending 6/30/2010

Summary of Uninsured I/P and O/P Hospital Services

Provider ID				Date(s) of Service		Routine Days of Care [1]	Service Indicator	Revenue Code	Total Charges for Services Provided	Total Payments for Services Provided (Accrual Basis)
	Patient A/C ID	L Name	F Name	FDOS	LDOS					

Inpatient Hospital
Outpatient Hospital
Physician I/P & O/P Hospital
Hospital-Based Pharmacy *
Hospital-Based RHC
Hospital-Based FQHC

Report will be sorted on service indicator and subtotals provided for each category that will agree to the provider survey. Line item charges will agree to billings.

* 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).

Note 1: Include only days for which patient was uninsured.