



**METHODOLOGY FOR VERMONT'S
DISPROPORTIONATE SHARE PAYMENTS
IN FEDERAL FISCAL YEAR 2012**

DEPARTMENT OF VERMONT HEALTH ACCESS

DECEMBER 30, 2011

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Section 1: Introduction

This document sets forth the criteria by which Vermont defines disproportionate share (DSH) hospitals and the methodology through which DSH payments are calculated and distributed. The document is updated each year to reflect the data used to calculate DSH payments.

The federal government shares in the cost of Medicaid DSH expenditures based on the Federal Medical Assistance Percentage (FMAP)¹ for each state. However, for each fiscal year, the amount of federal funds available to states for DSH payment is fixed. As such, the total amount of DSH payments for a state plan year will not exceed the federal allotment divided by the FMAP. The Centers for Medicare and Medicaid (CMS) publish preliminary allotments of the federal participation limit in advance of each new Federal Fiscal Year (FFY). The most recent allotment prescribed for by CMS for Vermont was for FFY 2011 at \$22,524,000. The FMAP rate for FFY 2012 is 57.58%. Therefore, using the FFY 2011 amount as a preliminary figure for FFY 2012, total DSH expenditures (state and federal funds combined) cannot exceed \$39,117,749. The Vermont Legislature provided state funding for DSH for FFY 2012 such that total funds (state and federal) spent by the Department of Vermont Health Access (DVHA) for DSH in FFY 2012 were \$37,448,781.

Federal law² states that aggregate DSH payments to Institutions for Mental Diseases³ (IMDs) in Vermont is restricted to the *lesser* of \$9,249,739 or 23.64% of the current year total DSH allotment. DSH payments to IMDs would be reduced proportionately to the extent necessary to ensure that the aggregate IMD limit is not exceeded. In FFY 2012, this was not an issue because no IMDs in Vermont received DSH payments.

Section 2: Hospital Eligibility Requirements

In order to be considered a DSH hospital in Vermont⁴, a hospital must:

- Be located in the state of Vermont;
- Submit the information required by Vermont to calculate DSH by the specified due date;
- Satisfy one of the conditions in Column A in the table on the next page;
- Satisfy one of the conditions in Column B; and
- Satisfy the conditions in Column C.

¹ 42 CFR 433.10 – Rates of FFP for program services.

² 42 CFR 447.297 – Limitation on aggregate payment for disproportionate share hospitals beginning October 1, 1992.

³ “Institutions for Mental Diseases” includes hospitals that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The IMD designation is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

⁴ Hospital eligibility requirements are in accordance with Vermont Medicaid State Plan Amendment 4.19-A pg. 1d and Section 1923(b) of the Social Security Act.

COLUMN A	COLUMN B	COLUMN C
<p>1. The hospital has a Medicaid Inpatient Utilization Rate (MIUR) which is at least one standard deviation above the mean MIUR for all hospitals receiving a Medicaid payment in the state (“Group 1”).</p> <p>2. The hospital has a Low Income Utilization Rate (LIUR) that exceeds 25% (“Group 2”).</p> <p>3. The hospital operates a post-graduate training program in the State of Vermont (“Group 3”).</p> <p>4. The hospital’s status is that of a privately-owned or privately-operated acute care general hospital or psychiatric facility with a MIUR of at least 1% that does not meet the criteria for Groups 1, 2 or 3 (“Group 4”).</p>	<p>1. The hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid patients.</p> <p>2. If the hospital is outside the Burlington-South Burlington Core Based Statistical Area (CBSA), item #1 above must be met but the term “obstetrician” includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures</p> <p>3. The patients of the hospital are predominantly under 18 years of age.</p> <p>4. The hospital was in existence on December 22, 1987 but did not offer non-emergency obstetric services as of that date.</p>	<p>1. The hospital has a MIUR of at least 1 percent.</p> <p>2. The hospital meets the requirements for participation as a hospital in Medicare (except in the case of medical supervision of nurse-midwife services). Therefore, for purposes of DSH, the facility must be Medicare-certified during the base year from which the DSH payment was derived.</p> <p>If a hospital is only Medicare-certified for part of the base year from which the DSH payment was derived, the eligibility and the payment will be calculated based on the period for which the hospital was Medicare-certified.</p>

In Column A, Groups 1 and 2 contain those hospitals that are deemed to be hospitals eligible to participate in DSH under federal Medicaid law. Groups 3 and 4 contain additional hospitals that the State has deemed to be hospitals eligible to participate in DSH within its federal authority to do so. The criteria listed in Columns B and C are federal eligibility requirements which apply regardless of whether or not the hospital is deemed or designated as a DSH hospital.

Using data available to DVHA prior to the release of the DSH Survey, the eligibility determination calculations shown above are performed annually for all hospitals located in the State of Vermont that are registered as providers with the DVHA. A hospital deemed eligible to participate does not mean that the hospital will receive a DSH payment. Additional federally-required tests must be conducted to determine if a DSH participating hospital is eligible for a payment. For hospitals deemed eligible to participate in DSH, the DSH payment calculations and tests are performed only for hospitals that agree to participate and have completed the DSH Survey⁵ sent to them by the DVHA as well as other information that may be requested by the DVHA. In order to be considered “completed”, the signed and attested DSH Survey must be received by DVHA by the due date specified in a request for information communicated to the

⁵ A template of the DSH Survey utilized for DSH FFY 2012 appears in Appendix 10.

Chief Financial Officer of the hospital each year. The deadline for submission of the DSH Survey was March 18, 2011.

One DSH eligible hospital, Retreat Health Care, submitted an attestation to DVHA that it chose not to participate in DSH for FFY 2012. As such, although Retreat Health Care was included in the initial eligibility calculations, it was excluded from DSH payment calculations in FFY 2012.

From the data reported and attested to on the DSH Survey, the DVHA verifies whether or not each hospital has satisfied the conditions under Columns B and C in the previous table. For hospitals that meet these criteria, the DVHA then assesses each hospital's eligibility for one of the Groups 1 through 4 in Column A.

The DVHA may redetermine any hospital's eligibility for any DSH payment should the agency become aware of any information that may prove that

- The hospital was not eligible for a DSH payment, or
- The hospital was eligible for another Group than was originally determined.

Section 3: Definitions of State Plan Payment Year and Base Year

DSH eligibility tests and payment calculations are made based on the State Plan Payment Year (SPY). The SPY is equivalent to the Federal Fiscal Year and runs from October 1 to September 30 of each year. The calculations to determine eligibility for, and the amount of, DSH payments are made on the basis of the Base Year. The Base Year is also equivalent to the Federal Fiscal Year but a look-back period is utilized. For DSH payments made in SPY 2012, the Base Year used was FFY 2009 (October 1, 2008 – September 30, 2009). This also corresponds to each Vermont hospitals' fiscal year with the exception of Retreat Health Care.⁶

Section 4: Medicaid Inpatient Utilization Rate (MIUR) Calculation

A hospital's MIUR determines the hospital's overall eligibility for DSH as well as the hospital's eligibility for Group 1. A hospital's MIUR is calculated using the following equation:

$$MIUR = \frac{\text{Total Medicaid Inpatient Days}}{\text{Total Number of Inpatient Days}}$$

The calculation is performed using data from the base year. If a hospital has a MIUR which is at least one standard deviation above the mean MIUR, it will meet the eligibility for Group 1. Otherwise, if the hospital does not meet the criteria for placement in Groups 2 or 3 and the hospital has an MIUR of at least 1%, then the hospital is placed in Group 4.

In performing the calculations:

⁶ Retreat Health Care utilizes the calendar year as its fiscal year. As such, cost report data was prorated across two of Retreat Health Care's hospital years in the DSH FFY 2012 eligibility tests—three months from the hospital's year ending 12/31/08 and nine months from the hospital's year ending 12/31/09. Claims data was used in the Base Year only.

1. “Medicaid Inpatient Days” includes all paid covered inpatient days for Title XIX clients (including days when the client is in a specialized ward and when the individual remains in the hospital for lack of suitable placement elsewhere). It does not include inpatient days in which a Title XIX client was in an IMD and the client was between 22 and 64 years of age or when a Title XIX client was in a hospital skilled nursing facility unit.

Data Source Used: Report MRMN503S, compiled by the DVHA’s fiscal agent, which enumerates paid covered Title XIX days for each hospital during the DSH Base Year. These figures are attested to by the hospital in the DSH Survey Sheet or updated, with supporting documentation, when necessary.

2. “Total Number of Inpatient Days” includes:
 - a. Fee-for-service and managed care days, and
 - b. Each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward, and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

Data Source Used: The total Inpatient Days reported on a hospital’s most recently filed Medicare Cost Report (MCR) from the Base Year, whether it was audited or not audited. The specific figures to be used are found on Worksheet S-3, Column 6 (Line 12 plus Line 14 minus Lines 3 and 4).

Calculation of the Mean MIUR and the Standard Deviation

The Mean MIUR is calculated as the average of the individual hospitals’ MIURs, weighted by Medicaid days. All hospitals with a MIUR in the base year that was greater than zero are in the calculation, including the MIURs from hospitals with a MIUR that is less than 1%. The Mean MIUR calculated for DSH SPY 2012 was 18.02%. The standard deviation is calculated utilizing the same individual hospital MIURs that were used in the calculation of the mean. The standard deviation for DSH SPY 2012 was 6.27%. Therefore, the threshold for hospitals to meet Group 1 eligibility in DSH SPY 2012 was 24.29%.

Refer to Appendix 3 for details on the MIUR calculations for DSH SPY 2012.

Section 5: Low Income Utilization Rate (LIUR) Calculation

A hospital’s LIUR determines the hospital’s eligibility for Group 2. A hospital’s LIUR is calculated by summing the following two equations:

Equation 1

$$\frac{\text{Total Medicaid Patient Revenues} + \text{Total State \& Local Cash Subsidies for Patient Services}}{\text{Total Revenues for Patient Services}}$$

Equation 2

$$\frac{\text{Total Inpatient Charges Attributable to Charity Care} - \text{Cash Subsidies Portion Attributable to Inpatient}}{\text{Total Inpatient Charges}}$$

The calculation is performed using hospital data from the base year. If a hospital has a LIUR that exceeds 25%, it will meet the eligibility for Group 2.

In performing the calculations:

1. “Total Medicaid Patient Revenues” includes Title XIX revenues for inpatient and outpatient services. It does not include DSH payments, payments made for Graduate Medical Education (GME), any other Title XIX supplemental payments that may be authorized by the Legislature, physician revenue or revenue from hospital-based skilled nursing facility (SNF) units.

Data Source Used: The DVHA confirmed with hospitals that for the Base Year, no DSH eligible hospitals reported this value separately on their audited financial statements. Thus, the DVHA defaulted to figures reported to the State of Vermont’s Banking, Insurance, Securities and Health Care Administration (BISHCA) on its Report #5 “Net Patient Care Revenue by Payer”. For DSH SPY 2012, the values in the column labeled “Actual 2009” were used. The hospitals attested to the accuracy of these figures on the DSH Survey and/or through supplemental correspondence.

2. “Total State and Local Cash Subsidies for Patient Services” includes payments made with state-only or local-only funds. Historically, there have been no state and local cash subsidies patient services in Vermont.

Data Source Used: Attestation from the hospitals of data populated by the hospitals on the DSH Survey.

3. “Total Revenues for Patient Services” includes total patient revenue for hospital services (including hospital subprovider charges). It does not include DSH payments, payments made for Graduate Medical Education (GME), any other Title XIX supplemental payments that may be authorized by the Legislature, physician revenue or revenue from hospital-based skilled nursing facility (SNF) units.

Data Source Used: DVHA defaulted to figures reported to the State of Vermont’s Banking, Insurance, Securities and Health Care Administration (BISHCA) on its Report #5 “Net Patient Care Revenue by Payer”. For DSH SPY 2012, the values in the column labeled “Actual 2009” were used. The hospitals attested to the accuracy of these figures on the DSH Survey and/or through supplemental correspondence.

4. “Total Inpatient Charges Attributable to Charity Care” includes the amount of inpatient services – stated as charges – that is provided free to individuals who cannot afford health care due to inadequate resources as determined by the hospital’s charity care policy and do not otherwise qualify for government subsidized insurance. It does not include bad debt expense or contractual allowances and discounts offered to third party payers or self-pay patients that do not qualify for charity care pursuant to the hospital’s charity care policy.

Data Source Used: Claim-level detail data was submitted by each hospital as an addendum to their DSH Survey. The DVHA verified that the totals on the addenda were properly carried forward to the DSH Survey.

5. “Cash Subsidies Portion Attributable to Inpatient” means that portion of “Total State and Local Cash Subsidies for Patient Services” that is attributable to inpatient services.

Data Source Used: Attestation from the hospitals of data populated by the hospitals on the DSH Survey.

6. “Total Inpatient Charges” includes total inpatient and hospital subprovider charges without any deductions for contractual allowances or discounts offered to third party payers or self pay patients.

Data Source Used: DVHA defaulted to figures reported to the State of Vermont’s Banking, Insurance, Securities and Health Care Administration (BISHCA) on its Report #5 “Net Patient Care Revenue by Payer”. For DSH SPY 2012, the values in the column labeled “Actual 2009” were used. The hospitals attested to the accuracy of these figures on the DSH Survey and/or through supplemental correspondence.

Refer to Appendix 4 for details on the LIUR calculations for DSH SPY 2012.

Section 6: State-designed Group Eligibility Determinations

Group 3 Eligibility Determination – Teaching Facilities

A privately-owned or privately-operated general acute care hospital with its headquarters in the State of Vermont that operates a post-graduate training program is deemed eligible for Group 3.

Group 4 Eligibility Determination – All Other Eligible Hospitals

By definition, if a hospital meets the federal requirement⁷ of having an MIUR of at least 1% in the base year and has not met the criteria for placement in Groups 1, 2 or 3, then the hospital is automatically eligible for Group 4.

Section 7: Satisfying the Obstetrical Requirement for Eligibility

In order to ensure that hospitals receiving DSH payments meet requirements related to obstetricians⁸, all hospitals that are determined to have a MIUR of at least 1% must make the obstetrical selection on the DSH Survey and sign the attestation below it certifying that the selection is true. Any hospital that fails to return the certification by the date specified by DVHA will not be eligible to receive DSH payments for the DSH SPY.

⁷ Requirements in accordance with Section 1923(d) of the Social Security Act.

⁸ Requirements in accordance with Vermont Medicaid State Plan Attachment 4.19A pg. 1d and Section 1923(d).

For the determination of a hospital's compliance with the obstetrician requirement, the certification will be based on the start of the base year for DSH through to actual date of certification.

The DSH Survey Sheet allows for the following selections:

- I certify that the hospital has at least two obstetricians with staff privileges who have agreed to provide obstetric services (emergency and non-emergency) to individuals eligible for Medicaid. OR
- I certify that the hospital is located in a rural area and has at least two qualified physicians with staff privileges who have agreed to provide non-emergency obstetric services to individuals eligible for Medicaid. OR
- I certify that the hospital did not offer non-emergency obstetric services to the general population as of December 22, 1987, or that the inpatients of the hospital are predominantly individuals under 18 years of age. OR

One of the selections must be attested to in order for the hospital to be eligible for DSH.

Section 8: Hospital-specific (OBRA) Limit Calculations

The OBRA limit is calculated using the following equation:

$$\begin{aligned} & \text{Costs Incurred Serving Medicaid Recipients} \\ & \text{Less Payments Received for Costs Incurred Serving Medicaid Recipients} \\ & \quad \text{[the "Medicaid Shortfall"]} \\ & \text{Plus Costs Incurred Serving Individuals with No Third Party Coverage} \\ & \text{Less Payments Received for Costs Incurred Serving Individuals with No Third Party} \\ & \quad \text{Coverage} \end{aligned}$$

Pursuant to the above equation:

$$\begin{aligned} & \text{Costs Incurred Serving Medicaid Recipients} = \\ & \text{[VT Medicaid Inpatient Days]} * \text{[Medicaid Hospital-specific Accommodation Cost Per Day]} + \\ & \text{[VT Medicaid Inpatient Ancillary Charges]} * \text{[Medicaid Inpatient Ancillary Cost-to-Charge Ratio} \\ & \quad \text{(CCR)]} \\ & + \text{[VT Medicaid Outpatient Charges]} * \text{[Medicaid Outpatient CCR]} + \\ & \text{[VT Medicare/Medicaid dual eligible Inpatient Days + Other State Medicaid eligible Inpatient Days]} * \\ & \quad \text{[Medicaid Hospital-specific Accommodation Cost Per Day]} + \\ & \text{[VT Medicare/Medicaid dual eligible Inpatient Ancillary Charges + Other State Medicaid eligible} \\ & \quad \text{Inpatient Ancillary Charges]} * \text{[Medicaid Inpatient Ancillary CCR]} + \end{aligned}$$

[VT Medicare/Medicaid dual eligible Outpatient Charges + Other State Medicaid eligible Outpatient Charges] * [Medicaid Outpatient CCR] +

[Medicaid Allocated Portion of Graduate Medical Education Costs Not Paid by Medicare]

Payments Received for Costs Incurred Serving Medicaid Recipients =

[Medicaid Inpatient Payments + Medicaid Outpatient Payments + Payments for Graduate Med. Ed.]

Costs Incurred Serving Individuals with No Third Party Coverage=

[Inpatient Days for Individuals with No Third Party Coverage] * [Medicaid Hospital-specific Accommodation Cost Per Day] +

[Inpatient Ancillary Charges for Individuals with No Third Party Coverage] * [Medicaid Inpatient Ancillary CCR] +

[Outpatient Charges for Individuals with No Third Party Coverage] * [Medicaid Outpatient CCR]

Payments Received for Costs Incurred Serving Individuals with no Third Party Coverage =

[Payments from Individuals] + [State/Local Subsidies for Patient Services] + [Section 1011 payments]

The OBRA limit used to compare against a DSH payment in a SPY is based on information from the Base Year utilized for the DSH SPY. For DSH SPY 2012, this Base Year was for the period 10/1/08 – 9/30/09 for all participating hospitals.

Data Sources for OBRA Limit Calculations

Refer to Appendix 5 for the calculation. Refer to Appendices 6, 7 and 8 for schedules of the data elements used to support the calculation.

1. For Costs Incurred Serving Medicaid Recipients

- a. Vermont Medicaid Inpatient Days: The MMIS Report MRMN503S was used, subject to attestation by the hospital. Inpatient Days were segmented using revenue codes to separately identify Adults & Peds, Nursery, ICU, NICU, Surgical ICU, Subprovider and step-down days (awaiting placement in a SNF).
- b. Medicaid Hospital-specific Accommodation Cost Per Day: Accommodation revenue codes were mapped to a hospital cost center. The cost per day value assigned to each revenue code was based on the cost center that the revenue code was assigned to. The cost per day values used were from among the following sources:

Worksheet D-1, Part II, Line 38:	Adults & Peds
Worksheet D-1, Part II, Line 42:	Nursery
Worksheet D-1, Part II, Line 43:	ICU
Worksheet D-1, Part II, Line 45.01:	NICU (only reported by Fletcher Allen)
Worksheet D-1, Part II, Line 46:	Surgical ICU (only reported by Fletcher Allen)
Worksheet D-1, Part II, Line 38 (Subprovider schedule):	Subprovider days

- c. Vermont Medicaid Inpatient Ancillary Charges: State Audit Report MRMN503S.
- d. Vermont Medicaid Outpatient Charges: State Audit Report MRMN503S.
- e. Medicaid Inpatient Ancillary CCR: The most recent filed MCR from the hospital's Base Year is used. The specific calculation is shown below.

The *Medicaid Inpatient Ancillary CCR* is calculated by dividing:

The sum of the amounts on the Title XIX schedules of Worksheet D-4 (Hospital),
Column 3, Line 101 and Worksheet D-4 (Subprovider), Column 3, Line 101

By

The sum of the amounts on the Title XIX schedules of Worksheet D-4 (Hospital),
Column 2, Line 101 and Worksheet D-4 (Subprovider), Column 2, Line 101

- f. Medicaid Outpatient CCR: The most recent filed MCR from the hospital's Base Year is used. The specific calculation is shown below.

The *Medicaid Outpatient CCR* is calculated by dividing:

The sum of the amounts on the Title XIX schedules of Worksheet D Part V, Column
9.01, Line 104 and Worksheet D Part V, Column 9.02, Line 104

By

The sum of the amounts on the Title XIX schedules of Worksheet D Part V, Column
5.01, Line 104 and Worksheet D Part V, Column 5.02, Line 104

- g. Medicare/Medicaid Dual Eligible Inpatient Days, Medicare/Medicaid Dual Eligible Inpatient Ancillary Charges, and Medicare/Medicaid Dual Eligible Outpatient Charges: Hospitals were instructed to either verify and attest to information provided by the DVHA's MMIS in the DSH Survey Supplemental Schedules 1 and 2 or to provide replacement Schedules 1 and 2 which can be supported by claim-level documentation. The Schedules 1 and 2 provided by the DVHA were an itemized claim-level detail of inpatient days, inpatient ancillary charges and outpatient charges for Medicare/Medicaid dual eligibles.
- h. Other State Medicaid Eligible Inpatient Days, Other State Medicaid Eligible Inpatient Ancillary Charges, and Other State Medicaid Eligible Outpatient Charges: Hospitals were instructed to complete Supplemental Schedules 1 and 2 in the DSH survey which can be supported by claim-level documentation. The Schedules 1 and 2 provided to the DVHA an itemized claim-level detail of inpatient days, inpatient ancillary charges and outpatient charges for other state Medicaid eligibles.
- i. Medicaid Allocated Portion of Graduate Medical Education Costs: The most recent filed MCR from the hospital's Base Year is used. The specific cell is on Worksheet E-3, Part IV, Title XIX schedule, Line 23.01.

2. For Payments Received for Costs Incurred Serving Medicaid Recipients
 - a. Vermont Medicaid Inpatient Payments: State Audit Report MRMN503S.
 - b. Vermont Medicaid Outpatient Payments: State Audit Report MRMN503S.
 - c. Medicare/Medicaid Dual Eligible Inpatient Payments: Reported by each hospital on Schedule 1 of the DSH Survey.
 - d. Medicare/Medicaid Dual Eligible Outpatient Payments: Reported by each hospital on Schedule 2 of the DSH Survey.
 - e. Other State Medicaid Eligible Inpatient Payments: Reported by each hospital on Schedule 1 of the DSH Survey.
 - f. Other State Medicaid Eligible Outpatient Payments: Reported by each hospital on Schedule 2 of the DSH Survey.
 - g. Payments for Graduate Medical Education: DVHA Finance Office (none were paid out in the Base Year).
3. For Costs Incurred Serving Individuals with no Third Party Coverage
 - a. Inpatient Days and Inpatient Ancillary Charges: Hospitals were instructed to complete Supplemental Schedule 3 in the DSH Survey which can be supported by claim-level documentation. The Schedule 3 provided to the DVHA is an itemized claim-level detail of inpatient days and inpatient ancillary charges for all cases where the individual had no third party coverage.
 - b. Outpatient Charges: Hospitals were instructed to complete Supplemental Schedule 4 in the DSH Survey which can be supported by claim-level documentation. The Schedule 4 provided to the DVHA is an itemized claim-level detail of outpatient charges for all cases where the individual had no third party coverage.
4. For Payments Received for Costs Incurred Serving Individuals with no Third Party Coverage
 - a. Inpatient Payments: Payments to the hospitals from individuals with no third party coverage were reported by each hospital on Schedule 3 of the DSH Survey.
 - b. Outpatient Payments: Payments to the hospitals from individuals with no third party coverage were reported by each hospital on Schedule 4 of the DSH Survey.
 - c. State & Local Subsidies for Patient Services: As reported and attested to by hospitals in their DSH Survey.

- d. Section 1011 payments: As attested to by hospitals in correspondence to the DVHA.

Section 9: Determining Funding for Each DSH Eligibility Group

Each year of the program, the DVHA determines the DSH Eligibility Group that each hospital is eligible for before calculating payments. If a hospital is eligible for more than one DSH Eligibility Group, for the purposes of computing the funding for each DSH Group, the hospital will be placed in only one DSH Eligibility Group in the following sequence:

DSH Eligibility Group #3
DSH Eligibility Group #1
DSH Eligibility Group #2
DSH Eligibility Group #4

Before the calculation of funding by DSH Group occurs, the calculation of each Hospital Specific Limit is completed as specified in Section 8. Funding for each Group is then completed as follows.

1. Funding for DSH Group #3 is done first. The amount funded for Group #3 is the lesser of 50% of the Total DSH Funding for the DSH SPY or 50% of the combined Hospital Specific Limit for all hospitals in the Group.
2. Subtract the amount funded for DSH Group #3 from the Total Available DSH Funding for the SPY to derive the remaining amount to be allocated between DSH Groups #1, #2 and #4.
3. Calculate for each hospital its percentage of Title XIX statewide days in the Base Year. (Refer to Appendix 3, Column 7)
 - a. The total statewide days value used in the calculation excludes the Title XIX days for any hospitals in DSH Group #3.
 - b. The total statewide days value used in the calculation excludes any hospital that has a Hospital Limit that is less than \$0 as computed in Step 8 above.
4. Sum the percentage of statewide days in the DSH Group.
 - a. If a hospital was paid for Title XIX days in the Base Year but was not eligible for DSH because it did not meet the minimum MIUR requirement, the percentage of its statewide days is excluded from all calculations.
 - b. If a hospital was paid for Title XIX days in the Base Year but was not eligible for DSH because it did not meet the obstetrical requirement, the percentage of its statewide days is excluded from all calculations.
 - c. If a hospital was paid for Title XIX days in the Base Year but was not eligible for DSH because its Hospital Specific Limit was less than \$0, the percentage of its statewide days is excluded from all calculations.

5. Calculate the DSH Allotment by DSH Eligibility Group using the following formula:

$$\frac{\text{Total Remaining DSH Funding Available (computed in Step 2)}}{\text{Total Percentage of Statewide Days in the DSH Group (computed in Step 4)}} *$$

For DSH SPY 2012, the allocation to each DSH Eligibility Group was as follows: Group 1: \$3,489,195; Group 2: \$0; Group 3: \$18,724,391; Group 4: \$15,235,196.

A summary of this allocation methodology is shown in Appendix 2.

Section 10: Calculation of Hospital-Specific Disproportionate Share Payments

Funding for hospitals in DSH Group #3 was described in Step 9. The DSH payments to each hospital in DSH Groups #1, #2 and #4 are made using the following methodology:

1. For each of the DSH Groups #1, #2 and #4, compute an Aggregate Hospital Limit that is the sum of the individual Hospital Specific Limits within the DSH Group for hospitals that are eligible for a DSH payment.
2. Determine each hospital's limit as a percentage of the DSH Group's Aggregate Hospital Limit.
3. Multiply the percentage computed in Step 2 by the DSH Group Allotment.

A summary of these calculations is shown in Appendix 2.

The DVHA ensures that the amount funded to each hospital does not exceed the Hospital Specific (OBRA) Limit⁹. If a hospital is found to have exceeded its OBRA limit, the amount of payment to the hospital in excess of its OBRA limit is recouped. The recouped amount is distributed proportionally based on the DSH payments to the eligible hospitals remaining in the DSH Group in which the hospital was placed. If no hospitals remain in the DSH Group, the recouped dollars are distributed proportionally to the remaining DSH Groups.

Section 11: State Plan Changes for DSH FFY 2012

The state plan was changed this year in the following manner:

- On page 1f, more precise language was added pertaining to the data sources used in the DSH tests and payment calculations
- On page 1g, the year of DSH funding was changed from DSH State Plan Year 2011 to State Plan Year 2012. The amount did not change.
- On page 1h, language was changed to reflect the policies described in this document under Section 9, 3(b) and 4(a), (b) and (c).

⁹ In accordance with Section 1923(g) of the Social Security Act.

Section 12: Other Provisions

A DSH payment will only be issued to the entity which is currently registered with the DVHA as a participating hospital provider. Therefore, it is expected that facilities will consider this information when negotiating ownership changes.

APPENDIX 1
Disproportionate Share Payments by Hospital in FFYs 2008, 2009, 2010, 2011 and 2012

	DSH FFY 2008 Payments	DSH FFY 2009 Payments	DSH FFY 2010 Payments	DSH FFY 2011 Payments	DSH FFY 2012 Payments	DSH FFY 2012 compared to DSH FFY 2011 Payments	Pct Diff 2012 to 2011	Pct Diff 2012 vs 2010
Brattleboro Memorial Hospital	\$ 1,352,000	\$ 883,724	\$ 1,393,697	\$ 1,368,678	\$ 1,176,989	\$ (191,689)	-14%	-16%
Central Vermont Medical Center	\$ 2,852,070	\$ 3,444,487	\$ 2,891,730	\$ 2,365,220	\$ 1,893,868	\$ (471,352)	-20%	-35%
Copley Hospital	\$ 1,267,840	\$ 931,518	\$ 1,486,958	\$ 719,895	\$ 677,478	\$ (42,417)	-6%	-54%
Fletcher Allen Health Care	\$ 17,182,875	\$ 17,131,743	\$ 16,903,464	\$ 16,738,071	\$ 18,724,391	\$ 1,986,320	12%	11%
Gifford Medical Center	\$ 941,389	\$ 294,586	\$ 975,804	\$ 560,302	\$ 875,394	\$ 315,092	56%	-10%
Grace Cottage Hospital	\$ 107,579	\$ 102,525	\$ -	\$ -	\$ 153,081	\$ 153,081		
Mt. Ascutney Hospital	\$ 680,832	\$ 102,525	\$ 500,038	\$ 686,822	\$ 302,698	\$ (384,125)	-56%	-39%
North Country Hospital	\$ 1,404,126	\$ 1,681,813	\$ 1,773,107	\$ 1,956,360	\$ 2,092,289	\$ 135,929	7%	18%
Northeastern Vermont Hospital	\$ 942,625	\$ 2,156,674	\$ 1,770,076	\$ 1,250,574	\$ 1,033,166	\$ (217,408)	-17%	-42%
Northwestern Medical Center	\$ 1,639,288	\$ 1,783,308	\$ 1,626,840	\$ 2,011,716	\$ 2,109,676	\$ 97,960	5%	30%
Porter Medical Center	\$ 1,118,329	\$ 496,697	\$ 1,016,911	\$ 1,292,983	\$ 753,493	\$ (539,490)	-42%	-26%
Retreat Health Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
Rutland Regional Medical Center	\$ 2,992,855	\$ 3,954,499	\$ 3,151,984	\$ 3,929,839	\$ 3,821,595	\$ (108,243)	-3%	21%
Southwestern Vermont Hospital	\$ 1,980,152	\$ 979,308	\$ 1,760,973	\$ 2,568,646	\$ 2,437,759	\$ (130,887)	-5%	38%
Springfield Hospital	\$ 1,722,434	\$ 2,605,376	\$ 1,297,199	\$ 1,999,676	\$ 1,396,906	\$ (602,771)	-30%	8%
Totals	\$ 36,184,394	\$ 36,548,782	\$ 36,548,781	\$ 37,448,781	\$ 37,448,781	\$ -	0%	2%

**Appendix 2
Calculations for Determining Disproportionate Share Payments Made in Federal Fiscal Year 2012**

Total DSH Allotment:	37,448,781
Less Allocation to DSH Group #3:	18,724,391
Allocation to Other Groups:	18,724,391

	Calculate Hospital Specific Limit	Calculate Pct of TXIX Days (excl. DSH Group #3)	Calculate DSH Allotment by Group	Compute Aggregate Limits by DSH Group	Determine Each Hospital's Limit as Pct of Group's Limit	Allocate DSH to Each Hospital	Effective Percent of Hospital Specific Limit Paid
			(Total Available DSH) * (Group's Pct Statewide Title XIX Days)			(Group DSH Allotment) * (Pct of Group Limit)	
DSH Group #1: MIUR			3,489,195	10,941,078			
North Country Hospital	6,560,797	6.4%			59.96%	2,092,289	31.89%
Springfield Hospital	4,380,281	12.2%			40.04%	1,396,906	31.89%
		18.6%				3,489,195	
DSH Group #2: LIUR							
			no hospitals eligible				
DSH Group #3: Teaching Hospitals			18,724,391	39,633,208			
Fletcher Allen Health Care	39,633,208				100.00%	18,724,391	
						18,724,391	47.24%
DSH Group #4: State-Designed Group			15,235,196	53,195,356			
Brattleboro Memorial Hospital	4,109,585	6.5%			7.73%	1,176,989	28.64%
Central Vermont Medical Center	6,612,648	14.7%			12.43%	1,893,868	28.64%
Copley Hospital	2,365,487	4.2%			4.45%	677,478	28.64%
Gifford Medical Center	3,056,534	3.3%			5.75%	875,394	28.64%
Grace Cottage Hospital	534,500	0.2%			1.00%	153,081	28.64%
Mt Ascutney Hospital	1,056,902	0.8%			1.99%	302,698	28.64%
Northeastern Vermont Hospital	3,607,412	5.2%			6.78%	1,033,166	28.64%
Northwestern Medical Center	7,366,165	5.9%			13.85%	2,109,676	28.64%
Porter Medical Center	2,630,902	3.6%			4.95%	753,493	28.64%
Retreat Health Care*	not considered						
Rutland Regional Medical Center	13,343,519	27.6%			25.08%	3,821,595	28.64%
Southwestern Vermont Hospital	8,511,703	9.3%			16.00%	2,437,759	28.64%
		81.4%			100.00%	15,235,196	
		100.0%	37,448,781			37,448,781	

* Waived participation in FFY 2012; preliminary estimate by DVHA found Retreat's hospital limit to be less than \$0.

APPENDIX 4
Supporting Schedule for Determining Eligibility for DSH Group #2 (LIUR) in Federal Fiscal Year 2012

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	
Variable for Calculation →	Net Medicaid Patient Revenue (IP+OP)	State & Local Cash Subsidies for Patient Services	Net All Payer Patient Revenue (IP+OP)	Ratio 1 of LIUR	Inpatient Charges Attributable to Individuals with No Third Party Coverage	State & Local Cash Subsidies for Inpatient Services	Total Gross Inpatient Charges	Ratio 2 of LIUR	Low Income Utilization Percentage	Group 2 Eligible?
Data Source →	DSH Survey (BISHCA Report)	Data request from hospitals with attestation	DSH Survey (BISHCA Report)	calculated as [(1)+(2)] / (3)	DSH Survey	DSH Survey	DSH Survey (BISHCA Report)	calculated as [(5)-(6)] / (7)	calculated as (4) + (8)	If (9) > 25%, then Yes
Brattleboro Memorial Hospital	4,418,259	0	52,891,019	8.35%	446,298	0	23,045,654	1.94%	10.29%	No
Central Vermont Medical Center	13,272,698	0	102,044,512	13.01%	874,962	0	48,971,872	1.79%	14.79%	No
Copley Hospital	4,380,869	0	41,814,612	10.48%	329,685	0	15,777,030	2.09%	12.57%	No
Fletcher Allen Health Care	47,328,603	0	622,305,718	7.61%	5,098,171	0	496,637,246	1.03%	8.63%	No
Gifford Medical Center	5,676,137	0	48,390,132	11.73%	331,501	0	14,356,081	2.31%	14.04%	No
Grace Cottage Hospital	324,781	0	7,738,890	4.20%	0	0	1,173,825	0.00%	4.20%	No
Mt. Ascutney Hospital	1,998,744	0	27,046,404	7.39%	11,860	0	5,207,844	0.23%	7.62%	No
North Country Hospital	6,573,357	0	53,849,806	12.21%	416,392	0	22,667,923	1.84%	14.04%	No
Northeastern Vermont Hospital	3,570,822	0	41,780,355	8.55%	482,736	0	23,229,869	2.08%	10.62%	No
Northwestern Medical Center	7,623,275	0	64,244,323	11.87%	202,094	0	28,053,047	0.72%	12.59%	No
Porter Medical Center	3,932,507	0	47,443,155	8.29%	164,231	0	19,010,547	0.86%	9.15%	No
Retreat Health Care										
Rutland Regional Medical Center	17,244,571	0	164,505,252	10.48%	3,593,721	0	125,198,477	2.87%	13.35%	No
Southwestern Vermont	10,912,424	0	113,769,527	9.59%	1,376,558	0	70,450,570	1.95%	11.55%	No
Springfield Hospital	5,729,142	0	45,667,505	12.55%	725,514	0	22,155,536	3.27%	15.82%	No
								Threshold	25.00%	

Net Medicaid Patient Revenue excludes physician revenue and revenue from hospital-based SNF units.
Net All Payer Patient Revenue excludes physician revenue and revenue from hospital-based SNF units.

Retreat Health Care calculations not shown since the hospital waived participation in DSH this year.

APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in
Disproportionate Share Payments Made in FFY 2012

VT Medicaid Eligible

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Variable for Calculation →	Adult & Peds Days	Nursery Days	ICU Days	NICU Days	Surgical ICU Days	Subprovider Days	Adult & Peds Cost Per Diem	Nursery Per Diem	ICU Per Diem	NICU Per Diem	Surgical ICU Per Diem	Subprovider Per Diem
Data Source →	Appendix 7, Column C	Appendix 7, Column D	Appendix 7, Column E	Appendix 7, Column F	Appendix 7, Column G	Appendix 7, Column H	Appendix 6, Column M	Appendix 6, Column N	Appendix 6, Column O	Appendix 6, Column P	Appendix 6, Column Q	Appendix 6, Column R
Brattleboro Memorial Hospital	899	438	62	0	0	0	1,680.54	1,680.54	2,117.63	0.00	0.00	0.00
Central Vermont Med Center	1,327	440	228	0	0	1,181	1,102.92	353.24	2,336.63	2,336.63	0.00	1,080.94
Copley Hospital	576	301	34	0	0	0	1,361.86	1,156.39	2,411.00	0.00	0.00	0.00
Fletcher Allen Health Care	13,158	1,766	888	2,228	714	1,272	1,055.87	563.63	1,682.34	1,483.91	1,952.39	955.98
Gifford Medical Center	554	142	11	0	0	0	981.48	1,572.74	1,830.35	1,830.35	0.00	0.00
Grace Cottage Hospital	47	0	0	0	0	0	1,214.73	0.00	0.00	0.00	0.00	0.00
Mt. Ascutney Hospital	179	0	1	0	0	0	1,181.61	0.00	1,181.61	0.00	0.00	0.00
North Country Hospital	967	358	62	0	0	0	1,132.00	620.28	3,557.16	0.00	0.00	0.00
Northeastern Vermont Hospital	788	265	67	0	0	0	1,447.50	751.16	3,052.93	0.00	0.00	0.00
Northwestern Medical Center	771	398	97	0	0	0	980.98	910.48	1,906.21	0.00	0.00	0.00
Porter Medical Center	481	270	26	0	0	0	1,381.24	1,242.16	2,915.31	0.00	0.00	0.00
Retreat Health Care	4,890	0	0	0	0	0	825.12	0.00	0.00	0.00	0.00	0.00
Rutland Regional Med Center	5,233	582	152	0	0	0	1,177.60	888.50	1,956.10	0.00	0.00	0.00
Southwestern Vermont	1,374	502	140	0	0	0	1,065.38	663.31	2,046.95	0.00	0.00	0.00
Springfield Hospital	875	224	100	0	0	1,437	948.71	700.94	1,489.14	0.00	0.00	843.83

APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in
Disproportionate Share Payments Made in FFY 2012

	(13)	(14)	(15)	(16)	(17)	(18)
Variable for Calculation	Total Medicaid Routine Costs	VT Medicaid Inpatient Ancillary Charges	Inpatient Ancillary CCR	VT Medicaid Outpatient Charges	Outpatient CCR	Total Medicaid Ancillary Costs
Data Source	calculated as $[(1)*(7) + (2)*(8) + (3)*(9) + (4)*(10) + (5)*(11) + (6)*(12)]$	Appendix 7, Column J	Appendix 6, Column W	Appendix 7, Column K	Appendix 6, Column L	calculated as $[(14)*(15) + (16)*(17)]$
Brattleboro Memorial Hospital	2,378,175	1,864,419	0.4727	8,066,583	0.4241	4,302,340
Central Vermont Med Center	3,428,342	4,211,988	0.4907	17,050,559	0.3945	8,792,908
Copley Hospital	1,214,479	1,820,222	0.4819	8,376,765	0.4867	4,953,640
Fletcher Allen Health Care	22,298,590	47,845,442	0.4275	69,851,819	0.3603	45,619,455
Gifford Medical Center	787,203	1,547,500	0.2783	7,050,552	0.4818	3,827,460
Grace Cottage Hospital	57,092	62,990	0.4936	1,147,618	0.6174	739,624
Mt. Ascutney Hospital	212,690	368,849	0.4803	2,907,039	0.4909	1,604,317
North Country Hospital	1,537,248	2,759,575	0.4188	14,847,073	0.4616	8,009,749
Northeastern Vermont Hospital	1,544,234	2,870,329	0.3465	9,690,150	0.4155	5,020,778
Northwestern Medical Center	1,303,609	2,969,888	0.6129	15,952,211	0.5080	9,923,913
Porter Medical Center	1,075,558	1,371,106	0.5631	7,037,848	0.4744	4,110,772
Retreat Health Care	4,034,837	894,611	0.5227	0	0.4739	467,594
Rutland Regional Med Center	6,976,815	11,160,348	0.4219	24,347,103	0.4324	15,235,489
Southwestern Vermont	2,083,387	4,147,987	0.4717	15,067,797	0.5014	9,510,862
Springfield Hospital	2,348,630	2,117,969	0.4782	8,868,988	0.4547	5,045,608

APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in
Disproportionate Share Payments Made in FFY 2012

		VT Medicare/Medicaid Dual Eligibles						Other State Medicaid Eligible					
		(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)
	Variable for Calculation →	Adult & Peds Days	Nursery Days	ICU Days	NICU Days	Surgical ICU Days	Subprovider Days	Adult & Peds Days	Nursery Days	ICU Days	NICU Days	Surgical ICU Days	Subprovider Days
	Data Source →	Appendix 8, Column C	Appendix 8, Column D	Appendix 8, Column E	Appendix 8, Column F	Appendix 8, Column G	Appendix 8, Column H	Appendix 8, Column J	Appendix 8, Column K	Appendix 8, Column L	Appendix 8, Column M	Appendix 8, Column N	Appendix 8, Column O
Brattleboro Memorial Hospital		454	0	94	0	0	0	62	42	8	0	0	0
Central Vermont Med Center		907	0	336	0	0	720	6	0	2	0	0	23
Copley Hospital		377	0	13	0	0	0	0	0	0	0	0	0
Fletcher Allen Health Care		6,506	0	732	0	320	264	2,603	55	196	899	354	318
Gifford Medical Center		641	0	28	0	0	0	0	0	0	0	0	0
Grace Cottage Hospital		79	0	0	0	0	0	0	0	0	0	0	0
Mt. Ascutney Hospital		193	0	6	0	0	60	3	0	0	0	0	0
North Country Hospital		835	0	132	0	0	0	10	0	0	0	0	0
Northeastern Vermont Hospital		546	0	69	0	0	0	20	5	7	0	0	0
Northwestern Medical Center		693	0	263	0	0	0	0	0	0	0	0	0
Porter Medical Center		419	0	0	0	0	0	86	49	0	0	0	0
Retreat Health Care		0	0	0	0	0	0	0	0	0	0	0	0
Rutland Regional Med Center		2,143	0	306	0	0	821	24	0	2	0	0	10
Southwestern Vermont		909	0	232	0	0	0	358	112	19	0	0	0
Springfield Hospital		559	0	70	0	0	339	54	13	3	0	0	14

APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in
Disproportionate Share Payments Made in FFY 2012

Individuals with No Third Party Insurance

		(31)	(32)	(33)	(34)	(35)	(36)	(37)	(38)	(39)
	Variable for Calculation →	Adult & Peds Days	Nursery Days	ICU Days	NICU Days	Surgical ICU Days	Subprovider Days	VT Medicare/Medicaid Eligibles Routine Costs	Other State Medicaid Beneficiaries Routine Costs	Individuals with No Third Party Coverage Routine Costs
	Data Source →	Appendix 8, Column Q	Appendix 8, Column R	Appendix 8, Column S	Appendix 8, Column T	Appendix 8, Column U	Appendix 8, Column V	calculated as [(19)*(7) + (20)*(8) + (21)*(9) + (22)*(10) + (23)*(11) + (24)*(12)]	calculated as [(25)*(7) + (26)*(8) + (27)*(9) + (28)*(10) + (29)*(11) + (30)*(12)]	calculated as [(31)*(7) + (32)*(8) + (33)*(9) + (34)*(10) + (35)*(11) + (36)*(12)]
Brattleboro Memorial Hospital		106	41	15	0	0	0	962,022	191,717	278,804
Central Vermont Med Center		121	6	34	0	0	111	2,563,733	36,152	335,003
Copley Hospital		77	5	4	0	0	0	544,764	0	120,289
Fletcher Allen Health Care		757	59	86	39	91	100	8,978,107	5,438,351	1,308,367
Gifford Medical Center		157	43	2	0	0	0	680,378	0	225,381
Grace Cottage Hospital		0	0	0	0	0	0	95,964	0	0
Mt. Ascutney Hospital		9	0	0	0	0	0	235,140	3,545	10,634
North Country Hospital		73	6	4	0	0	0	1,414,765	11,320	100,586
Northeastern Vermont Hospital		89	6	7	0	0	0	1,000,987	54,076	154,705
Northwestern Medical Center		46	13	3	0	0	0	1,181,152	0	62,680
Porter Medical Center		30	10	0	0	0	0	578,740	179,652	53,859
Retreat Health Care		0	0	0	0	0	0	0	0	0
Rutland Regional Med Center		611	16	47	0	0	345	3,122,163	32,175	825,666
Southwestern Vermont		273	25	25	0	0	0	1,443,323	494,589	358,605
Springfield Hospital		121	7	25	0	0	162	920,627	76,624	293,629

APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in
Disproportionate Share Payments Made in FFY 2012

	(40)	(41)	(42)	(43)	(44)	(45)	(46)	(47)
Variable for Calculation →	VT Medicare/ Medicaid Eligibles Inpatient Ancillary Charges	Other State Medicaid Beneficiaries Inpatient Ancillary Charges	Individuals with No Third Party Coverage Inpatient Ancillary Charges	VT Medicare/ Medicaid Eligibles Inpatient Ancillary Costs	Other State Medicaid Beneficiaries Inpatient Ancillary Costs	Individuals with No Third Party Coverage Inpatient Ancillary Costs	VT Medicare/ Medicaid Eligibles Outpatient Charges	Other State Medicaid Beneficiaries Outpatient Charges
Data Source →	Appendix 8, Column F	Appendix 8, Column G	Appendix 8, Column H	calculated as (40)*(15)	calculated as (41)*(15)	calculated as (42)*(15)	Appendix 8, Column I	Appendix 8, Column J
Brattleboro Memorial Hospital	1,133,916	112,494	286,348	536,013	53,177	135,360	2,821,133	538,648
Central Vermont Med Center	3,591,165	22,079	547,667	1,762,032	10,833	268,717	7,092,728	78,004
Copley Hospital	644,821	0	250,944	310,707	0	120,917	2,429,600	18,757
Fletcher Allen Health Care	21,242,579	13,517,374	4,083,823	9,081,685	5,778,984	1,745,927	38,721,824	6,932,695
Gifford Medical Center	1,201,505	0	198,464	334,418	0	55,239	2,557,403	54,870
Grace Cottage Hospital	84,653	0	0	41,781	0	0	399,296	5,890
Mt. Ascutney Hospital	328,500	62,921	6,240	157,794	30,224	2,997	1,145,830	419,942
North Country Hospital	2,921,372	12,913	311,056	1,223,413	5,408	130,264	9,347,074	102,356
Northeastern Vermont Hospital	1,943,017	50,369	364,082	673,250	17,453	126,153	2,934,047	122,613
Northwestern Medical Center	2,921,506	0	156,128	1,790,517	0	95,687	3,837,825	0
Porter Medical Center	831,056	218,538	128,675	467,998	123,067	72,462	2,881,083	240,191
Retreat Health Care	0	0	0	0	0	0	0	0
Rutland Regional Med Center	7,501,153	90,086	2,339,268	3,164,817	38,008	986,962	11,572,507	155,728
Southwestern Vermont	3,556,168	868,216	927,797	1,677,364	409,518	437,621	6,352,915	1,666,986
Springfield Hospital	1,423,767	143,264	448,481	680,792	68,503	214,447	3,505,974	704,321

APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in
Disproportionate Share Payments Made in FFY 2012

	(48)	(49)	(50)	(51)	(52)	(53)
Variable for Calculation →	Individuals with No Third Party Coverage Outpatient Charges	VT Medicare/Medicaid Eligibles Outpatient Costs	Other State Medicaid Beneficiaries Outpatient Costs	Individuals with No Third Party Coverage Outpatient Costs	Medicaid Portion of Graduate Medical Education Costs	Total Cost of Care
Data Source →	Appendix 8, Column K	calculated as (46)*(17)	calculated as (47)*(17)	calculated as (48)*(17)	Appendix 6, Column X	calculated as (13)+(18)+(37)+(38)+(39)+(43)+(44)+(45)+(49)+(50)+(51)+(52)
Brattleboro Memorial Hospital	1,306,667	1,196,433	228,439	554,153	0	10,816,633
Central Vermont Med Center	3,576,311	2,798,006	30,772	1,410,817	0	21,437,315
Copley Hospital	1,315,954	1,182,369	9,128	640,411	0	9,096,704
Fletcher Allen Health Care	10,115,175	13,949,717	2,497,535	3,644,039	2,607,620	122,948,377
Gifford Medical Center	2,182,042	1,232,078	26,435	1,051,241	0	8,219,834
Grace Cottage Hospital	146,169	246,524	3,636	90,244	0	1,274,866
Mt. Ascutney Hospital	598,211	562,518	206,160	293,677	0	3,319,698
North Country Hospital	2,092,311	4,315,040	47,252	965,907	0	17,760,952
Northeastern Vermont Hospital	1,947,981	1,219,084	50,945	809,378	0	10,671,043
Northwestern Medical Center	3,096,453	1,949,620	0	1,573,002	0	17,880,180
Porter Medical Center	1,815,659	1,366,744	113,943	861,322	0	9,004,116
Retreat Health Care	0	0	0	0	0	4,502,430
Rutland Regional Med Center	4,769,595	5,003,539	67,331	2,062,203	0	37,515,168
Southwestern Vermont	4,057,911	3,185,081	835,756	2,034,463	0	22,470,568
Springfield Hospital	3,043,711	1,594,224	320,266	1,384,025	0	12,947,375

APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in
Disproportionate Share Payments Made in FFY 2012

		(54)	(55)	(56)	(57)	(58)	(59)	(60)	(61)	(62)	(62)	(63)
	Variable for Calculation →	VT Medicaid Inpatient Payments	VT Medicaid Outpatient Payments	VT Medicare/Medicaid Eligibles-Inpatient Payments	VT Medicare/Medicaid Eligibles-Outpatient Payments	Other State Medicaid Beneficiaries-Inpatient Payments	Other State Medicaid Beneficiaries-Outpatient Payments	Individuals with No Third Party Coverage-Inpatient Payments	Individuals with No Third Party Coverage-Outpatient Payments	Other State DSH Payments	Section 1011 Payments	Total Payments
	Data Source →	Appendix 7, Column L	Appendix 7, Column M	Appendix 8, Column L	Appendix 8, Column M	Appendix 8, Column N	Appendix 8, Column O	Appendix 8, Column P	Appendix 8, Column Q	Appendix 8, Column R	Appendix 8, Column S	calculated as (54)+(55)+(56)+ (57)+(58)+ (59)+(60)+(61)+ (62)+(63)
Brattleboro Memorial Hospital		1,811,891	2,392,532	1,135,605	930,834	58,125	179,354	28,756	169,951	0	0	6,707,048
Central Vermont Med Center		4,207,391	4,954,932	3,143,567	2,044,022	31,423	28,370	47,220	367,742	0	0	14,824,667
Copley Hospital		1,496,786	2,757,410	884,445	1,376,341	0	4,090	21,399	190,746	0	0	6,731,217
Fletcher Allen Health Care		28,845,593	17,752,339	14,960,447	11,549,714	7,340,458	1,678,735	173,104	1,014,779	0	0	83,315,169
Gifford Medical Center		1,021,072	1,877,031	808,976	1,265,184	0	15,848	11,569	163,620	0	0	5,163,300
Grace Cottage Hospital		68,647	302,088	124,238	214,264	0	215	0	30,914	0	0	740,366
Mt. Ascutney Hospital		323,863	658,197	363,118	604,178	11,208	121,403	6,360	174,469	0	0	2,262,796
North Country Hospital		2,315,057	3,023,336	2,294,413	3,231,951	14,843	16,948	35,977	267,631	0	0	11,200,156
Northeastern Vermont Hospital		1,928,814	2,353,439	1,442,001	1,190,107	20,192	27,598	0	101,480	0	0	7,063,631
Northwestern Medical Center		2,504,027	4,541,978	1,992,345	1,164,329	0	0	12,396	298,940	0	0	10,514,015
Porter Medical Center		1,310,997	1,989,644	1,039,006	1,479,514	87,860	99,675	17,453	349,065	0	0	6,373,214
Retreat Health Care		4,834,764	0	0	0	0	0	0	0	0	0	4,834,764
Rutland Regional Med Center		7,697,236	6,857,011	5,534,671	3,505,191	28,216	33,312	97,375	418,637	0	0	24,171,649
Southwestern Vermont		3,345,638	4,490,657	2,266,944	2,130,255	456,570	571,892	51,673	645,236	0	0	13,958,865
Springfield Hospital		2,897,603	2,176,021	1,540,739	1,450,841	57,652	186,862	57,950	199,426	0	0	8,567,094

APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in
Disproportionate Share Payments Made in FFY 2012

(64)

	Variable for Calculation →	Hospital Specific Limit FFY 2012
	Data Source →	calculated as (53) - (63)
Brattleboro Memorial Hospital		4,109,585
Central Vermont Med Center		6,612,648
Copley Hospital		2,365,487
Fletcher Allen Health Care		39,633,208
Gifford Medical Center		3,056,534
Grace Cottage Hospital		534,500
Mt. Ascutney Hospital		1,056,902
North Country Hospital		6,560,797
Northeastern Vermont Hospital		3,607,412
Northwestern Medical Center		7,366,165
Porter Medical Center		2,630,902
Retreat Health Care		-332,334
Rutland Regional Med Center		13,343,519
Southwestern Vermont		8,511,703
Springfield Hospital		4,380,281

APPENDIX 6

Supporting Schedule of Medicare Cost Report Data Elements Used to Calculate Hospital-specific Limits & the MIUR in Federal Fiscal Year 2012

Data Source: Latest Medicare Cost Reports for the hospital year ending 9/30/09
(Retreat Health Care 12/31/09) from Medicare fiscal intermediary on 1/3/11.

	Hospital	Hospital's MCR Filing Status	Worksheet S-3, Col 6, Line 12	Worksheet S-3, Col 6, Line 14	Worksheet S-3, Col 6, Line 14.01 ³	Total of All Patient Days
470011	Brattleboro Memorial Hospital	As Submitted	7,475	0	0	7,475
470001	Central Vermont Hospital	As Submitted	12,084	3,814	0	15,898
471305	Copley Hospital	As Submitted	4,366	0	0	4,366
470003	Fletcher Allen Health Care	As Submitted	107,182	9,452	0	116,634
471301	Gifford Hospital	As Submitted	3,700	0	0	3,700
471300	Grace Cottage Hospital	As Submitted	626	0	0	626
471302	Mt. Ascutney Hospital	As Submitted	1,778	2,805	0	4,583
471304	North Country Hospital	As Submitted	5,233	0	0	5,233
471303	Northeastern Vermont Hospital	As Submitted	5,184	0	0	5,184
470024	Northwestern Medical Center	As Submitted	6,848	0	0	6,848
470006	Porter Hospital	As Submitted	5,564	0	0	5,564
474001	Retreat Health Care	see below	22,548	0	0	22,548
470005	Rutland Regional Medical Center	As Submitted	25,518	2,933	4,411	32,862
470012	Southwestern Vermont Hospital	As Submitted	16,758	0	0	16,758
471306	Springfield Hospital	As Submitted	6,840	2,999	0	9,839

¹ Neonatal ICU

² Surgical ICU

³ Subprovider II

Apportion 25% of 12/31/08 MCR and 75% of 12/31/09 MCR to data used in calculations.

474001	Retreat Health Care	12/31/08 Settled	21,643	0	0	21,643
474001	Retreat Health Care	12/31/09 As Sub	22,849	0	0	22,849
474001	Retreat Health Care	Blend	22,548	0	0	22,548

APPENDIX 6

Supporting Schedule of Medicare Cost Report Data Elements Used to Calculate Hospital-specific Limits & the MIUR in Federal Fiscal Year 2012

	Hospital	Worksheet D, Part V, Col 5.01, Line 104	Worksheet D, Part V, Col 5.02 ⁴ , Line 105	Worksheet D, Part V, Col 9.01, Line 104	Worksheet D, Part V, Col 9.02 ⁵ , Line 105	Outpatient CCR
470011	Brattleboro Memorial Hospital	6,291,750	0	2,668,310	0	0.4241
470001	Central Vermont Hospital	5,936,304	0	2,341,809	0	0.3945
471305	Copley Hospital	8,376,767	0	4,076,567	0	0.4867
470003	Fletcher Allen Health Care	29,849,487	0	10,753,416	0	0.3603
471301	Gifford Hospital	3,549,628	0	1,710,102	0	0.4818
471300	Grace Cottage Hospital	729,588	0	450,445	0	0.6174
471302	Mt. Ascutney Hospital	2,151,709	0	1,056,330	0	0.4909
471304	North Country Hospital	4,283,188	0	1,977,317	0	0.4616
471303	Northeastern Vermont Hospital	9,690,149	0	4,026,217	0	0.4155
470024	Northwestern Medical Center	8,744,135	0	4,442,032	0	0.5080
470006	Porter Hospital	5,305,520	0	2,516,861	0	0.4744
474001	Retreat Health Care	1,057,681	0	501,241	0	0.4739
470005	Rutland Regional Medical Center	24,347,103	0	10,526,818	0	0.4324
470012	Southwestern Vermont Hospital	7,006,681	0	3,512,851	0	0.5014
471306	Springfield Hospital	4,272,148	0	1,942,616	0	0.4547

⁴ For some hospitals, this is Column 5.03

⁵ For some hospitals, this is Column 9.03

Apportion 25% of 12/31/08 MCR and 75% of 12/31/09 MCR to data used in calculations.

474001	Retreat Health Care	1,120,115	0	453,919	0	0.4052
474001	Retreat Health Care	1,036,869	0	517,015	0	0.4986
474001	Retreat Health Care	1,057,681	0	501,241	0	0.4739

APPENDIX 6

Supporting Schedule of Medicare Cost Report Data Elements Used to Calculate Hospital-specific Limits & the MIUR in Federal Fiscal Year 2012

		Adult & Peds Per Diem	Nursery Per Diem	ICU Per Diem	NICU Per Diem	Surgical ICU Per Diem	Subprovider Per Diem
	Hospital	Worksheet D-1, Part II, Line 38	Worksheet D-1, Part II, Line 42	Worksheet D-1, Part II, Line 43	Worksheet D-1, Part II, Line 45.01	Worksheet D-1, Part II, Line 46	Worksheet D-1, Part II, Line 38 (Subprovider)
470011	Brattleboro Memorial Hospital	1,680.54	not shown	2,117.63	0.00	0.00	0.00
470001	Central Vermont Hospital	1,102.92	353.24	2,336.63	0.00	0.00	1,080.94
471305	Copley Hospital	1,361.86	1,156.39	2,411.00	0.00	0.00	0.00
470003	Fletcher Allen Health Care	1,055.87	563.63	1,682.34	1,483.91	1,952.39	955.98
471301	Gifford Hospital	981.48	1,572.74	1,830.35	0.00	0.00	0.00
471300	Grace Cottage Hospital	1,214.73	0.00	0.00	0.00	0.00	0.00
471302	Mt. Ascutney Hospital	1,181.61	0.00	0.00	0.00	0.00	0.00
471304	North Country Hospital	1,132.00	620.28	3,557.16	0.00	0.00	0.00
471303	Northeastern Vermont Hospital	1,447.50	751.16	3,052.93	0.00	0.00	0.00
470024	Northwestern Medical Center	980.98	910.48	1,906.21	0.00	0.00	0.00
470006	Porter Hospital	1,381.24	1,242.16	2,915.31	0.00	0.00	0.00
474001	Retreat Health Care	825.12	0.00	0.00	0.00	0.00	0.00
470005	Rutland Regional Medical Center	1,177.60	888.50	1,956.10	0.00	0.00	0.00
470012	Southwestern Vermont Hospital	1,065.38	663.31	2,046.95	0.00	0.00	0.00
471306	Springfield Hospital	948.71	700.94	1,489.14	0.00	0.00	843.83

Apportion 25% of 12/31/07 MCR and 75% of 12/31/08 MCR to data used in calculations.

474001	Retreat Health Care	861.09	0.00	0.00	0.00	0.00	0.00
474001	Retreat Health Care	813.13	0.00	0.00	0.00	0.00	0.00
474001	Retreat Health Care	825.12	0.00	0.00	0.00	0.00	0.00

APPENDIX 6

Supporting Schedule of Medicare Cost Report Data Elements Used to Calculate Hospital-specific Limits & the MIUR in Federal Fiscal Year 2012

							Medicaid Portion of GME
	Hospital	Worksheet D-4 (Hospital), Col 2, Line 101	Worksheet D-4 (Hospital), Col 3, Line 101	Worksheet D-4 (Subprovider ⁶), Col 2, Line 101	Worksheet D-4 (Subprovider ⁶), Col 3, Line 101	Inpatient Ancillary CCR	Worksheet E-3 Part IV (Title XIX), Line 23.01
470011	Brattleboro Memorial Hospital	1,858,707	878,629	0	0	0.4727	0
470001	Central Vermont Hospital	3,815,065	1,882,030	396,851	184,578	0.4907	0
471305	Copley Hospital	1,820,222	877,074	0	0	0.4819	0
470003	Fletcher Allen Health Care	47,772,818	20,423,965	0	0	0.4275	2,607,620
471301	Gifford Hospital	1,571,007	437,263	0	0	0.2783	0
471300	Grace Cottage Hospital	62,992	31,090	0	0	0.4936	0
471302	Mt. Ascutney Hospital	368,606	177,059	0	0	0.4803	0
471304	North Country Hospital	2,759,579	1,155,657	0	0	0.4188	0
471303	Northeastern Vermont Hospital	2,870,328	994,560	0	0	0.3465	0
470024	Northwestern Medical Center	2,589,734	1,587,182	0	0	0.6129	0
470006	Porter Hospital	1,342,326	755,913	0	0	0.5631	0
474001	Retreat Health Care	980,139	512,297	0	0	0.5227	0
470005	Rutland Regional Medical Center	11,160,349	4,708,671	0	0	0.4219	0
470012	Southwestern Vermont Hospital	4,138,571	1,952,070	0	0	0.4717	0
471306	Springfield Hospital	1,821,440	852,127	169,181	99,713	0.4782	0

⁶ For Rutland Regional, this includes Subprovider I and Subprovider II data

Apportion 25% of 12/31/07 MCR and 75% of 12/31/08 MCR to data used in calculations.

474001	Retreat Health Care	906,790	538,302	0	0	0.5936	0
474001	Retreat Health Care	1,004,589	503,629	0	0	0.5013	0
474001	Retreat Health Care	980,139	512,297	0	0	0.5227	0

APPENDIX 7

Supporting Schedule of MMIS Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2012

Data Source: Reports produced by HP, DVHA's fiscal agent
for services rendered for the 12-month period ending 9/30/09

		Adult & Peds	Nursery	ICU	NICU	Surgical ICU	Subprovider
		Inpatient Days Billed to Revenue Codes 110- 119,120-150, 190	Inpatient Days Billed to Revenue Codes 170-171	Inpatient Days Billed to Revenue Codes 200-206	Inpatient Days Billed to Revenue Codes 173-179	Inpatient Days Billed to Revenue Codes 210-214	Inpatient Days Billed to Revenue Codes 110-119,120-150
Hospital							
470011	Brattleboro Memorial Hospital	899	438	62	0	0	0
470001	Central Vermont Hospital	1,327	440	228	0	0	1,181
471305	Copley Hospital	576	301	34	0	0	0
470003	Fletcher Allen Health Care	13,158	1,766	888	2,228	714	1,272
471301	Gifford Hospital	554	142	11	0	0	0
471300	Grace Cottage Hospital	47	0	0	0	0	0
471302	Mt. Ascutney Hospital	179	0	1	0	0	0
471304	North Country Hospital	967	358	62	0	0	0
471303	Northeastern Vermont Hospital	788	265	67	0	0	0
470024	Northwestern Medical Center	771	398	97	0	0	0
471307	Porter Hospital	481	270	26	0	0	0
474001	Retreat Health Care	4,890	0	0	0	0	0
470005	Rutland Regional Medical Center	5,233	582	152	0	0	0
470012	Southwestern Vermont Hospital	1,374	502	140	0	0	0
471306	Springfield Hospital	875	224	100	0	0	1,437

APPENDIX 7

Supporting Schedule of MMIS Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2012

	Hospital	VT Medicaid Inpatient Ancillary Changes	VT Medicaid Outpatient Changes	VT Medicaid Inpatient Payments	VT Medicaid Outpatient Payments
470011	Brattleboro Memorial Hospital	1,864,419	8,066,583	1,811,891	2,392,532
470001	Central Vermont Hospital	4,211,988	17,050,559	4,207,391	4,954,932
471305	Copley Hospital	1,820,222	8,376,765	1,496,786	2,757,410
470003	Fletcher Allen Health Care	47,845,442	69,851,819	28,845,593	17,752,339
471301	Gifford Hospital	1,547,500	7,050,552	1,021,072	1,877,031
471300	Grace Cottage Hospital	62,990	1,147,618	68,647	302,088
471302	Mt. Ascutney Hospital	368,849	2,907,039	323,863	658,197
471304	North Country Hospital	2,759,575	14,847,073	2,315,057	3,023,336
471303	Northeastern Vermont Hospital	2,870,329	9,690,150	1,928,814	2,353,439
470024	Northwestern Medical Center	2,969,888	15,952,211	2,504,027	4,541,978
471307	Porter Hospital	1,371,106	7,037,848	1,310,997	1,989,644
474001	Retreat Health Care	894,611	0	4,834,764	0
470005	Rutland Regional Medical Center	11,160,348	24,347,103	7,697,236	6,857,011
470012	Southwestern Vermont Hospital	4,147,987	15,067,797	3,345,638	4,490,657
471306	Springfield Hospital	2,117,969	8,868,988	2,897,603	2,176,021

APPENDIX 8

Supporting Schedule of DSH Survey Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2012

VT Medicare/Medicaid Eligibles

Data Source: Hospital DSH Survey and Supplemental Schedules

Hospital	Adult & Peds	Nursery	ICU	NICU	Surgical ICU	Subprovider
	Inpatient Days Billed to Revenue Codes 110-119,120-150, 190	Inpatient Days Billed to Revenue Codes 170-171	Inpatient Days Billed to Revenue Codes 200-206	Inpatient Days Billed to Revenue Codes 173-179	Inpatient Days Billed to Revenue Codes 210-214	Inpatient Days Billed to Revenue Codes 119,120-150
470011 Brattleboro Memorial Hospital	454	0	94	0	0	0
470001 Central Vermont Hospital	907	0	336	0	0	720
471305 Copley Hospital	377	0	13	0	0	0
470003 Fletcher Allen Health Care	6,506	0	732	0	320	264
471301 Gifford Hospital	641	0	28	0	0	0
471300 Grace Cottage Hospital	79	0	0	0	0	0
471302 Mt. Ascutney Hospital	193	0	6	0	0	60
471304 North Country Hospital	835	0	132	0	0	0
471303 Northeastern Vermont Hospital	546	0	69	0	0	0
470024 Northwestern Medical Center	693	0	263	0	0	0
470006 Porter Hospital	419	0	0	0	0	0
474001 Retreat Health Care						
470005 Rutland Regional Medical Center	2,143	0	306	0	0	821
470012 Southwestern Vermont Hospital	909	0	232	0	0	0
471306 Springfield Hospital	559	0	70	0	0	339

APPENDIX 8

Supporting Schedule of DSH Survey Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2012

Other State Medicaid

Data Source: Hospital DSH Survey and Supplemental Schedules

Hospital	Adult & Peds	Nursery	ICU	NICU	Surgical ICU	Subprovider
	Inpatient Days Billed to Revenue Codes 110-119,120-150, 190	Inpatient Days Billed to Revenue Codes 170-171	Inpatient Days Billed to Revenue Codes 200-206	Inpatient Days Billed to Revenue Codes 173-179	Inpatient Days Billed to Revenue Codes 210-214	Inpatient Days Billed to Revenue Codes 119,120-150
470011 Brattleboro Memorial Hospital	62	42	8	0	0	0
470001 Central Vermont Hospital	6	0	2	0	0	23
471305 Copley Hospital	0	0	0	0	0	0
470003 Fletcher Allen Health Care	2,603	55	196	899	354	318
471301 Gifford Hospital	0	0	0	0	0	0
471300 Grace Cottage Hospital	0	0	0	0	0	0
471302 Mt. Ascutney Hospital	3	0	0	0	0	0
471304 North Country Hospital	10	0	0	0	0	0
471303 Northeastern Vermont Hospital	20	5	7	0	0	0
470024 Northwestern Medical Center	0	0	0	0	0	0
470006 Porter Hospital	86	49	0	0	0	0
474001 Retreat Health Care						
470005 Rutland Regional Medical Center	24	0	2	0	0	10
470012 Southwestern Vermont Hospital	358	112	19	0	0	0
471306 Springfield Hospital	54	13	3	0	0	14

APPENDIX 8

Supporting Schedule of DSH Survey Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2012

No Third Party Coverage

Data Source: Hospital DSH Survey and Supplemental Schedules

Hospital	Adult & Peds	Nursery	ICU	NICU	Surgical ICU	Subprovider
	Inpatient Days Billed to Revenue Codes 110-119,120-150, 190	Inpatient Days Billed to Revenue Codes 170-171	Inpatient Days Billed to Revenue Codes 200-206	Inpatient Days Billed to Revenue Codes 173-179	Inpatient Days Billed to Revenue Codes 210-214	Inpatient Days Billed to Revenue Codes 119,120-150
470011 Brattleboro Memorial Hospital	106	41	15	0	0	0
470001 Central Vermont Hospital	121	6	34	0	0	111
471305 Copley Hospital	77	5	4	0	0	0
470003 Fletcher Allen Health Care	757	59	86	39	91	100
471301 Gifford Hospital	157	43	2	0	0	0
471300 Grace Cottage Hospital	0	0	0	0	0	0
471302 Mt. Ascutney Hospital	9	0	0	0	0	0
471304 North Country Hospital	73	6	4	0	0	0
471303 Northeastern Vermont Hospital	89	6	7	0	0	0
470024 Northwestern Medical Center	46	13	3	0	0	0
470006 Porter Hospital	30	10	0	0	0	0
474001 Retreat Health Care						
470005 Rutland Regional Medical Center	611	16	47	0	0	345
470012 Southwestern Vermont Hospital	273	25	25	0	0	0
471306 Springfield Hospital	121	7	25	0	0	162

APPENDIX 8
Supporting Schedule of DSH Survey Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2012

	Hospital	Inpatient Ancillary Charges			Outpatient Charges		
		VT Medicare/ Medicaid Eligibles	Other State Medicaid Beneficiaries	Individuals with No Third Party Coverage	VT Medicare/ Medicaid Eligibles	Other State Medicaid Beneficiaries	Individuals with No Third Party Coverage
470011	Brattleboro Memorial Hospital	1,133,916	112,494	286,348	2,821,133	538,648	1,306,667
470001	Central Vermont Hospital	3,591,165	22,079	547,667	7,092,728	78,004	3,576,311
471305	Copley Hospital	644,821	0	250,944	2,429,600	18,757	1,315,954
470003	Fletcher Allen Health Care	21,242,579	13,517,374	4,083,823	38,721,824	6,932,695	10,115,175
471301	Gifford Hospital	1,201,505	0	198,464	2,557,403	54,870	2,182,042
471300	Grace Cottage Hospital	84,653	0	0	399,296	5,890	146,169
471302	Mt. Ascutney Hospital	328,500	62,921	6,240	1,145,830	419,942	598,211
471304	North Country Hospital	2,921,372	12,913	311,056	9,347,074	102,356	2,092,311
471303	Northeastern Vermont Hospital	1,943,017	50,369	364,082	2,934,047	122,613	1,947,981
470024	Northwestern Medical Center	2,921,506	0	156,128	3,837,825	0	3,096,453
470006	Porter Hospital	831,056	218,538	128,675	2,881,083	240,191	1,815,659
474001	Retreat Health Care	0	0	0	0	0	0
470005	Rutland Regional Medical Center	7,501,153	90,086	2,339,268	11,572,507	155,728	4,769,595
470012	Southwestern Vermont Hospital	3,556,168	868,216	927,797	6,352,915	1,666,986	4,057,911
471306	Springfield Hospital	1,423,767	143,264	448,481	3,505,974	704,321	3,043,711

APPENDIX 8
Supporting Schedule of DSH Survey Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2012

	Hospital	Payments							
		VT Medicare/ Medicaid Eligibles- Inpatient	VT Medicare/ Medicaid Eligibles- Outpatient	Other State Medicaid Beneficiaries- Inpatient	Other State Medicaid Beneficiaries- Outpatient	Individuals with No Third Party Coverage- Inpatient	Individuals with No Third Party Coverage- Outpatient	Other State DSH Payments	State & Local Subsidies + Sect. 1011 Payments
470011	Brattleboro Memorial Hospital	1,135,605	930,834	58,125	179,354	28,756	169,951	0	0
470001	Central Vermont Hospital	3,143,567	2,044,022	31,423	28,370	47,220	367,742	0	0
471305	Copley Hospital	884,445	1,376,341	0	4,090	21,399	190,746	0	0
470003	Fletcher Allen Health Care	14,960,447	11,549,714	7,340,458	1,678,735	173,104	1,014,779	0	0
471301	Gifford Hospital	808,976	1,265,184	0	15,848	11,569	163,620	0	0
471300	Grace Cottage Hospital	124,238	214,264	0	215	0	30,914	0	0
471302	Mt. Ascutney Hospital	363,118	604,178	11,208	121,403	6,360	174,469	0	0
471304	North Country Hospital	2,294,413	3,231,951	14,843	16,948	35,977	267,631	0	0
471303	Northeastern Vermont Hospital	1,442,001	1,190,107	20,192	27,598	0	101,480	0	0
470024	Northwestern Medical Center	1,992,345	1,164,329	0	0	12,396	298,940	0	0
470006	Porter Hospital	1,039,006	1,479,514	87,860	99,675	17,453	349,065	0	0
474001	Retreat Health Care	0	0	0	0	0	0	0	0
470005	Rutland Regional Medical Center	5,534,671	3,505,191	28,216	33,312	97,375	418,637	0	0
470012	Southwestern Vermont Hospital	2,266,944	2,130,255	456,570	571,892	51,673	645,236	0	0
471306	Springfield Hospital	1,540,739	1,450,841	57,652	186,862	57,950	199,426	0	0

APPENDIX 9
Formulas Used in the Calculation of the Hospital-Specific Limit in Federal Fiscal Year 2012

Inpatient Accommodation Cost Per Day- Adults & Peds = [Adults & Peds Days] * [General Routine Cost Per Day]

Source data for Medicaid days is the state's MMIS. Source data for other cases is the DSH Survey.

Source for per diem cost is Worksheet D-1, Part II, Line 38.

Inpatient Accommodation Cost Per Day- Nursery = [Nursery Days] * [Nursery Cost Per Day]

Source data for Medicaid days is the state's MMIS.

Source for per diem cost is Worksheet D-1, Part II, Line 42.

Inpatient Accommodation Cost Per Day- ICU = [ICU Days] * [ICU Cost Per Day]

Source data for Medicaid days is the state's MMIS.

Source for per diem cost is Worksheet D-1, Part II, Line 43.

Fletcher Allen Health Care also separately reported NICU and Surgery ICU costs per day which are used in the calculation.

Inpatient Accommodation Cost Per Day- Subprovider = [Subprovider Days] * [General Routine Cost Per Day]

Source data for Medicaid days is the state's MMIS.

Source for per diem cost is Worksheet D-1, Part II, Line 38 (Subprovider schedule).

Inpatient Ancillary Cost-to-Charge Ratio = [Inpatient Ancillary Costs] / [Inpatient Ancillary Charges]

Inpatient Ancillary Costs from Worksheet D-4, Column 3, Row 101; Inpatient Ancillary Charges from Worksheet D-4, Column 2, Row 101

If there is a Subprovider schedule reported, then the same data elements from the subprovider schedule are added to the main schedule in the numerator and the denominator.

Outpatient Cost-to-Charge Ratio = [Outpatient Costs] / [Outpatient Charges]

Outpatient Costs from Worksheet D, Part V, Column 9.01, Line 104 + Column 9.02, Line 104

Outpatient Charges from Worksheet D, Part V, Column 5.01, Line 104 + Column 5.02, Line 104

Note: In some situations, only 9.01 and 5.01 are reported. In other cases, 9.03 and 5.03 are shown instead of 9.02 and 5.02.

APPENDIX 10

SAMPLE DSH VERIFICATION SHEET SENT TO HOSPITALS

Hospital DSH Survey Page 1

Hospital Name _____

Medicare ID _____

ALL CELLS SHADED YELLOW REQUIRE DATA ENTRY BY THE HOSPITAL.

A. Hospital Contact for DVHA

Name _____
Address _____

Phone _____
E-mail _____
Fax _____

B. Hospital Medicare Cost Report (MCR) Status

For this year's DSH calculations, the DVHA is using the Hospital MCRs for the year ending 9/30/09. DVHA received MCR cost reports from National Government Services on 1/3/11. The status of the MCR that DVHA received is shown below.

Indicate if the Hospital has an MCR more current than the one received from National Government Services.

DVHA On File
 As Filed
 Final
 Amended Final

Hospital Modification
 As Filed
 Final
 Amended Final

If the MCR that DVHA has on file is not the most current, the hospital must enter data in the Override fields (shaded blue) on Pages 2 and 3. Additionally, submit copies of the appropriate MCR schedules that show where the figures were derived.

Worksheet S, Part I and II, Cover Sheet (signed)
Worksheet D, Part V
Worksheet D-4

Worksheet S-3 Part I
Worksheet D-1, Part II
Worksheet E-3, Part III

C. Obstetric Certification

Place an X in one of the boxes below:

I certify that the hospital has at least two obstetricians with staff privileges who have agreed to provide obstetric services (emergency and nonemergency) to individuals eligible for Medicaid.

I certify that the hospital is located in a rural area and has at least two (2) qualified physicians with staff privileges who have agreed to provide non-emergency obstetric services to individuals eligible for Medicaid.

I certify that the hospital did not offer non-emergency obstetric services to the general population as of December 22, 1987, or that the inpatients of the hospital are predominantly individuals under 18 years of age.

D. Certification

If you choose to participate in the DSH program for FFY 2012, you must complete and submit all documentation requested below to the Department of Vermont Health Access, Attn Mary Andes, Director of Data Analysis and Reimbursement, no later than **Friday, March 18, 2011**.

1. Survey pages 1 through 3
2. A spreadsheet that shows the information to support the values submitted for I.A.7-12, I.B.2, and I.E.3. (see sample 1)
3. A spreadsheet that shows the information to support the values submitted for I.C.2 and I.E.4. (see sample 2)
4. A spreadsheet that shows the information to support the values submitted for I.A.13-18, I.B.3, and I.E.5. (see sample 1)
5. A spreadsheet that shows the information to support the values submitted for I.C.3 and I.E.6. (see sample 2)
6. A spreadsheet that shows the information to support the values submitted for I.A.19-24 and I.B.4. (see sample 3)
7. A spreadsheet that shows the information to support the values submitted for I.C.4. (see sample 4)
8. Hospital Audited Financial Statement to support the values submitted for I.E.7-10 and II.B.1-6.

Additionally, the statement below must be signed by the hospital CEO or CFO:

The information included in this document and the attachments is true, accurate and complete to the best of my knowledge and belief. I understand that DVHA will rely on this Certification Statement at the time DVHA certifies its expenditures to the Centers for Medicare and Medicaid Services and that the hospital is responsible for reimbursing the DVHA for any monies resulting from federal recoupment due to inaccurate information provided and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

Signature

Date

Typed Name

Title

Hospital DSH Survey Page 1

If you choose not to participate in the DSH program for FFY 2012, you must complete and submit this page to the Department of Vermont Health Access, Attn Mary Andes, Director of Data Analysis and Reimbursement, with a signature attesting to the statement below no later than **Friday, March 18, 2011.**

To be completed by hospital CEO:

As the Chief Executive Officer of the above-named hospital, I attest to the fact that we waive our right to participate in the Department of Vermont Health Access's Disproportionate Share Program for Federal Fiscal Year 2012. We waive this right due to the fact that we have determined that (place an X in one of the boxes below):

Our Medicaid Inpatient Utilization Rate is less than 1.0% for the DSH year examined and, therefore, we will not be eligible for a DSH payment in FFY 2012.

Our Hospital-Specific Limit is less than \$0 for the DSH year examined and, therefore, we will not be eligible for a DSH payment in FFY 2012.

Other (please specify): _____

Signature

Date

Typed Name

Title

ALL CELLS SHADED GREY DISPLAY DATA COMPILED BY DVHA FROM THE SOURCES CITED.
 ALL CELLS SHADED BLUE ARE OPTIONAL. ONLY FILL IN IF YOU HAVE UPDATED DATA TO OVERRIDE DVHA'S FIGURES.
 ALL CELLS SHADED YELLOW REQUIRE HOSPITAL DATA ENTRY SINCE THE SOURCE DATA IS SUPPLIED BY HOSPITALS.

I. INPUTS TO CALCULATE THE HOSPITAL SPECIFIC LIMIT

A. Inputs to Calculate Routine Costs

<u>Data Variable</u>	<u>Source</u>		
1. Vermont Medicaid Inpatient Days for Adults & Peds	HP MRMN503S report		
2. Vermont Medicaid Inpatient Days for Nursery	HP MRMN503S report		
3. Vermont Medicaid Inpatient Days for ICU	HP MRMN503S report		
4. Vermont Medicaid Inpatient Days for NICU	HP MRMN503S report		
5. Vermont Medicaid Inpatient Days for Surgical ICU	HP MRMN503S report		
6. Vermont Medicaid Inpatient Days for Distinct Part Psych Unit	HP MRMN503S report		
7. VT Medicaid/Medicare Eligible Inpatient Days for Adults & Peds	Hospital data source		
8. VT Medicaid/Medicare Eligible Inpatient Days for Nursery	Hospital data source		
9. VT Medicaid/Medicare Eligible Inpatient Days for ICU	Hospital data source		
10. VT Medicaid/Medicare Eligible Inpatient Days for NICU	Hospital data source		
11. VT Medicaid/Medicare Eligible Inpatient Days for Surgical ICU	Hospital data source		
12. VT Medicaid/Medicare Eligible Inpatient Days for Distinct Part Psych	Hospital data source		
13. Other State Medicaid Inpatient Days for Adults & Peds	Hospital data source		
14. Other State Medicaid Inpatient Days for Nursery	Hospital data source		
15. Other State Medicaid Inpatient Days for ICU	Hospital data source		
16. Other State Medicaid Inpatient Days for NICU	Hospital data source		
17. Other State Medicaid Inpatient Days for Surgical ICU	Hospital data source		
18. Other State Medicaid Inpatient Days for Distinct Part Psych Unit	Hospital data source		
19. Adults & Peds Days for Individuals with No Third Party Coverage	Hospital data source		
20. Nursery Days for Individuals with No Third Party Coverage	Hospital data source		
21. ICU Days for Individuals with No Third Party Coverage	Hospital data source		
22. NICU Days for Individuals with No Third Party Coverage	Hospital data source		
23. Surgical ICU Days for Individuals with No Third Party Coverage	Hospital data source		
24. Distinct Part Psych Unit Days for Individuals with No Third Party	Hospital data source		
25. Per Diem Cost for Adults & Peds (Title XIX schedule)	MCR D-1, Pt II, Ln 38		
26. Per Diem Cost for Nursery (Title XIX schedule)	MCR D-1, Pt II, Ln 42		
27. Per Diem Cost for ICU (Title XIX schedule)	MCR D-1, Pt II, Ln 43		
28. Per Diem Cost for NICU (Title XIX schedule)	MCR D-1, Pt II, Ln 45		
29. Per Diem Cost for Surgical ICU (Title XIX schedule)	MCR D-1, Pt II, Ln 46		
30. Per Diem Cost for Distinct Part Psych Unit (from Subprovider wksht)	MCR D-1, Pt II, Ln 38		

B. Inputs to Calculate Inpatient Ancillary Costs

<u>Data Variable</u>	<u>Source</u>		
1. Vermont Medicaid Inpatient Ancillary Charges	HP MRMN503S report		
2. VT Medicaid/Medicare Eligible Inpatient Ancillary Charges	Hospital data source		
3. Other State Medicaid Inpatient Ancillary Charges	Hospital data source		
4. Inpatient Ancillary Charges for Individuals with No Third Party	Hospital data source		
5. Title XIX Inpatient Ancillary Charges- Hospital	MCR D-4 Col 2, Ln 101		
6. Title XIX Inpatient Ancillary Costs- Hospital	MCR D-4 Col 3, Ln 101		
7. Title XIX Inpatient Ancillary Charges- Subprovider (Subprov wksht)	MCR D-4 Col 2, Ln 101		
8. Title XIX Inpatient Ancillary Costs- Subprovider (Subprov wksht)	MCR D-4 Col 3, Ln 101		

ALL CELLS SHADED GREY DISPLAY DATA COMPILED BY DVHA FROM THE SOURCES CITED.
 ALL CELLS SHADED BLUE ARE OPTIONAL. ONLY FILL IN IF YOU HAVE UPDATED DATA TO OVERRIDE DVHA'S FIGURES.
 ALL CELLS SHADED YELLOW REQUIRE HOSPITAL DATA ENTRY SINCE THE SOURCE DATA IS SUPPLIED BY HOSPITALS.

C. Inputs to Calculate Outpatient Ancillary Costs

<u>Data Variable</u>	<u>Source</u>		
1. Vermont Medicaid Outpatient Ancillary Charges	HP MRMN503S report		
2. VT Medicaid/Medicare Eligible Outpatient Ancillary Charges	Hospital data source		
3. Other State Medicaid Outpatient Ancillary Charges	Hospital data source		
4. Outpatient Ancillary Charges for Individuals with No Third Party	Hospital data source		
5. Title XIX Outpatient Ancillary Charges- Hospital	MCR D Pt V, Col 5, Ln		
6. Title XIX Outpatient Ancillary Costs- Hospital	MCR D Pt V, Col 9, Ln		
7. Title XIX Outpatient Ancillary Charges- Subprovider (Subprov wksht)	MCR D Pt V, Col 5, Ln		
8. Title XIX Outpatient Ancillary Costs- Subprovider (Subprov wksht)	MCR D Pt V, Col 9, Ln		

D. Inputs to Calculate Applicable Graduate Medical Education Costs

<u>Data Variable</u>	<u>Source</u>		
1. Medicaid Portion of Grad Med Ed Costs Not Reimbursed by DVHA	MCR E-3 Pt IV, Ln 23.01 (Title XIX schedule)		

E. Inputs to Calculate the Payments for Care

1. Payments for I/P Services to VT Medicaid Beneficiaries	HP MRMN502V report		
2. Payments for O/P Services to VT Medicaid Beneficiaries	HP MRMN502V report		
3. Payments for I/P Services to VT Medicaid/Medicare Dual Beneficiaries	Hospital data source		
4. Payments for O/P Services to VT Medicaid/Medicare Dual	Hospital data source		
5. Payments for I/P Services to Medicaid Beneficiaries Outside VT	Hospital data source		
6. Payments for O/P Services to Medicaid Beneficiaries Outside VT	Hospital data source		
7. Payments for I/P Services to Individuals with No Third Party Coverage	Hospital data source		
8. Payments for O/P Services to Individuals with No Third Party Coverage	Hospital data source		
9. DSH Payments from a Medicaid agency other than Vermont	Hospital data source		
10. Section 1011 Payments	Hospital data source		

ALL CELLS SHADED GREY DISPLAY DATA COMPILED BY DVHA FROM THE SOURCES CITED.
 ALL CELLS SHADED BLUE ARE OPTIONAL. ONLY FILL IN IF YOU HAVE UPDATED DATA TO OVERRIDE DVHA'S FIGURES.
 ALL CELLS SHADED YELLOW REQUIRE HOSPITAL DATA ENTRY SINCE THE SOURCE DATA IS SUPPLIED BY HOSPITALS.

II. INPUTS TO CALCULATE THE FEDERALLY REQUIRED DSH GROUPS

A. Inputs to Calculate the Medicaid Inpatient Utilization Rate			
<u>Data Variable</u>	<u>Source</u>		
1. Vermont Medicaid Inpatient Days	Survey pg 2, I.A.1-6	#VALUE!	
2. All Patient Days- Total Excluding Subproviders	MCR Wksht S-3, Col 6, Line 12		
3. All Patient Days- Subproviders	MCR Wksht S-3, Col 6, Line 14		
Medicaid Inpatient Utilization Rate (II.A.1 / (II.A.2 + II.A.3))		#VALUE!	

B. Inputs to Calculate the Low Income Utilization Rate			
<u>Data Variable</u>	<u>Source</u>		
1. Total Net Medicaid Patient Service Revenue, Inpatient and Outpatient Services	Hospital data source		
2. State & Local Subsidies for Inpatient Services	Hospital data source		
3. State & Local Subsidies for Outpatient Services	Hospital data source		
<i>Include subsidies from government for the general support of the hospital or for indigent or uninsured patients. Do not include any DSH payments and do not include any amount shown on page 2, Section I.E.</i>			
<i>Do not include federally funded programs, payments for individuals who are adjudicated or incarcerated or made by law enforcement agencies, payments for the health care of employees of state or local governments, or payments from DVHA.</i>			
4. Total Net All Payer Patient Service Revenue, Inpatient and Outpatient Services	Hospital data source		
5. Total Inpatient Charges Attributable to Individuals with no Third Party Coverage	Hospital data source		
6. Total Gross Inpatient Charges, All Payers	Hospital data source		
LIUR Equation 1 (II.B.1 + II.B.2 + II.B.3) divided by II.B.4		#VALUE!	
LIUR Equation 2 (II.B.5 - II.B.2) divided by II.B.6		#VALUE!	
Total LIUR (Value of Equation 1 + Equation 2)		#VALUE!	

**Template for Itemizing Inpatient Services for
Vermont Medicare/Medicaid Dual Eligibles and Medicaid Eligibles Outside Vermont**

Notes:

1. The supporting schedule that you provide does not need to look exactly like this, so long as all of the data elements requested appear on your hospital-designed report. The information you provide does not need to be entered into this Excel spreadsheet. A separate attachment is acceptable.
2. Include claims when the Ending Date of Service falls within the hospital fiscal year end (9/30/09 for most hospitals), regardless of when payment(s) were received.
3. Include any payments received after 9/30/09 for the services reported on this schedule.
4. Ancillary Services are those billed on revenue codes 250 and higher.

Example of Template

Internal Claim Reference Number	Begin Date of Service	Ending Date of Service	Total Days	Adult & Ped Days	Nursery Days	ICU Days	NICU Days	Surgical ICU Days	Psych Unit Days	Billed Amount for Ancillary Services	Payment Received from All Sources
---------------------------------	-----------------------	------------------------	------------	------------------	--------------	----------	-----------	-------------------	-----------------	--------------------------------------	-----------------------------------

sample

85962385103	1/1/2009	1/4/2009	4	3	0	1	0	0	0	\$2,500.00	\$3,600.00
-------------	----------	----------	---	---	---	---	---	---	---	------------	------------

**Template for Itemizing Outpatient Services for
Vermont Medicare/Medicaid Dual Eligibles and Medicaid Eligibles Outside Vermont**

Notes:

1. The supporting schedule that you provide does not need to look exactly like this, so long as all of the data elements requested appear on your hospital-designed report. The information you provide does not need to be entered into this Excel spreadsheet. A separate attachment is acceptable.
2. Include claims when the Ending Date of Service falls within the hospital fiscal year end (9/30/09 for most hospitals), regardless of when payment(s) were received.
3. Include any payments received after 9/30/09 for the services reported on this schedule.
4. Ancillary Services are those billed on revenue codes 250 and higher.

Example of Template

Internal Claim Reference Number	Begin Date of Service	Ending Date of Service	Billed Amount for Ancillary Services	Payment Received from All Sources
---------------------------------	-----------------------	------------------------	--------------------------------------	-----------------------------------

sample

58697412569	1/1/2009	1/4/2009	\$2,500.00	\$3,600.00
-------------	----------	----------	------------	------------

Template for Itemizing Inpatient Services for Individuals with No Third Party Coverage

Notes:

1. The supporting schedule that you provide does not need to look exactly like this, so long as all of the data elements requested appear on your hospital-designed report. The information you provide does not need to be entered into this Excel spreadsheet. A separate attachment is acceptable.
2. Include claims when the Ending Date of Service falls within the hospital fiscal year end (9/30/09 for most hospitals), regardless of when payment(s) were received.
3. CMS has provided guidance that hospitals do not need to tie payments back to specific services in the hospital year examined. In other words, the payments you will report that you received within the hospital fiscal year for individuals with no third party coverage will not necessarily be revenues against the services offered to the individuals with no third party coverage who received services in the hospital year. On this schedule, only report the days of service and charges for ancillary services, not the payments. The payments for individuals with no third party coverage will tie to your financial statements.
4. Ancillary Services are those billed on revenue codes 250 and higher.

Example of Template

Internal Claim Reference Number	Begin Date of Service	Ending Date of Service	Total Days	Adult & Ped Days	Nursery Days	ICU Days	NICU Days	Surgical ICU Days	Psych Unit Days	Billed Amount for Ancillary Services
---------------------------------	-----------------------	------------------------	------------	------------------	--------------	----------	-----------	-------------------	-----------------	--------------------------------------

sample

69347185963	1/1/2009	1/4/2009	4	3	0	1	0	0	0	\$2,500.00
-------------	----------	----------	---	---	---	---	---	---	---	------------

Template for Itemizing Outpatient Services for Individuals with No Third Party Coverage

Notes:

1. The supporting schedule that you provide does not need to look exactly like this, so long as all of the data elements requested appear on your hospital-designed report. The information you provide does not need to be entered into this Excel spreadsheet. A separate attachment is acceptable.
2. Include claims when the Ending Date of Service falls within the hospital fiscal year end (9/30/09 for most hospitals), regardless of when payment(s) were received.
3. CMS has provided guidance that hospitals do not need to tie payments back to specific services in the hospital year examined. In other words, the payments you will report that you received within the hospital fiscal year for individuals with no third party coverage will not necessarily be revenues against the services offered to the individuals with no third party coverage who received services in the hospital year. On this schedule, only report the days of service and charges for ancillary services, not the payments. The payments for individuals with no third party coverage will tie to your financial statements.
4. Ancillary Services are those billed on revenue codes 250 and higher.

Example of Template

Internal Claim Reference Number	Begin Date of Service	Ending Date of Service	Billed Amount for Ancillary Services
---------------------------------	-----------------------	------------------------	--------------------------------------

sample

69347185963	1/1/2009	1/4/2009	\$2,500.00
-------------	----------	----------	------------