METHODOLOGY FOR VERMONT’S
DISPROPORTIONATE SHARE PAYMENTS
IN FEDERAL FISCAL YEAR 2013

DEPARTMENT OF VERMONT HEALTH ACCESS

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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 2012 at $23,041,882². The FMAP rate for FFY 2013 is 56.04%. Therefore, using the FFY 2012 amount as a preliminary figure for FFY 2013, total DSH expenditures (state and federal funds combined) cannot exceed $41,116,849. The Department of Vermont Health Access (DVHA) has allocated state funding for DSH in FFY 2013 so that total DSH funding (state and federal funds combined) will not exceed $37,448,781.

Federal law³ states that aggregate DSH payments to Institutions for Mental Diseases⁴ (IMDs) in Vermont is restricted to the lesser of $9,320,580 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 2013, 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 Vermont⁵, 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.
³ 42 CFR 447.297 – Limitation on aggregate payment for disproportionate share hospitals beginning October 1, 1992.
⁴ “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.
⁵ 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

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”).

2. The hospital has a Low Income Utilization Rate (LIUR) that exceeds 25% (“Group 2”).

3. The hospital operates a post-graduate training program in the State of Vermont (“Group 3”).

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”).

### COLUMN B

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.

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.

3. The patients of the hospital are predominantly under 18 years of age.

4. The hospital was in existence on December 22, 1987 but did not offer non-emergency obstetric services as of that date.

### COLUMN C

1. The hospital has a MIUR of at least 1 percent.

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.

3. 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.

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 Survey 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 completed.

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6 A template of the DSH Survey utilized for DSH FFY 2013 appears in Appendix 10.
received by DVHA by the due date specified in a request for information communicated to the
Chief Financial Officer of the hospital each year. The deadline for submission of the DSH Survey was March 30, 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 or more 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 2013, the Base Year used was FFY 2010 (October 1, 2009 – September 30, 2010). This also corresponds to each Vermont hospitals’ fiscal year with the exception of Retreat Health Care.7

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:

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

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:

1. “Medicaid Inpatient Days” includes all paid covered inpatient days for Title XIX clients including:
   a. Days for individuals dually eligible for Medicare and Medicaid;

---

7 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 2013 eligibility tests—three months from the hospital’s year ending 12/31/09 and nine months from the hospital’s year ending 12/31/10. Claims data was used in the Base Year only.
b. Days when the client is in a specialized ward; and
c. Days 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:
1. Report MRMN503S, compiled by the DVHA’s fiscal agent, which enumerates paid covered Title XIX days for each hospital during the DSH Base Year when DVHA is the primary payer.
2. DVHA claims for Medicare/Medicaid dual eligibles or a detailed report from the hospital.

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 2013 was 28.85%. 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 2013 was 10.34%. Therefore, the threshold for hospitals to meet Group 1 eligibility in DSH SPY 2013 was 39.19%.

Refer to Appendix 3 for details on the MIUR calculations for DSH SPY 2013.

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 is the ratio of

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

Equation 2 is the ratio of

\[
\frac{\text{Total Inpatient Charges Attributable to Charity Care–Cash Subsidies Portion Attributable to Inpatient}}{\text{Total Inpatient Charges}}
\]

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 2013, the values in the column labeled “Actual 2010” 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.

   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 2013, the values in the column labeled “Actual 2010” 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 2013, the values in the column labeled “Actual 2010” 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 2013.

**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 requirement\(^8\) 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 obstetricians\(^9\), all hospitals that are determined to have a MIUR of at least 1% must make the

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\(^8\) Requirements in accordance with Section 1923(d) of the Social Security Act.

\(^9\)
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.

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.

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

Section 8: Hospital-specific Limit Calculations

The hospital-specific limit is calculated using the following equation:

\[
\text{Costs Incurred Serving Medicaid Recipients} - \text{Payments Received for Costs Incurred Serving Medicaid Recipients} + \text{Costs Incurred Serving Individuals with No Third Party Coverage} - \text{Payments Received for Costs Incurred Serving Individuals with No Third Party Coverage}
\]

Pursuant to the above equation:

\[
\text{Costs Incurred Serving Medicaid Recipients} = \\
[\text{VT Medicaid Inpatient Days}] \times [\text{Medicaid Hospital-specific Accommodation Cost Per Day}] + \\
[\text{VT Medicaid Inpatient Ancillary Charges}] \times [\text{Medicaid Inpatient Ancillary Cost-to-Charge Ratio (CCR)}]
\]

9 Requirements in accordance with Vermont Medicaid State Plan Attachment 4.19A pg. 1d and Section 1923(d).
+ [VT Medicaid Outpatient Charges] * [Medicaid Outpatient CCR] +
[VT Medicare/Medicaid dual eligible Inpatient Days + Other State Medicaid eligible Inpatient Days] * [Medicaid Hospital-specific Accommodation Cost Per Day] +
[VT Medicare/Medicaid dual eligible Inpatient Ancillary Charges + Other State Medicaid eligible Inpatient Ancillary Charges] * [Medicaid Inpatient Ancillary CCR] +
[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] during the Base Year for services delivered during the Base Year or any prior year

The hospital-specific 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 2013, this Base Year was for the period 10/1/09 – 9/30/10 for all participating hospitals.

Data Sources for Hospital-specific 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:
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:

\[
\frac{\text{The sum of the amounts on the Title XIX schedules of Worksheet D-4 (Hospital), Column 3, Line 101 and Worksheet D-4 (Subprovider), Column 3, Line 101}}{\text{The sum of the amounts on the Title XIX schedules of Worksheet D-4 (Hospital), Column 2, Line 101 and Worksheet D-4 (Subprovider), Column 2, Line 101}}
\]

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:

\[
\frac{\text{The sum of the amounts on the Title XIX schedules of Worksheet D Part V, Column 9.01, Line 104 and Worksheet D Part V, Column 9.02, Line 104}}{\text{The sum of the amounts on the Title XIX schedules of Worksheet D Part V, Column 5.01, Line 104 and Worksheet D Part V, Column 5.02, Line 104}}
\]

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 5 and 9 or to provide replacement Schedules 5 and 9 which can be supported by claim-level documentation. The Schedules 5 and 9 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 6, 7, 10 and 11 in the DSH survey which can be supported by claim-level documentation.
The Schedules 6, 7, 10 and 11 provided to the DVHA an itemized claim-level detail of inpatient days, inpatient ancillary charges and outpatient charges for other state Medicaid eligibles, both fee-for-service and HMO days/services.

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 5 of the DSH Survey.
   d. Medicare/Medicaid Dual Eligible Outpatient Payments: Reported by each hospital on Schedule 9 of the DSH Survey.
   e. Other State Medicaid Eligible Inpatient Payments: Reported by each hospital on Schedules 6 and 7 of the DSH Survey.
   f. Other State Medicaid Eligible Outpatient Payments: Reported by each hospital on Schedules 10 and 11 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 8 in the DSH Survey which can be supported by claim-level documentation. The Schedule 8 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 12 in the DSH Survey which can be supported by claim-level documentation. The Schedule 12 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 8 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 12 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 based upon the DSH Group that will maximize their DSH payment in the SPY.

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:

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

For DSH SPY 2013, the allocation to each DSH Eligibility Group was as follows: Group 1: $0; Group 2: $0; Group 3: $18,115,526; Group 4: $19,333,255.

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 Limit. 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 2013**

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

- On pages 1f and 1g, date references were changed to account for the new DSH SPY

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10 In accordance with Section 1923(g) of the Social Security Act.
• On page 1g, a change was also made to reference the logic described in Section 9 above that states that if a hospital is eligible in more than one DSH Group, the hospital will be placed in only one DSH Eligibility Group based upon the DSH Group that will maximize their DSH payment in the SPY.

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 2009 through 2013

<table>
<thead>
<tr>
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<td>Brattleboro Memorial Hospital</td>
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<td>$1,393,697</td>
<td>$1,368,678</td>
<td>$1,176,989</td>
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<td>Fletcher Allen Health Care</td>
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<td>$16,903,464</td>
<td>$16,738,071</td>
<td>$18,724,391</td>
<td>$18,115,526</td>
<td>($608,865)</td>
<td>-3%</td>
</tr>
<tr>
<td>Gifford Medical Center</td>
<td>$294,586</td>
<td>$975,804</td>
<td>$560,302</td>
<td>$875,394</td>
<td>$807,107</td>
<td>($68,287)</td>
<td>-8%</td>
</tr>
<tr>
<td>Grace Cottage Hospital</td>
<td>$102,525</td>
<td>$0</td>
<td>$0</td>
<td>$153,081</td>
<td>$216,999</td>
<td>$63,918</td>
<td>42%</td>
</tr>
<tr>
<td>Mt. Ascutney Hospital</td>
<td>$102,525</td>
<td>$500,038</td>
<td>$686,822</td>
<td>$302,698</td>
<td>$283,346</td>
<td>($19,351)</td>
<td>-6%</td>
</tr>
<tr>
<td>North Country Hospital</td>
<td>$1,681,813</td>
<td>$1,773,107</td>
<td>$1,956,360</td>
<td>$2,092,289</td>
<td>$1,848,818</td>
<td>($243,471)</td>
<td>-12%</td>
</tr>
<tr>
<td>Northeastern Vermont Hospital</td>
<td>$2,156,674</td>
<td>$1,770,076</td>
<td>$1,250,574</td>
<td>$1,033,166</td>
<td>$1,293,715</td>
<td>$260,549</td>
<td>25%</td>
</tr>
<tr>
<td>Northwestern Medical Center</td>
<td>$1,783,308</td>
<td>$1,626,840</td>
<td>$2,011,716</td>
<td>$2,109,676</td>
<td>$2,128,462</td>
<td>$18,786</td>
<td>1%</td>
</tr>
<tr>
<td>Porter Medical Center</td>
<td>$496,697</td>
<td>$1,016,911</td>
<td>$1,292,983</td>
<td>$753,493</td>
<td>$827,357</td>
<td>$73,865</td>
<td>10%</td>
</tr>
<tr>
<td>Retreat Health Care</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>0%</td>
</tr>
<tr>
<td>Rutland Regional Medical Center</td>
<td>$3,954,499</td>
<td>$3,151,984</td>
<td>$3,929,839</td>
<td>$3,821,595</td>
<td>$4,251,425</td>
<td>$429,829</td>
<td>11%</td>
</tr>
<tr>
<td>Southwestern Vermont Hospital</td>
<td>$979,308</td>
<td>$1,760,973</td>
<td>$2,568,646</td>
<td>$2,437,759</td>
<td>$2,073,221</td>
<td>($364,538)</td>
<td>-15%</td>
</tr>
<tr>
<td>Springfield Hospital</td>
<td>$2,605,376</td>
<td>$1,297,199</td>
<td>$1,999,676</td>
<td>$1,396,906</td>
<td>$1,641,055</td>
<td>$244,150</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>$ 36,548,782</strong></td>
<td><strong>$ 36,548,781</strong></td>
<td><strong>$ 37,448,781</strong></td>
<td><strong>$ 37,448,781</strong></td>
<td><strong>$ 37,448,781</strong></td>
<td><strong>$0</strong></td>
<td><strong>0%</strong></td>
</tr>
</tbody>
</table>
APPENDIX 2
Calculations for Determining Disproportionate Share Payments Made in Federal Fiscal Year 2013

<table>
<thead>
<tr>
<th>Total DSH Allotment:</th>
<th>37,448,781</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Allocation to DSH Group #3:</td>
<td>18,115,526</td>
</tr>
<tr>
<td>Allocation to Other Groups:</td>
<td>19,333,255</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calculate Hospital Specific Limit</th>
<th>Calculate Pct of TXIX Days (excl. DSH Group #3)</th>
<th>Calculate DSH Allotment by Group</th>
<th>Compute Aggregate Limits by DSH Group</th>
<th>Determine Each Hospital's Limit as Pct of Group's Limit</th>
<th>Allocate DSH to Each Hospital</th>
<th>Effective Percent of Hospital Specific Limit Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Total Available DSH) * (Group's Pct Statewide Title XIX Days)</td>
<td>(Group DSH Allotment) * (Pct of Group Limit)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DSH Group #1: MIUR**
North Country Hospital was eligible for DSH Group #1, but the total computed DSH payment is higher in DSH Group #4.

**DSH Group #2: LIUR**
no hospitals eligible

**DSH Group #3: Teaching Hospitals**
Fletcher Allen Health Care: 36,231,052 (100.00%) 18,115,526

**DSH Group #4: State-Designed Group**
Brattleboro Memorial Hospital: 4,233,102 (5.8%) 6.40% 1,236,502 29.21%
Central Vermont Medical Center: 7,044,735 (15.4%) 10.64% 2,057,789 29.21%
Copley Hospital: 2,285,012 (4.0%) 3.45% 667,459 29.21%
Gifford Medical Center: 2,763,087 (4.4%) 4.17% 807,107 29.21%
Grace Cottage Hospital: 742,886 (0.3%) 1.12% 216,999 29.21%
Mt Ascutney Hospital: 970,021 (1.9%) 1.47% 283,346 29.21%
North Country Hospital: 6,329,332 (7.0%) 9.56% 1,848,818 29.21%
Northeastern Vermont Hospital: 4,428,966 (4.9%) 6.69% 1,293,715 29.21%
Northwestern Medical Center: 7,286,678 (5.6%) 11.01% 2,128,462 29.21%
Porter Medical Center: 2,832,414 (4.0%) 4.28% 827,357 29.21%
Retreat Health Care*: not considered
Rutland Regional Medical Center: 14,554,532 (26.9%) 21.99% 4,251,425 29.21%
Southwestern Vermont Hospital: 7,097,564 (9.5%) 10.72% 2,073,221 29.21%
Springfield Hospital: 5,618,067 (10.4%) 8.49% 1,641,055 29.21%

<table>
<thead>
<tr>
<th>Total DSH Payments</th>
<th>37,448,781</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Allocation to DSH Group #3:</td>
<td>18,115,526</td>
</tr>
<tr>
<td>Allocation to Other Groups:</td>
<td>19,333,255</td>
</tr>
</tbody>
</table>

* Retreat's hospital limit was determined to be ($698,486) in this DSH SPY.

Department of Vermont Health Access
October 12, 2012
## APPENDIX 3
### Supporting Schedule for Determining Eligibility for DSH Group #1 (MIUR) and for Assignment of Dollars to DSH Eligibility Groups in Federal Fiscal Year 2013

<table>
<thead>
<tr>
<th>Variable for Calculation</th>
<th>Medicaid Inpatient Days</th>
<th>All Payer Days</th>
<th>Medicaid Inpatient Utilization Rate (MIUR)</th>
<th>Eligible for DSH at all?</th>
<th>Group 1 (MIUR) Eligible?</th>
<th>Percent of Statewide Title XIX Inpatient Days</th>
<th>Percent of Statewide Title XIX Inpatient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source</td>
<td>Hospital's MCR Filing Status</td>
<td>DSH Survey Schedule 3, II.A.3</td>
<td>Hospital Year End 2010 MCR Worksheet S-3, Part I, Column 6</td>
<td>calculated as (1) / (2)</td>
<td>If (3) &gt;= 1%, then Yes</td>
<td>calculated as value in (1) / sum of column (1)</td>
<td>Same formula as Column 6 but excludes Fletcher Allen Health Care and Retreat</td>
</tr>
<tr>
<td>Brattleboro Memorial Hospital</td>
<td>As Submitted</td>
<td>2,107</td>
<td>7,505</td>
<td>28.07%</td>
<td>Yes</td>
<td>No</td>
<td>2.7%</td>
</tr>
<tr>
<td>Central Vermont Medical Center</td>
<td>As Submitted</td>
<td>5,629</td>
<td>15,546</td>
<td>36.21%</td>
<td>Yes</td>
<td>No</td>
<td>7.2%</td>
</tr>
<tr>
<td>Copley Hospital</td>
<td>As Submitted</td>
<td>1,449</td>
<td>4,837</td>
<td>29.96%</td>
<td>Yes</td>
<td>No</td>
<td>1.9%</td>
</tr>
<tr>
<td>Fletcher Allen Health Care</td>
<td>As Submitted</td>
<td>34,312</td>
<td>114,879</td>
<td>29.87%</td>
<td>Yes</td>
<td>No</td>
<td>44.1%</td>
</tr>
<tr>
<td>Gifford Medical Center</td>
<td>As Submitted</td>
<td>1,604</td>
<td>5,730</td>
<td>27.99%</td>
<td>Yes</td>
<td>No</td>
<td>2.1%</td>
</tr>
<tr>
<td>Grace Cottage Hospital</td>
<td>As Submitted</td>
<td>105</td>
<td>3,837</td>
<td>2.74%</td>
<td>Yes</td>
<td>No</td>
<td>0.1%</td>
</tr>
<tr>
<td>Mt. Ascutney Hospital</td>
<td>As Submitted</td>
<td>685</td>
<td>9,524</td>
<td>7.19%</td>
<td>Yes</td>
<td>No</td>
<td>0.9%</td>
</tr>
<tr>
<td>North Country Hospital</td>
<td>As Submitted</td>
<td>2,561</td>
<td>6,179</td>
<td>41.45%</td>
<td>Yes</td>
<td>Yes</td>
<td>3.3%</td>
</tr>
<tr>
<td>Northeastern Vermont Hospital</td>
<td>As Submitted</td>
<td>1,775</td>
<td>5,641</td>
<td>31.47%</td>
<td>Yes</td>
<td>No</td>
<td>2.3%</td>
</tr>
<tr>
<td>Northwestern Medical Center</td>
<td>As Submitted</td>
<td>2,028</td>
<td>6,277</td>
<td>32.31%</td>
<td>Yes</td>
<td>No</td>
<td>2.6%</td>
</tr>
<tr>
<td>Porter Medical Center</td>
<td>As Submitted</td>
<td>1,449</td>
<td>5,208</td>
<td>27.82%</td>
<td>Yes</td>
<td>No</td>
<td>1.9%</td>
</tr>
<tr>
<td>Retreat Health Care</td>
<td>As Submitted</td>
<td>7,108</td>
<td>26,573</td>
<td>26.75%</td>
<td>Yes</td>
<td>No</td>
<td>9.1%</td>
</tr>
<tr>
<td>Rutland Regional Medical Center</td>
<td>As Submitted</td>
<td>9,799</td>
<td>33,248</td>
<td>29.47%</td>
<td>Yes</td>
<td>No</td>
<td>12.6%</td>
</tr>
<tr>
<td>Southwestern Vermont</td>
<td>As Submitted</td>
<td>3,475</td>
<td>15,167</td>
<td>22.91%</td>
<td>Yes</td>
<td>No</td>
<td>4.5%</td>
</tr>
<tr>
<td>Springfield Hospital</td>
<td>As Submitted</td>
<td>3,795</td>
<td>9,811</td>
<td>38.68%</td>
<td>Yes</td>
<td>No</td>
<td>4.9%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>77,881</strong></td>
<td><strong>269,962</strong></td>
<td><strong>28.85%</strong></td>
<td></td>
<td></td>
<td><strong>100.0%</strong></td>
</tr>
<tr>
<td><strong>Total Excluding Fletcher Allen and Retreat</strong></td>
<td></td>
<td><strong>36,461</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Department of Vermont Health Access

October 12, 2012
## APPENDIX 4
### Supporting Schedule for Determining Eligibility for DSH Group #2 (LIUR) in Federal Fiscal Year 2013

<table>
<thead>
<tr>
<th>Variable for Calculation</th>
<th>Data Source</th>
<th>Net Medicaid Patient Revenue (IP+OP)</th>
<th>State &amp; Local Cash Subsidies for Patient Services</th>
<th>Net All Payer Patient Revenue (IP+OP)</th>
<th>Ratio 1 of LIUR</th>
<th>Inpatient Charges Attributable to Individuals with No Third Party Coverage</th>
<th>State &amp; Local Cash Subsidies for Inpatient Services</th>
<th>Total Gross Inpatient Charges</th>
<th>Ratio 2 of LIUR</th>
<th>Low Income Utilization Percentage</th>
<th>Group 2 Eligible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DSH Survey Schedule 4, III.A.9</td>
<td>calculated as $\frac{(1)+(2)}{(3)}$</td>
<td>DSH Survey Schedule 4, III.B.1+III.B.2</td>
<td>calculated as $\frac{(5)-(6)}{(7)}$</td>
<td>DSH Survey Schedule 4, III.C.14</td>
<td>calculated as $\frac{(4) + (8)}{(9)}$</td>
<td>DSH Survey Schedule 4, III.B.1</td>
<td>DSH Survey Schedule 4, III.C.1</td>
<td>DSH Survey Schedule 4, III.D.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brattleboro Memorial Hospital</td>
<td>4,296,539</td>
<td>54,623,664</td>
<td>7.87%</td>
<td>427,050</td>
<td>0</td>
<td>25,458,284</td>
<td>1.68%</td>
<td>9.54%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Vermont Medical Center</td>
<td>14,367,058</td>
<td>111,972,815</td>
<td>12.83%</td>
<td>740,127</td>
<td>0</td>
<td>57,851,551</td>
<td>1.28%</td>
<td>14.11%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copley Hospital</td>
<td>4,596,009</td>
<td>42,590,011</td>
<td>10.79%</td>
<td>116,504</td>
<td>0</td>
<td>17,613,484</td>
<td>0.66%</td>
<td>11.45%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fletcher Allen Health Care</td>
<td>49,791,448</td>
<td>650,163,192</td>
<td>7.66%</td>
<td>3,998,343</td>
<td>0</td>
<td>513,791,891</td>
<td>0.78%</td>
<td>8.44%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gifford Medical Center</td>
<td>5,823,782</td>
<td>44,255,518</td>
<td>13.16%</td>
<td>507,434</td>
<td>0</td>
<td>18,469,620</td>
<td>2.75%</td>
<td>15.91%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grace Cottage Hospital</td>
<td>332,217</td>
<td>8,164,894</td>
<td>4.07%</td>
<td>32,894</td>
<td>0</td>
<td>1,272,112</td>
<td>2.59%</td>
<td>6.65%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mt. Ascutney Hospital</td>
<td>2,065,531</td>
<td>28,229,034</td>
<td>7.32%</td>
<td>147,017</td>
<td>0</td>
<td>5,704,138</td>
<td>2.58%</td>
<td>9.89%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Country Hospital</td>
<td>7,174,443</td>
<td>57,322,878</td>
<td>12.52%</td>
<td>404,680</td>
<td>0</td>
<td>23,386,661</td>
<td>1.73%</td>
<td>14.25%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northeastern Vermont Hospital</td>
<td>3,881,249</td>
<td>43,642,385</td>
<td>8.89%</td>
<td>782,214</td>
<td>0</td>
<td>24,007,336</td>
<td>3.26%</td>
<td>12.15%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northwestern Medical Center</td>
<td>9,340,318</td>
<td>69,825,926</td>
<td>13.38%</td>
<td>29,260</td>
<td>0</td>
<td>27,163,814</td>
<td>0.11%</td>
<td>13.48%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Porter Medical Center</td>
<td>4,033,019</td>
<td>45,995,182</td>
<td>8.77%</td>
<td>437,602</td>
<td>0</td>
<td>19,467,554</td>
<td>2.25%</td>
<td>11.02%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retreat Health Care</td>
<td>10,892,429</td>
<td>36,528,930</td>
<td>29.82%</td>
<td>42,927</td>
<td>0</td>
<td>59,714,002</td>
<td>0.07%</td>
<td>29.89%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rutland Regional Medical Center</td>
<td>13,627,417</td>
<td>157,002,866</td>
<td>8.68%</td>
<td>3,701,619</td>
<td>0</td>
<td>127,107,238</td>
<td>2.91%</td>
<td>11.59%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southwestern Vermont</td>
<td>11,699,018</td>
<td>120,718,129</td>
<td>9.73%</td>
<td>1,089,059</td>
<td>0</td>
<td>66,613,642</td>
<td>1.63%</td>
<td>11.36%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Springfield Hospital</td>
<td>6,171,235</td>
<td>45,612,020</td>
<td>13.53%</td>
<td>643,211</td>
<td>0</td>
<td>23,688,545</td>
<td>2.72%</td>
<td>16.25%</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
### APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in Disproportionate Share Payments Made in FFY 2013

<table>
<thead>
<tr>
<th>Variable for Calculation</th>
<th>VT Medicaid Eligible</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source</td>
<td>Appendix 7, Column C</td>
<td>Appendix 7, Column D</td>
<td>Appendix 7, Column E</td>
<td>Appendix 7, Column F</td>
<td>Appendix 7, Column G</td>
<td>Appendix 7, Column H</td>
<td>Appendix 7, Column I</td>
<td>Appendix 6, Column J</td>
<td>Appendix 6, Column K</td>
<td>Appendix 6, Column L</td>
<td>Appendix 6, Column M</td>
</tr>
<tr>
<td>Brattleboro Memorial Hospital</td>
<td>897</td>
<td>448</td>
<td>113</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,559.95</td>
<td>1,559.95</td>
<td>1,936.40</td>
<td>0.00</td>
</tr>
<tr>
<td>Central Vermont Med Center</td>
<td>1,437</td>
<td>488</td>
<td>220</td>
<td>0</td>
<td>7</td>
<td>1,458</td>
<td>0</td>
<td>1,080.09</td>
<td>736.57</td>
<td>2,721.64</td>
<td>2,721.64</td>
</tr>
<tr>
<td>Copley Hospital</td>
<td>632</td>
<td>277</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,360.67</td>
<td>1,385.87</td>
<td>2,468.23</td>
<td>0.00</td>
</tr>
<tr>
<td>Fletcher Allen Health Care</td>
<td>13,699</td>
<td>1,714</td>
<td>641</td>
<td>2,357</td>
<td>576</td>
<td>1,355</td>
<td>0</td>
<td>1,064.54</td>
<td>582.78</td>
<td>2,106.77</td>
<td>1,716.50</td>
</tr>
<tr>
<td>Gifford Medical Center</td>
<td>718</td>
<td>230</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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Department of Vermont Health Access

Page 2 of 9

October 12, 2012
## APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in Disproportionate Share Payments Made in FFY 2013

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### APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in Disproportionate Share Payments Made in FFY 2013

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Data Source: Appendix 8, Column O

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### APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in Disproportionate Share Payments Made in FFY 2013

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<th>ICU Days</th>
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October 12, 2012
## APPENDIX 5

Calculations for Determining Hospital-specific Limits to be Applied in Disproportionate Share Payments Made in FFY 2013

<table>
<thead>
<tr>
<th>Variable for Calculation</th>
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<th>Other State Medicaid Beneficiaries Inpatient Ancillary Charges</th>
<th>Individuals with No Third Party Coverage Inpatient Ancillary Charges</th>
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### APPENDIX 5

**Calculations for Determining Hospital-specific Limits to be Applied in Disproportionate Share Payments Made in FFY 2013**

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### Calculations for Determining Hospital-specific Limits to be Applied in Disproportionate Share Payments Made in FFY 2013

| 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 Eligibles-Inpatient Payments | Other State Medicaid Eligibles-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 (59)+(60)+(61)+(62)+(63)+(64)+(65)+(66)+(67)+(68) |
| Brattleboro Memorial Hospital | 2,016,643                     | 2,687,882                     | 938,823                                       | 872,681                                       | 99,250                                       | 183,036                                      | 23,539                                       | 143,920                                       | 0                                             | 0                                             | 6,965,774                          |
| Central Vermont Med Center | 4,954,121                     | 5,453,410                     | 4,067,942                                     | 2,594,405                                     | 25,948                                       | 17,919                                       | 71,633                                       | 470,418                                       | 0                                             | 0                                             | 17,655,796                        |
| Copley Hospital           | 1,568,477                     | 2,738,448                     | 1,279,104                                     | 1,537,059                                     | 0                                            | 7,810                                        | 4,509                                        | 172,305                                       | 0                                             | 0                                             | 7,307,712                          |
| Fletcher Allen Health Care | 33,444,492                    | 18,593,260                    | 22,845,403                                    | 16,791,016                                    | 5,396,054                                    | 931,946                                      | 233,026                                      | 1,172,783                                     | 0                                             | 0                                             | 99,406,980                        |
| Gifford Medical Center    | 1,530,343                     | 2,587,091                     | 1,197,998                                     | 1,313,542                                     | 0                                            | 11,320                                       | 4,220                                        | 137,025                                       | 0                                             | 0                                             | 6,781,539                          |
| Grace Cottage Hospital     | 71,316                        | 309,844                       | 90,678                                        | 187,617                                       | 0                                            | 1,321                                        | 0                                            | 38,534                                       | 0                                             | 0                                             | 699,310                           |
| Mt. Ascutney Hospital      | 496,569                       | 632,222                       | 474,879                                       | 778,366                                       | 232,921                                      | 271,255                                      | 24,036                                       | 109,381                                       | 0                                             | 0                                             | 3,019,629                          |
| North Country Hospital     | 2,453,574                     | 3,245,687                     | 2,637,468                                     | 3,520,160                                     | 0                                            | 19,884                                       | 15,205                                       | 300,246                                       | 0                                             | 0                                             | 12,192,224                         |
| Northeastern Vermont Hospital | 2,110,809                    | 2,310,387                     | 1,346,031                                     | 1,355,026                                     | 13,803                                       | 17,286                                       | 6,320                                        | 124,898                                       | 0                                             | 0                                             | 7,284,560                          |
| Northwestern Medical Center | 3,380,987                     | 4,947,088                     | 1,834,870                                     | 1,833,952                                     | 2,926                                        | 5,658                                        | 12,541                                       | 396,116                                       | 0                                             | 0                                             | 12,414,138                         |
| Porter Medical Center      | 1,417,821                     | 2,230,397                     | 1,072,772                                     | 1,490,195                                     | 61,109                                       | 29,365                                       | 32,468                                       | 445,626                                       | 0                                             | 0                                             | 6,779,753                          |
| Retreat Health Care       | 5,705,047                     | 0                            | 28,025                                        | 13,679                                        | 1,257,095                                    | 1,240                                        | 26,710                                       | 17,950                                       | 0                                             | 0                                             | 7,049,746                          |
| Rutland Regional Med Center | 9,104,817                    | 7,278,415                     | 5,876,597                                     | 4,245,789                                     | 108,469                                      | 36,065                                       | 93,560                                       | 508,823                                       | 0                                             | 0                                             | 27,252,535                        |
| Southwestern Vermont       | 3,612,922                     | 4,964,587                     | 2,165,523                                     | 2,098,758                                     | 601,347                                      | 730,759                                      | 52,380                                       | 517,014                                       | 0                                             | 40,614                                      | 14,783,904                        |
| Springfield Hospital       | 3,314,928                     | 2,362,774                     | 1,608,887                                     | 1,744,408                                     | 69,005                                       | 131,269                                      | 44,195                                       | 345,791                                       | 0                                             | 0                                             | 9,621,257                          |
## APPENDIX 5
Calculations for Determining Hospital-specific Limits to be Applied in Disproportionate Share Payments Made in FFY 2013

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## APPENDIX 6
### Supporting Schedule of Medicare Cost Report Data Elements Used to Calculate Hospital-specific Limits & the MIUR in Federal Fiscal Year 2013

Data Source: Latest Medicare Cost Reports for the hospital year ending 9/30/10
(Retreat Health Care 12/31/10) from Medicare fiscal intermediary on 1/16/12.

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<th>Worksheet D, Part V, Col 5.01, Line 105</th>
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<td>5,036,495</td>
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<td>see below</td>
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<td>2,649,921</td>
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<td>0.5327</td>
</tr>
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</table>

1 Neonatal ICU  
2 Surgical ICU  
3 Subprovider II  
4 For some hospitals, this is Column 5.03  
5 For some hospitals, this is Column 9.03

Apportion 25% of 12/31/09 MCR and 75% of 12/31/10 MCR to data used in calculations.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Type</th>
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<th>MCR</th>
<th>Outpatient CCR</th>
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</thead>
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<td>Retreat Health Care</td>
<td>Blend</td>
<td>26,573</td>
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</table>
## APPENDIX 6

### Supporting Schedule of Medicare Cost Report Data Elements Used to Calculate Hospital-specific Limits & the MIUR in Federal Fiscal Year 2013

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Adult &amp; Peds Per Diem</th>
<th>Nursery Per Diem</th>
<th>ICU Per Diem</th>
<th>NICU Per Diem</th>
<th>Surgical ICU Per Diem</th>
<th>Subprovider I Per Diem</th>
<th>Subprovider II Per Diem</th>
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<tr>
<td></td>
<td>Worksheet D-1, Part II, Line 38</td>
<td>Worksheet D-1, Part II, Line 42</td>
<td>Worksheet D-1, Part II, Line 43</td>
<td>Worksheet D-1, Part II, Line 45.01</td>
<td>Worksheet D-1, Part II, Line 38 (Subprovider)</td>
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<td>1,559.95</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
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<td>1,385.87</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>470003 Fletcher Allen Health Care</td>
<td>1,064.54</td>
<td>582.78</td>
<td>2,106.77</td>
<td>1,716.50</td>
<td>2,324.97</td>
<td>932.99</td>
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<td>0.00</td>
<td>0.00</td>
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</tr>
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<td>1,375.54</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>471302 Mt. Ascutney Hospital</td>
<td>1,228.63</td>
<td>0.00</td>
<td>1,228.63</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1,228.63</td>
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<tr>
<td>471304 North Country Hospital</td>
<td>1,099.98</td>
<td>572.69</td>
<td>3,512.09</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
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<td>1,180.21</td>
<td>772.06</td>
<td>2,310.67</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>471307 Porter Hospital</td>
<td>1,452.71</td>
<td>1,167.45</td>
<td>2,770.94</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>474001 Retreat Health Care</td>
<td>745.56</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
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<td>1,229.24</td>
<td>999.99</td>
<td>2,036.57</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1,537.44</td>
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<tr>
<td>470012 Southwestern Vermont Hospital</td>
<td>1,120.75</td>
<td>800.86</td>
<td>2,346.71</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>471306 Springfield Hospital</td>
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<td>666.17</td>
<td>1,305.71</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>903.74</td>
</tr>
</tbody>
</table>

Apportion 25% of 12/31/09 MCR and 75% of 12/31/10 MCR to data used in calculations.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Apportioned Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>474001 Retreat Health Care</td>
<td>813.13</td>
</tr>
<tr>
<td>474001 Retreat Health Care</td>
<td>723.03</td>
</tr>
<tr>
<td>474001 Retreat Health Care</td>
<td>745.56</td>
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</tbody>
</table>
**APPENDIX 6**
Supporting Schedule of Medicare Cost Report Data Elements Used to Calculate Hospital-specific Limits & the MIUR in Federal Fiscal Year 2013

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Worksheet D-4 (Hospital), Col 2, Line 101</th>
<th>Worksheet D-4 (Hospital), Col 3, Line 101</th>
<th>Worksheet D-4 (Subprovider(^6)), Col 2, Line 101</th>
<th>Worksheet D-4 (Subprovider(^6)), Col 3, Line 101</th>
<th>Inpatient Ancillary CCR</th>
<th>Worksheet E-3 Part IV (Title XIX), Line 23.01</th>
</tr>
</thead>
<tbody>
<tr>
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<td>2,014,832</td>
<td>919,722</td>
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<td>0</td>
<td>0.4565</td>
<td>0</td>
</tr>
<tr>
<td>470001 Central Vermont Hospital</td>
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<td>2,027,268</td>
<td>621,748</td>
<td>280,756</td>
<td>0.4939</td>
<td>0</td>
</tr>
<tr>
<td>471305 Copley Hospital</td>
<td>1,577,964</td>
<td>804,391</td>
<td>0</td>
<td>0</td>
<td>0.5098</td>
<td>0</td>
</tr>
<tr>
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<td>48,088,973</td>
<td>19,940,167</td>
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<td>0</td>
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<td>0</td>
<td>0.3299</td>
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<tr>
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<td>517,358</td>
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<td>0</td>
<td>0.4909</td>
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</tr>
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<td>156,907</td>
<td>93,302</td>
<td>0.4531</td>
<td>0</td>
</tr>
</tbody>
</table>

\(^6\) For Rutland Regional, this includes Subprovider I and Subprovider II data

Apportion 25% of 12/31/09 MCR and 75% of 12/31/10 MCR to data used in calculations.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Worksheet D-4 (Hospital), Col 2, Line 101</th>
<th>Worksheet D-4 (Hospital), Col 3, Line 101</th>
<th>Worksheet D-4 (Subprovider(^6)), Col 2, Line 101</th>
<th>Worksheet D-4 (Subprovider(^6)), Col 3, Line 101</th>
<th>Inpatient Ancillary CCR</th>
<th>Worksheet E-3 Part IV (Title XIX), Line 23.01</th>
</tr>
</thead>
<tbody>
<tr>
<td>474001 Retreat Health Care</td>
<td>1,004,589</td>
<td>503,629</td>
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<td>0</td>
<td>0.5013</td>
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<td>0</td>
<td>0.4876</td>
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</tr>
<tr>
<td>474001 Retreat Health Care</td>
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<td>517,358</td>
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<td>0</td>
<td>0.4909</td>
<td>0</td>
</tr>
</tbody>
</table>
## APPENDIX 7
Supporting Schedule of MMIS Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2013

**Data Source:** Reports produced by HP, DVHA's fiscal agent for services rendered for the 12-month period ending 9/30/10

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Adult &amp; Peds</th>
<th>Nursery</th>
<th>ICU</th>
<th>NICU</th>
<th>Surgical ICU</th>
<th>Subprovider I</th>
<th>Subprovider II</th>
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<tr>
<td></td>
<td>Inpatient Days Billed to Revenue Codes 110-119,120-150, 190</td>
<td>Inpatient Days Billed to Revenue Codes 170-171</td>
<td>Inpatient Days Billed to Revenue Codes 200-206</td>
<td>Inpatient Days Billed to Revenue Codes 173-179</td>
<td>Inpatient Days Billed to Revenue Codes 210-214</td>
<td>Inpatient Days Billed to Revenue Codes 110-119,120-150</td>
<td>Inpatient Days Billed to Revenue Codes 110-119,120-150</td>
</tr>
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<td>0</td>
<td>0</td>
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</tr>
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<td>7</td>
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<td>178</td>
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</table>

Department of Vermont Health Access  
Page 1 of 2  
October 12, 2012
### APPENDIX 7
Supporting Schedule of MMIS Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2013

<table>
<thead>
<tr>
<th>Hospital</th>
<th>VT Medicaid Inpatient Ancillary Charges</th>
<th>VT Medicaid Inpatient Payments</th>
<th>VT Medicaid Outpatient Charges</th>
<th>VT Medicaid Outpatient Payments</th>
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<td>DSH Survey I.E.1</td>
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<td>5,453,410</td>
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</tr>
<tr>
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<tr>
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<td>1,530,343</td>
<td>2,587,091</td>
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<tr>
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<td>49,150</td>
<td>71,316</td>
<td>309,844</td>
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<tr>
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<td>632,222</td>
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</tr>
<tr>
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<tr>
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<td>2,110,809</td>
<td>2,310,387</td>
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</tr>
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</tr>
<tr>
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<td>1,417,821</td>
<td>2,230,397</td>
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<tr>
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</tr>
<tr>
<td>470005 Rutland Regional Medical Center</td>
<td>12,672,549</td>
<td>9,104,817</td>
<td>7,276,415</td>
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</tr>
<tr>
<td>470012 Southwestern Vermont Hospital</td>
<td>4,330,857</td>
<td>3,612,922</td>
<td>4,964,587</td>
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<td>2,465,811</td>
<td>3,314,928</td>
<td>2,362,774</td>
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</tbody>
</table>
## APPENDIX 8

Supporting Schedule of DSH Survey Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2013

VT Medicare/Medicaid Eligibles

**Data Source:** Hospital DSH Survey and Supplemental Schedules

<table>
<thead>
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### Other State Medicaid

**Data Source:** Hospital DSH Survey and Supplemental Schedules

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### APPENDIX 8

**Supporting Schedule of DSH Survey Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2013**

No Third Party Coverage  
Data Source: Hospital DSH Survey and Supplemental Schedules

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<th>Nursery</th>
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## APPENDIX 8

Supporting Schedule of DSH Survey Elements Used to Calculate Hospital-specific Limits in Federal Fiscal Year 2013

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<th>Other State Medicaid Beneficiaries-Inpatient</th>
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<td>17,950</td>
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<tr>
<td>470005 Rutland Regional Medical Center</td>
<td>5,876,597</td>
<td>4,245,789</td>
<td>108,469</td>
<td>36,065</td>
<td>93,560</td>
<td>508,823</td>
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<td>470012 Southwestern Vermont Hospital</td>
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<td>2,098,758</td>
<td>601,347</td>
<td>730,759</td>
<td>52,380</td>
<td>517,014</td>
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<td>40,614</td>
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<td>471306 Springfield Hospital</td>
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<td>1,744,408</td>
<td>69,005</td>
<td>131,269</td>
<td>44,195</td>
<td>345,791</td>
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</tbody>
</table>
APPENDIX 9
Formulas Used in the Calculation of the Hospital-Specific Limit in Federal Fiscal Year 2013

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 Cover Page**

**CELLS SHADeD YELLOW REQUIRE DATA ENTRY BY THE HOSPITAL.**

**A. Hospital Contact for DVHA**

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Medicare ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Completing</td>
<td>Phone</td>
</tr>
<tr>
<td>Email</td>
<td>Fax</td>
</tr>
</tbody>
</table>

**B. Hospital Medicare Cost Report (MCR) Status**

For this year's DSH calculations, the DVHA is using the Hospital MCRs for the year ending 9/30/10.

DVHA received MCR cost reports from National Government Services on 1/6/12.

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.

<table>
<thead>
<tr>
<th>DVHA On File</th>
<th>As Submitted</th>
<th>As Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Modification</td>
<td>Final</td>
<td>Final</td>
</tr>
<tr>
<td>Amended Final</td>
<td>Amended Final</td>
<td></td>
</tr>
</tbody>
</table>

*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 Schedules 1, 2 or 3. Additionally, submit copies of the appropriate MCR schedules that show where the figures were derived.

**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 of Participation and Accuracy of Data Submitted**

If you choose to participate in the DSH program for FFY 2013, you must complete and submit all documentation requested below to the Department of Vermont Health Access, Attn Deb Stempel no later than **Friday, March 30, 2012**.

For questions, contact Deb at Deborah.Stempel@state.vt.us or (802) 879-5926.

1. Survey Cover Page (emailed with scanned original signature) and Schedules 1, 2, 3 and 4 (emailed)
2. Completion of the DVHA VT duals schedules with the payment column filled in or a replacement Schedule 5 and 9.
3. Completion of Schedule 5 with totals that tie out to Schedule 1, I.A.8-14, Schedule 2, I.B.2 and I.E.2. (emailed)
4. Completion of Schedule 6 with totals that tie out to Schedule 1, I.A.15-22, Schedule 2, I.B.3 and I.E.3. (emailed)
5. Completion of Schedule 7 with totals that tie out to Schedule 1, I.A.23-30, Schedule 2, I.B.4 and I.E.4. (emailed)
6. Completion of Schedule 8 with totals that tie out to Schedule 1, I.A.31-38, Schedule 2, I.B.5 and I.E.5. (emailed)
7. Completion of Schedule 9 with totals that tie out to Schedule 2, I.C.2 and I.E.7. (emailed)
8. Completion of Schedule 10 with totals that tie out to Schedule 2, I.C.3 and I.E.8. (emailed)
9. Completion of Schedule 11 with totals that tie out to Schedule 2, I.C.4 and I.E.9. (emailed)
10. Completion of Schedule 12 with totals that tie out to Schedule 2, I.C.5 and I.E.10. (emailed)
11. Hospital Audited Financial Statement to support the values submitted for Schedule 4, II.C.1-III.C.6 (emailed)
12. Documentation supporting your selection in Part C (Obstetrical Certification) above. (emailed)

*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**

**Printed or Typed Name**

**Title**

Appendix 10 DSH Survey Worksheets for FFY 2013__template
E. Certification of Waiver from Participation in the Disproportionate Share Program for FFY 2013

If you choose not to participate in the DSH program for FFY 2013, do not complete Part D. Instead, you must complete and submit Section E to the Department of Vermont Health Access, Attn Deb Stempel no later than Friday, March 30, 2012.

For questions, contact Deb at Deborah.Stempel@state.vt.us or (802) 879-5926.

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 2013. We waive this right due to the fact that, based on our analysis, 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 2013.
- 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 2013.
- Other (please specify):

  [ ]

Signature                              Date

Printed or Typed Name                Title
### A. Inputs to Calculate Routine Costs

<table>
<thead>
<tr>
<th>Data Variable</th>
<th>Source</th>
<th>Revenue Codes</th>
<th>Hospital Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Vermont Medicaid Inpatient Days for Adults &amp; Peds</td>
<td>HP MRMN503S report</td>
<td>110-119, 120-150</td>
<td>DVHA Fill In or Override</td>
</tr>
<tr>
<td>2. Vermont Medicaid Inpatient Days for Nursery</td>
<td>HP MRMN503S report</td>
<td>170-171</td>
<td>DVHA Fill In or Override</td>
</tr>
<tr>
<td>3. Vermont Medicaid Inpatient Days for Waiting Placement to LTC</td>
<td>HP MRMN503S report</td>
<td>190</td>
<td>DVHA Fill In or Override</td>
</tr>
<tr>
<td>4. Vermont Medicaid Inpatient Days for ICU</td>
<td>HP MRMN503S report</td>
<td>200-206</td>
<td>DVHA Fill In or Override</td>
</tr>
<tr>
<td>5. Vermont Medicaid Inpatient Days for Neonatal ICU</td>
<td>HP MRMN503S report</td>
<td>173-179</td>
<td>DVHA Fill In or Override</td>
</tr>
<tr>
<td>6. Vermont Medicaid Inpatient Days for Surgical ICU</td>
<td>HP MRMN503S report</td>
<td>210-214</td>
<td>DVHA Fill In or Override</td>
</tr>
<tr>
<td>7. Vermont Medicaid Inpatient Days for Subprovider I</td>
<td>HP MRMN503S report separate schedule</td>
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<td>DVHA Fill In or Override</td>
</tr>
<tr>
<td>8. VT Medicaid/Medicare Eligible Inpatient Days for Adults &amp; Peds</td>
<td>DVHA claims extract or Hospital data source</td>
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<td>DVHA Fill In or Override</td>
</tr>
<tr>
<td>9. VT Medicaid/Medicare Eligible Inpatient Days for Nursery</td>
<td>DVHA claims extract or Hospital data source</td>
<td></td>
<td>DVHA Fill In or Override</td>
</tr>
<tr>
<td>10. VT Medicaid/Medicare Eligible Inpatient Days for Waiting Place.</td>
<td>DVHA claims extract or Hospital data source</td>
<td></td>
<td>DVHA Fill In or Override</td>
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<td>11. VT Medicaid/Medicare Eligible Inpatient Days for ICU</td>
<td>DVHA claims extract or Hospital data source</td>
<td></td>
<td>DVHA Fill In or Override</td>
</tr>
<tr>
<td>12. VT Medicaid/Medicare Eligible Inpatient Days for Neonatal ICU</td>
<td>DVHA claims extract or Hospital data source</td>
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<td>DVHA Fill In or Override</td>
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<tr>
<td>13. VT Medicaid/Medicare Eligible Inpatient Days for Surgical ICU</td>
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<td></td>
<td>DVHA Fill In or Override</td>
</tr>
<tr>
<td>14. VT Medicaid/Medicare Eligible Inpatient Days for Subprovider I</td>
<td>DVHA claims extract or Hospital data source</td>
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<td>15. Other State FFS Medicaid Inpatient Days for Adults &amp; Peds</td>
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<td>16. Other State FFS Medicaid Inpatient Days for Nursery</td>
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<td>17. Other State FFS Medicaid Inpatient Days for Waiting Place.</td>
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<td>Hospital data source</td>
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<td>18. Other State FFS Medicaid Inpatient Days for ICU</td>
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<tr>
<td>19. Other State FFS Medicaid Inpatient Days for Neonatal ICU</td>
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<tr>
<td>20. Other State FFS Medicaid Inpatient Days for Surgical ICU</td>
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<tr>
<td>21. Other State FFS Medicaid Inpatient Days for Subprovider I</td>
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<tr>
<td>22. Other State FFS Medicaid Inpatient Days for Subprovider II</td>
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<td>23. Other State HMO Medicaid Inpatient Days for Adults &amp; Peds</td>
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<td>25. Other State HMO Medicaid Inpatient Days for Waiting Place.</td>
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<td>26. Other State HMO Medicaid Inpatient Days for ICU</td>
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<td>27. Other State HMO Medicaid Inpatient Days for Neonatal ICU</td>
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<td>28. Other State HMO Medicaid Inpatient Days for Surgical ICU</td>
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<td>Hospital data source</td>
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<tr>
<td>29. Other State HMO Medicaid Inpatient Days for Subprovider I</td>
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<tr>
<td>30. Other State HMO Medicaid Inpatient Days for Subprovider II</td>
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<td>31. Indiv. No 3rd Party Coverage Days for Adults &amp; Peds</td>
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<td>32. Indiv. No 3rd Party Coverage Days for Nursery</td>
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<td>33. Indiv. No 3rd Party Coverage Days for Waiting Placement</td>
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<td>34. Indiv. No 3rd Party Coverage Days for ICU</td>
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<td>35. Indiv. No 3rd Party Coverage Days for Neonatal ICU</td>
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<td>36. Indiv. No 3rd Party Coverage Days for Surgical ICU</td>
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<td>37. Indiv. No 3rd Party Coverage Days for Subprovider I</td>
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<td>38. Indiv. No 3rd Party Coverage Days for Subprovider II</td>
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<tr>
<td>39. Per Diem Cost for Adults &amp; Peds</td>
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<td>42. Per Diem Cost for Neonatal ICU</td>
<td>MCR D-1, Pt II, Ln 45</td>
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<td>43. Per Diem Cost for Surgical ICU</td>
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<td>44. Per Diem Cost for Subprovider I</td>
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<td>45. Per Diem Cost for Subprovider II</td>
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<td>46. If more than one Subprovider, state Subprovider I type</td>
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<tr>
<td>47. If more than one Subprovider, state Subprovider II type</td>
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</table>
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

### B. Inputs to Calculate Inpatient Ancillary Costs

<table>
<thead>
<tr>
<th>Data Variable</th>
<th>Source</th>
<th>DVHA Fill In</th>
<th>Hospital Fill In or</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Vermont Medicaid Inpatient Ancillary Charges</td>
<td>HP MRMN503S report</td>
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<td></td>
</tr>
<tr>
<td>2. VT Medicaid/Medicare Eligible Inpatient Ancillary Charges</td>
<td>DVHA claims extract or Hospital data source</td>
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<td></td>
</tr>
<tr>
<td>3. Other State FFS Medicaid Inpatient Ancillary Charges</td>
<td>Hospital data source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Other State HMO Medicaid Inpatient Ancillary Charges</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Indiv. No 3rd Party Coverage Inpatient Ancillary Charges</td>
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<tr>
<td>6. Title XIX Inpatient Ancillary Charges- Hospital</td>
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<tr>
<td>7. Title XIX Inpatient Ancillary Costs- Hospital</td>
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</tr>
<tr>
<td>8. Title XIX Inpatient Ancillary Charges- Subprovider (Subprov wksh)</td>
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<td></td>
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<td>9. Title XIX Inpatient Ancillary Costs- Subprovider (Subprov wksh)</td>
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### C. Inputs to Calculate Outpatient Ancillary Costs

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<th>Hospital Fill In or</th>
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</thead>
<tbody>
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<td>1. Vermont Medicaid Outpatient Ancillary Charges</td>
<td>HP MRMN503S report</td>
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<td></td>
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<tr>
<td>2. VT Medicaid/Medicare Eligible Outpatient Ancillary Charges</td>
<td>DVHA claims extract or Hospital data source</td>
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<td></td>
</tr>
<tr>
<td>3. Other State FFS Medicaid Outpatient Ancillary Charges</td>
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</tr>
<tr>
<td>4. Other State HMO Medicaid Outpatient Ancillary Charges</td>
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</tr>
<tr>
<td>5. Indiv. No 3rd Party Coverage Outpatient Ancillary Charges</td>
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<tr>
<td>6. Title XIX Outpatient Ancillary Charges- Hospital</td>
<td>MCR D Pt V, Col 5.01, Ln 104</td>
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<tr>
<td>7. Title XIX Outpatient Ancillary Charges- Hospital</td>
<td>MCR D Pt V, Col 5.03, Ln 104</td>
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<tr>
<td>8. Title XIX Outpatient Ancillary Costs- Hospital</td>
<td>MCR D Pt V, Col 9.01, Ln 104</td>
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</tr>
<tr>
<td>9. Title XIX Outpatient Ancillary Costs- Hospital</td>
<td>MCR D Pt V, Col 9.03, Ln 104</td>
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<tr>
<td>10. Title XIX Outpatient Ancillary Charges- Subprovider (Subprov wksh)</td>
<td>MCR D Pt V, Col 5.01, Ln 104</td>
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<tr>
<td>11. Title XIX Outpatient Ancillary Charges- Subprovider (Subprov wksh)</td>
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<tr>
<td>12. Title XIX Outpatient Ancillary Costs- Subprovider (Subprov wksh)</td>
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<tr>
<td>13. Title XIX Outpatient Ancillary Costs- Subprovider (Subprov wksh)</td>
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### D. Inputs to Calculate Applicable Graduate Medical Education Costs

<table>
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<th>Source</th>
<th>DVHA Fill In</th>
<th>Hospital Fill In or</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicaid Portion of Grad Med Ed Costs (Title XIX schedule)</td>
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### E. Inputs to Calculate the Payments for Care

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<th>Source</th>
<th>DVHA Fill In</th>
<th>Hospital Fill In or</th>
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<tbody>
<tr>
<td>1. Payments for I/P Services to VT Medicaid Beneficiaries</td>
<td>HP MRMN502V report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Payments for I/P Services to VT Medicaid/Medicare Dual Eligibles</td>
<td>Hospital completes DVHA schedule or supplies separate schedule</td>
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<td></td>
</tr>
<tr>
<td>3. Payments for I/P FFS Services to Medicaid Beneficiaries Outside VT</td>
<td>Hospital data source (includes duals)</td>
<td></td>
<td></td>
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<tr>
<td>4. Payments for I/P HMO Services to Medicaid Beneficiaries Outside VT</td>
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<td></td>
</tr>
<tr>
<td>5. Payments for I/P Services to Indiv. with No 3rd Party Coverage</td>
<td>Hospital data source</td>
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<td></td>
</tr>
<tr>
<td>6. Payments for O/P Services to VT Medicaid Beneficiaries</td>
<td>HP MRMN502V report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Payments for O/P Services to VT Medicaid/Medicare Dual Eligibles</td>
<td>Hospital completes DVHA schedule or supplies separate schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Payments for O/P FFS Services to Medicaid Beneficiaries Outside VT</td>
<td>Hospital data source (includes duals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Payments for O/P HMO Services to Medicaid Beneficiaries Outside VT</td>
<td>Hospital data source (includes duals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Payments for O/P Services to Indiv. with No 3rd Party Coverage</td>
<td>Hospital data source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. State and Local Subsidies- Inpatient Services</td>
<td>Hospital data source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. State and Local Subsidies- Outpatient Services</td>
<td>Hospital data source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. DSH Payments from a Medicaid agency other than Vermont</td>
<td>Hospital data source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Section 1011 Payments</td>
<td>Hospital data source</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### II. Inputs to Calculate the Medicaid Inpatient Utilization Rate

#### A. Inputs to Calculate the Medicaid Inpatient Utilization Rate

<table>
<thead>
<tr>
<th>Data Variable</th>
<th>Source</th>
<th>DVHA Fill In</th>
<th>Hospital Fill</th>
<th>In or Override</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calculation 1 for Medicaid Days: Using DVHA MMIS and Hospital Data</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Vermont Medicaid Inpatient Days</td>
<td>Survey Schedule 1, I.A.1-I.A.14</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2. Out of State Medicaid Inpatient Days</td>
<td>Survey Schedule 1, I.A.15-I.A.30</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3. Total Medicaid Days per DVHA MMIS &amp; Hospital Data</td>
<td>Calculation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Calculation 2 for Medicaid Days: Using Medicare Cost Report Data</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Title XIX Adults &amp; Peds Days</td>
<td>MCR Wksh S-3, Col 5, Line 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Title XIX HMO days</td>
<td>MCR Wksh S-3, Col 5, Line 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Title XIX IRF PPS Subprovider Days</td>
<td>MCR Wksh S-3, Col 5, Line 2.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Title XIX ICU Days</td>
<td>MCR Wksh S-3, Col 5, Line 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Title XIX Neonatal ICU Days</td>
<td>MCR Wksh S-3, Col 5, Line 8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Title XIX Surgical ICU Days</td>
<td>MCR Wksh S-3, Col 5, Line 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Title XIX Nursery Days</td>
<td>MCR Wksh S-3, Col 5, Line 11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Title XIX Subprovider Days</td>
<td>MCR Wksh S-3, Col 5, Line 14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Total Medicaid Days per Medicare Cost Report</td>
<td>Calculation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does the sum of days from Calculation 1 = sum of days from Calculation 2? **YES**

#### Total Patient Days: Using Medicare Cost Report Data

<table>
<thead>
<tr>
<th>Data Variable</th>
<th>Source</th>
<th>DVHA Fill In</th>
<th>Hospital Fill</th>
<th>In or Override</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. All Patients Adults &amp; Peds Days</td>
<td>MCR Wksh S-3, Col 6, Line 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. All Patients HMO days</td>
<td>MCR Wksh S-3, Col 6, Line 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. All Patients IRF PPS Subprovider Days</td>
<td>MCR Wksh S-3, Col 6, Line 2.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. All Patients ICU Days</td>
<td>MCR Wksh S-3, Col 6, Line 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. All Patients Neonatal ICU Days</td>
<td>MCR Wksh S-3, Col 6, Line 8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. All Patients Surgical ICU Days</td>
<td>MCR Wksh S-3, Col 6, Line 9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. All Patients Nursery Days</td>
<td>MCR Wksh S-3, Col 6, Line 11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. All Patients Subprovider Days</td>
<td>MCR Wksh S-3, Col 6, Line 14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Total All Patient Days per Medicare Cost Report</td>
<td>Calculation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medicaid Inpatient Utilization Rate (II.A.12 / II.A.21) **#DIV/0!**
### III. INPUTS TO CALCULATE THE LOW INCOME UTILIZATION RATE

#### A. Inputs to Calculate Net Medicaid Patient Revenue

<table>
<thead>
<tr>
<th>Data Variable</th>
<th>Source</th>
<th>DVHA Fill In</th>
<th>Hospital Fill In or Override</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicaid Inpatient Care Revenue</td>
<td>BISHCA Report 5, Actual 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Medicaid Outpatient Care Revenue</td>
<td>BISHCA Report 5, Actual 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Total Medicaid Inpatient + Outpatient Revenue calculation</td>
<td>A.1 + A.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Total Medicaid Patient Services Revenue</td>
<td>BISHCA Report 5, Actual 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Medicaid Outpatient Care Revenue- Physician</td>
<td>BISHCA Report 5, Actual 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Total Medicaid Patient Services Net of Physician</td>
<td>calculation A.4 - A.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Contractual Allowances- all but Physician</td>
<td>BISHCA Report 5, Actual 2010</td>
<td>#VALUE!</td>
<td>#VALUE!</td>
</tr>
</tbody>
</table>

#### B. Inputs to Calculate State and Local Subsidies

1. State & Local Subsidies for Inpatient Services
   - Survey Schedule 2, I.E.11

2. State & Local Subsidies for Outpatient Services
   - Survey Schedule 2, I.E.12

#### C. Inputs to Calculate Net All Payer Patient Revenue

1. All Payer Inpatient Care Revenue                          | BISHCA Report 5, Actual 2010                |              |                              |
2. All Payer Outpatient Care Revenue                         | BISHCA Report 5, Actual 2010                |              |                              |
3. Total All Payer Inpatient + Outpatient Revenue calculation | C.1 + C.2                                  |              |                              |
4. Total All Payer Patient Services Revenue                  | BISHCA Report 5, Actual 2010                |              |                              |
5. All Payer Outpatient Care Revenue- Physician              | BISHCA Report 5, Actual 2010                |              |                              |
6. Total All Payer Patient Services Net of Physician          | calculation C.4 - C.5                       |              |                              |
7. Contractual Allowances- all but Physician                | BISHCA Report 5, Actual 2010                |              |                              |
8. Commercial Discounts                                      | BISHCA Report 5, Actual 2010                |              |                              |
9. Free Care                                                 | BISHCA Report 5, Actual 2010                |              |                              |
10. Employee Discounts                                       | BISHCA Report 5, Actual 2010                |              |                              |
11. Other Discounts                                          | BISHCA Report 5, Actual 2010                |              |                              |
12. Total Allowances/Discounts                               | sum C.7 - C.11                             |              |                              |
14. Net All Payer Patient Revenue                            | C.3 - C.13                                 |              |                              |

#### D. Inputs to Calculate Portion of LIUR Formula Related to Charges

1. Total Inpatient Charges Attributable to Individuals with no Third Party Coverage
   - Hospital should enter total charges that appear on their Schedule xx

#### E. Low Income Utilization Rate Formula

- LIUR Equation 1: \((A.9 + B.1 + B.2) / C.14\) #VALUE!
- LIUR Equation 2: \((D.1 - B.1) / C.1\) #VALUE!
- Total LIUR: Equation 1 + Equation 2 #VALUE!
Hospital DSH Survey Schedule 5
Template for Itemizing Inpatient Services for Vermont Medicare/Medicaid Dual Eligibles

Respondents have one of two options:
1. Use the claims report supplied by DVHA and fill in only the column for Total Payments Received.
2. Submit a complete replacement report that includes all of the information shown in the template below.

Respondents should remit information under Option 1 or Option 2 above, but not both.

Notes if Option 2 is selected:
1. The supporting schedule that you provide does not need to look exactly like this, so long as all of the data elements requested below 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 period 10/1/09 - 9/30/10, regardless of when payment(s) were received.
3. Include any payments received after 9/30/10 for the services reported on this schedule.
4. Ancillary Services are those billed on revenue codes 250 and higher.

Example of Template

<table>
<thead>
<tr>
<th>Internal Claim Reference Number</th>
<th>Begin Date of Service</th>
<th>Ending Date of Service</th>
<th>Total Days</th>
<th>Adult &amp; Ped Days</th>
<th>Nursery Days</th>
<th>Waiting Placement Days</th>
<th>ICU Days</th>
<th>NICU Days</th>
<th>Surgical ICU Days</th>
<th>Sub-provider Days</th>
<th>Billed Amount for Ancillary Services</th>
<th>Billed Amount for Ancillary Services</th>
<th>Payment Received from All Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>sample</td>
<td>2/1/2010</td>
<td>2/4/2010</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6,250.00</td>
<td>2,314.82</td>
<td>3,748.96</td>
</tr>
</tbody>
</table>
Hospital DSH Survey Schedule 6
Template for Itemizing Inpatient Services for Other State FFS Medicaid Inpatient Days

Respondents must complete the template as shown below.
Include only fee-for-service days on this schedule.
Respondents should include other state Medicaid dual eligible days on this schedule.

The format for this schedule is the same as is shown for Schedule 5:
1. The supporting schedule that you provide does not need to look exactly like this, so long as all of the data elements requested below 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 period 10/1/09 - 9/30/10, regardless of when payment(s) were received.

3. Include any payments received after 9/30/10 for the services reported on this schedule.

4. Ancillary Services are those billed on revenue codes 250 and higher.

Example of Template

<table>
<thead>
<tr>
<th>Internal Claim Reference Number</th>
<th>Begin Date of Service</th>
<th>Ending Date of Service</th>
<th>Total Days</th>
<th>Adult &amp; Ped Days</th>
<th>Nursery Days</th>
<th>Waiting Placement Days</th>
<th>ICU Days</th>
<th>NICU Days</th>
<th>Surgical ICU Days</th>
<th>Sub-provider Days</th>
<th>Billed Amount Accommodation Charges</th>
<th>Billed Amount for Ancillary Services</th>
<th>Payment Received from All Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>sample</td>
<td>2/1/2010</td>
<td>2/4/2010</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$6,250.00</td>
<td>$2,314.82</td>
<td>$3,748.96</td>
</tr>
</tbody>
</table>
Hospital DSH Survey Schedule 7
Template for Itemizing Inpatient Services for Other State HMO Medicaid Inpatient Days

Respondents must complete the template as shown below if they have Medicaid HMO days. The total number of HMO days should tie to the total shown on the hospital’s Medicare Cost Report, Worksheet S-3, Part I, Column 5, Line 2. Respondents should include other state Medicaid dual eligible days on this schedule.

The format for this schedule is the same as is shown for Schedule 5:
1. The supporting schedule that you provide does not need to look exactly like this, so long as all of the data elements requested below 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 period 10/1/09 - 9/30/10, regardless of when payment(s) were received.
3. Include any payments received after 9/30/10 for the services reported on this schedule.
4. Ancillary Services are those billed on revenue codes 250 and higher.

Example of Template

<table>
<thead>
<tr>
<th>Internal Claim Reference Number</th>
<th>Begin Date of Service</th>
<th>Ending Date of Service</th>
<th>Total Days</th>
<th>Adult &amp; Ped Days</th>
<th>Nursery Days</th>
<th>Waiting Placement Days</th>
<th>ICU Days</th>
<th>NICU Days</th>
<th>Surgical ICU Days</th>
<th>Sub-provider Days</th>
<th>Billed Amount for Ancillary Services</th>
<th>Billed Amount Accommodation Charges</th>
<th>Payment Received from All Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>sample</td>
<td>85962385103</td>
<td>2/1/2010</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$6,250.00</td>
<td>$2,314.82</td>
<td>$3,748.96</td>
</tr>
</tbody>
</table>
The format for this schedule is the same as is shown for Schedule 5, with one exception:

CMS has provided guidance that hospitals may record payments received for individuals with no third party coverage based on the date the payment was received. Therefore, there may be situations where the patient received the service in the year ending 9/30/10 but not make any payment for the service until after 9/30/10. In other situations, the payment may have been received in the year ending 9/30/10 but the service was delivered in a prior year.

For DSH calculations, the information is included in the formulas as follows:
1. When the claim was incurred in the year ending 9/30/10 and payments were received against it, both data elements are used.
2. When the claim was incurred in the year ending 9/30/10 and no payments were received against it, only the cost of the claim is used.
3. When the claim was incurred prior to the year ending 9/30/10 but a payments was received against it in the year ending 9/30/10, only the payment is used.

Therefore, please break up the inpatient stays into two categories as illustrated below.

Example of Template

### Claims incurred when the Ending Date of Service occurred between 10/1/09 and 9/30/10

<table>
<thead>
<tr>
<th>Internal Claim Reference Number</th>
<th>Begin Date of Service</th>
<th>Ending Date of Service</th>
<th>Total Days</th>
<th>Adult &amp; Ped Days</th>
<th>Nursery Days</th>
<th>Waiting Placement Days</th>
<th>ICU Days</th>
<th>NICU Days</th>
<th>Surgical ICU Days</th>
<th>Sub-provider Days</th>
<th>Billed Amount Accommodation Charges</th>
<th>Billed Amount for Ancillary Services</th>
<th>Payments Received in the Year Ending 9/30/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>sample</td>
<td>11/5/2009</td>
<td>11/10/2009</td>
<td>6</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$9,525.00</td>
<td>$6,741.65</td>
<td>$450.00</td>
</tr>
<tr>
<td></td>
<td>9/7/2010</td>
<td>9/9/2010</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$4,500.00</td>
<td>$798.63</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### Claims incurred when the Ending Date of Service occurred prior to 10/1/09 but payments were received in the year ending 9/30/10

<table>
<thead>
<tr>
<th>Internal Claim Reference Number</th>
<th>Begin Date of Service</th>
<th>Ending Date of Service</th>
<th>Total Days</th>
<th>Adult &amp; Ped Days</th>
<th>Nursery Days</th>
<th>Waiting Placement Days</th>
<th>ICU Days</th>
<th>NICU Days</th>
<th>Surgical ICU Days</th>
<th>Sub-provider Days</th>
<th>Billed Amount Accommodation Charges</th>
<th>Billed Amount for Ancillary Services</th>
<th>Payments Received in the Year Ending 9/30/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>sample</td>
<td>12/4/2008</td>
<td>12/6/2008</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$3,200.00</td>
<td>$658.47</td>
<td>$125.00</td>
</tr>
</tbody>
</table>
Hospital DSH Survey Schedule 9
Template for Itemizing Outpatient Services for Vermont Medicare/Medicaid Dual Eligibles

Respondents have one of two options:
1. Use the claims report supplied by DVHA and fill in only the column for Total Payments Received.
2. Submit a complete replacement report that includes all of the information shown in the template below.

Respondents should remit information under Option 1 or Option 2 above, but not both.

Notes if Option 2 is selected, this schedule follows the same format as the corresponding Inpatient Schedule 5 except accommodation information is removed:
1. The supporting schedule that you provide does not need to look exactly like this, so long as all of the data elements requested below 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 period 10/1/09 - 9/30/10, regardless of when payment(s) were received.
3. Include any payments received after 9/30/10 for the services reported on this schedule.
4. Ancillary Services are those billed on revenue codes 250 and higher.

Example of Template

<table>
<thead>
<tr>
<th>Internal Claim Reference Number</th>
<th>Begin Date of Service</th>
<th>Ending Date of Service</th>
<th>Billed Amount for Ancillary Services</th>
<th>Payment Received from All Sources</th>
</tr>
</thead>
</table>
Hospital DSH Survey Schedule 10
Template for Itemizing Other State FFS Outpatient Services

Respondents must complete the template as shown below.
Include only fee-for-service information on this schedule.
Respondents should include other state Medicaid dual eligible days on this schedule.

The format for this schedule is the same as is shown for Schedule 9:
1. The supporting schedule that you provide does not need to look exactly like this, so long as all of the data elements requested below 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 period 10/1/09 - 9/30/10, regardless of when payment(s) were received.

3. Include any payments received after 9/30/10 for the services reported on this schedule.

4. Ancillary Services are those billed on revenue codes 250 and higher.

Example of Template

<table>
<thead>
<tr>
<th>Internal Claim Reference Number</th>
<th>Begin Date of Service</th>
<th>Ending Date of Service</th>
<th>Billed Amount for Ancillary Services</th>
<th>Payment Received from All Sources</th>
</tr>
</thead>
</table>
Hospital DSH Survey Schedule 11
Template for Itemizing Other State HMO Outpatient Services

Respondents must complete the template as shown below if they have Medicaid HMO outpatient services.
Include only HMO information on this schedule.
Respondents should include other state Medicaid dual eligible days on this schedule.

The format for this schedule is the same as is shown for Schedule 10:
1. The supporting schedule that you provide does not need to look exactly like this, so long as all of the data elements requested below 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 period 10/1/09 - 9/30/10, regardless of when payment(s) were received.

3. Include any payments received after 9/30/10 for the services reported on this schedule.

4. Ancillary Services are those billed on revenue codes 250 and higher.

Example of Template

<table>
<thead>
<tr>
<th>Internal Claim Reference Number</th>
<th>Begin Date of Service</th>
<th>Ending Date of Service</th>
<th>Billed Amount for Ancillary Services</th>
<th>Payment Received from All Sources</th>
</tr>
</thead>
</table>
Hospital DSH Survey Schedule 12
Template for Itemizing Outpatient Services for Individuals with No Third Party Coverage

Respondents must complete the template as shown below.

The format for this schedule follows what was shown for Schedule 8, except that the accommodation information is removed:

- CMS has provided guidance that hospitals may record payments received for individuals with no third party coverage based on the date the payment was received. Therefore, there may be situations where the patient received the service in the year ending 9/30/10 but not make any payment for the service until after 9/30/10. In other situations, the payment may have been received in the year ending 9/30/10 but the service was delivered in a prior year.

For DSH calculations, the information is included in the formulas as follows:
1. When the claim was incurred in the year ending 9/30/10 and payments were received against it, both data elements are used.
2. When the claim was incurred in the year ending 9/30/10 and no payments were received against it, only the cost of the claim is used.
3. When the claim was incurred prior to the year ending 9/30/10 but a payments was received against it in the year ending 9/30/10, only the payment is used.

Therefore, please break up the outpatient stays into two categories as illustrated below.
1. The supporting schedule that you provide does not need to look exactly like this, so long as all of the data elements requested below 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. Ancillary Services are those billed on revenue codes 250 and higher.

Example of Template

Claims incurred when the Ending Date of Service occurred between 10/1/09 and 9/30/10

<table>
<thead>
<tr>
<th>Internal Claim Reference Number</th>
<th>Begin Date of Service</th>
<th>Ending Date of Service</th>
<th>Billed Amount for Ancillary Services</th>
<th>Payment Received from All Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1852370163</td>
<td>9/7/2010</td>
<td>9/7/2010</td>
<td>$1,247.63</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Claims incurred when the Ending Date of Service occurred prior to 10/1/09 but payments were received in the year ending 9/30/10

<table>
<thead>
<tr>
<th>Internal Claim Reference Number</th>
<th>Begin Date of Service</th>
<th>Ending Date of Service</th>
<th>Billed Amount for Ancillary Services</th>
<th>Payment Received from All Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>sample</td>
<td>1/2/2009</td>
<td>1/2/2009</td>
<td>$876.32</td>
<td>$50.00</td>
</tr>
</tbody>
</table>