

Medicare

Provider Reimbursement Manual -

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 36, Form CMS-2552-96

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

Transmittal 9

Date: AUGUST 2002

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NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates, Chapter 36, Hospital and Hospital Healthcare Complex Cost Report, Form CMS 2552-96 to reflect further clarification to existing instructions and to implement the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for cost reporting periods beginning on or after January 1, 2002 in accordance with the Benefits Improvement and Protection Act (BIPA) 2000. The effective date for instructional changes will vary due to various implementation dates.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after August 31, 2000.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

5. Round to 6 decimal places:
 - a. Ratios (e.g., unit cost multipliers, cost/charge ratios, days to days)

Where a difference exists within a column as a result of computing costs using a fraction or decimal, and therefore the sum of the parts do not equal the whole, the highest amount in that column must either be increased or decreased by the difference. If it happens that there are two high numbers equaling the same amount, adjust the first high number from the top of the worksheet for which it applies.

3600.2 Acronyms and Abbreviations.--Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

A&G	-	Administrative and General
AHSEA	-	Adjusted Hourly Salary Equivalency Amount
ASC	-	Ambulatory Surgical Center
BBA	-	Balanced Budget Act
BBRA	-	Balanced Budget Reform Act
BIPA	-	Benefits Improvement and Protection Act
CAH	-	Critical Access Hospitals (10/97)
CAPD	-	Continuous Ambulatory Peritoneal Dialysis
CAP-REL	-	Capital-Related
CCPD	-	Continuous Cycling Peritoneal Dialysis
CCU	-	Coronary Care Unit
CFR	-	Code of Federal Regulations
CMHC	-	Community Mental Health Center
CMS	-	Center for Medicare and Medicaid Services
COL	-	Column
CORF	-	Comprehensive Outpatient Rehabilitation Facility
CRNA	-	Certified Registered Nurse Anesthetist
CTC	-	Certified Transplant Center
DRG	-	Diagnostic Related Group
DSH	-	Disproportionate Share
EACH	-	Essential Access Community Hospital
ESRD	-	End Stage Renal Disease
FQHC	-	Federally Qualified Health Center
FR	-	Federal Register
FTE	-	Full Time Equivalent
GME	-	Graduate Medical Education
HHA	-	Home Health Agency
HMO	-	Health Maintenance Organization
I & Rs	-	Interns and Residents
ICF/MR	-	Intermediate Care Facility for the Mentally Retarded (9/96)
ICU	-	Intensive Care Unit
IME	-	Indirect Medical Education
INPT	-	Inpatient
IRF	-	Inpatient Rehabilitation Facility
LIP	-	Low Income Patient
LOS	-	Length of Stay
LCC	-	Lesser of Reasonable Cost or Customary Charges
MCP	-	Monthly Capitation Payment
MDH	-	Medicare Dependent Hospital (10/97)
MED-ED	-	Medical Education
MSA	-	Metropolitan Statistical Area (10/97)

MSP	-	Medicare Secondary Payer
NF	-	Nursing Facility
NHCMQ	-	Nursing Home Case Mix and Quality Demonstration
OBRA	-	Omnibus Budget Reconciliation Act
OLTC	-	Other Long Term Care
OOT	-	Outpatient Occupational Therapy
OPD	-	Outpatient Department
OPO	-	Organ Procurement Organization
OPPS	-	Outpatient Prospective Payment
OPT	-	Outpatient Physical Therapy
OSP	-	Outpatient Speech Pathology
ORF	-	Outpatient Rehabilitation Facility
PBP	-	Provider-Based Physician
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PRO	-	Professional Review Organization
PS&R	-	Provider Statistical and Reimbursement System
PT	-	Physical Therapy
RCE	-	Reasonable Compensation Equivalent
RHC	-	Rural Health Clinic
RPCH	-	Rural Primary Care Hospitals
RT	-	Respiratory Therapy
RUG	-	Resource Utilization Group
SCH	-	Sole Community Hospitals
SNF	-	Skilled Nursing Facility
SSI	-	Supplemental Security Income
TEFRA	-	Tax Equity and Fiscal Responsibility Act of 1982
TOPPS	-	Transitional Corridor Payment for Outpatient Prospective Payment System
WKST	-	Worksheet

NOTE: In this chapter, TEFRA refers to §1886(b) of the Act and not to the entire Tax Equity and Fiscal Responsibility Act.

3600.3 Instructional, Regulatory and Statutory Effective Dates.--Throughout the Medicare cost report instructions, various effective dates implementing instructions, regulations and/or statutes are utilized.

Where applicable, at the end of select paragraphs and/or sentences the effective date(s) is indicated in parentheses () for cost reporting periods ending on or after that date, i.e., (12/31/01). Dates followed by a “b” are effective for cost reporting periods beginning on or after the specified date, i.e., (1/1/01b). Dates followed by an “s” are effective for services rendered on or after the specified date, i.e., (4/1/01s). Instructions not followed by an effective date are effective retroactive back to 9/30/96 (transmittal 1).

<u>Hospital/ Hospital Component</u>	<u>FROM</u>			
	<u>Title V</u>	<u>Title XVIII Part A</u>	<u>Title XVIII Part B</u>	<u>Title XIX</u>
SNF	Wkst. E-3, Part III, Line 58	Wkst. E-3, Part II, line 33 or Wkst. E-3, Part III line 58	Wkst. E, Part B, line 35	Wkst. E-3, Part III, line 58
NF, ICF/MR (9/96)	Wkst. E-3, Part III, line 58	N/A	N/A	Wkst. E-3, Part III, line 58
Home Health Agency	Wkst. H-7, Part II, sum of cols. 1&2, line 26	Wkst. H-7, Part II, col.1, line 26	Wkst. H-7, Part II, col. 2, line 26	Wkst. H-7, Part I, sum of cols. 1 & 2, line 26
Outpatient Rehabilitation Providers	Wkst. J-3, line 28	N/A	Wkst. J-3, line 28	Wkst. J-3, line 28
Rural Health Clinic/ Federally Qualified Health Clinic (1/98)	Wkst. M-3 line 25	N/A	Wkst. M-3 line 25	Wkst. M-3 line 25

IDENTIFICATION DATA

The information required on this worksheet is needed to properly identify the provider. **The responses to all lines are Yes or No unless otherwise indicated by the type of question.**

Lines 1 and 1.01--Enter the street address, post office box (if applicable), the city, state, zip code, and county of the hospital.

Lines 2 through 17--Enter on the appropriate lines and columns indicated the names, provider identification numbers, and certification dates of the hospital and its various components, if any. Indicate for each health care program the payment system applicable to the hospital and its various PPS hospital or subprovider checks O for all cost reporting periods through the end of its first 12 month cost reporting period. The 12 month cost reporting period also becomes the TEFRA base period unless an exemption under 42 CFR 413.40(f) is granted. If such an exemption is granted, check O through the end of the exemption period. The last 12 month period of the exemption is the TEFRA base period. Cost reimbursement designation of O is no longer applicable for TEFRA facilities for periods beginning on or after October 1, 1997.

Line 2--This is an institution which meets the requirements of §1861(e) of the Act and participates in the Medicare program or is a federally controlled institution approved by CMS.

Line 3--This is a portion of a general hospital which has been issued a subprovider identification number because it offers a clearly different type of service from the remainder of the hospital, e.g., long term psychiatric. See CMS Pub. 15-I, chapter 23, for a complete explanation of separate cost entities in multiple facility hospitals. While an excluded unit in a hospital subject to PPS may not meet the definition of a subprovider, treat it as a subprovider for cost reporting purposes. If you have more than one subprovider, subscript this line. Cost reimbursement designation of O is no longer applicable for TEFRA facilities for periods beginning on or after October 1, 1997.

Line 4--This is a rural hospital with fewer than 100 beds that is approved by CMS to use these beds interchangeably as hospital and skilled nursing facility beds with payment based on the specific care provided. This is authorized by §1883 of the Act. (See CMS Pub. 15-I, §§2230-2230.6.)

Line 5--This is a rural hospital with fewer than 100 beds that has a Medicare swing bed agreement approved by CMS and that is approved by the State Medicaid agency to use these beds interchangeably as hospital and other nursing facility beds, with payment based on the specific level of care provided. This is authorized by §1913 of the Act. Swing bed-NF services are not payable under the Medicare program but are payable under State Medicaid programs if included in the Medicaid State plan.

Line 6--This is a distinct part skilled nursing facility that has been issued an SNF identification number and which meets the requirements of §1819 of the Act. For cost reporting periods beginning on or after October 1, 1996, a complex can not contain more than one hospital-based SNF or hospital-based NF.

Line 7--This is a distinct part nursing facility which has been issued a separate identification number and which meets the requirements of §1905 of the Act. (See 42 CFR 442.300 and 42 CFR 442.400 for standards for other nursing facilities, for other than facilities for the mentally retarded, and for facilities for the mentally retarded.) If your state recognizes only one level of care, i.e., skilled, do not complete any lines designated as NF and report all activity on the SNF line for all programs. The NF line is used by facilities having two levels of care, i.e., either 100 bed facility all certified for NF and partially certified for SNF or 50 beds certified for SNF only and 50 beds certified for NF only. If the facility operates an Intermediate Care Facility/Mental Retarded (ICF/MR) subscript line 7 to 7.01 and enter the data on that line Note: Subscripting is allowed only for the purpose of reporting an ICF/MR. FIs will reject a cost report attempting to report more than one nursing facility (9/96).

Line 8--This is any other hospital-based facility not listed above. The beds in this unit are not certified for titles V, XVIII, or XIX.

Line 9--This is a distinct part HHA that has been issued an HHA identification number and which meets the requirements of §§1861(o) and 1891 of the Act. If you have more than one hospital-based HHA, subscript this line, and report the required information for each HHA.

Line 10--Do not use this line.

Line 11--This is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and which meets the conditions for coverage in 42 CFR 416, Subpart B. The ASC operated by a hospital must be a separately identifiable entity which is physically, administratively, and financially independent and distinct from other operations of the hospital. (See 42 CFR 416.30(f).) Under this restriction, hospital outpatient departments providing ambulatory surgery (among other services) are not eligible. (See 42 CFR 416.120(a).)

Line 12--This is a distinct part hospice and separately certified component of a hospital which meets the requirements of §1861(dd) of the Act. No payment designation is required in columns 4,5, and 6. (10/00)

Line 13--Do not use this line.

Line 14--This line is used by rural health clinics (RHC) and/or Federally qualified health clinics (FQHC) which have been issued a provider number and meet the requirements of §1861(aa) of the Act. If you have more than one RHC, report on lines 14 through 14.09. For FQHCs, report on lines 14.10 through 14.19. Report the required information in the appropriate column for each. (See Exhibit 2, Table 4, Part IV, page 36-755.)

Line 15--This line is used by hospital-based comprehensive outpatient rehabilitation facilities, community mental health centers, outpatient physical therapy, outpatient occupation therapy, and/or outpatient speech pathology clinics. Report these provider types on lines 15 through 15.09; 15.10 through 15.19; 15.20 through 15.29, 15.30 through 15.39; and 15.40 through 15.49, respectively. (See Exhibit 2, Table 4, Part III, page 36-755.)

Line 16--If this facility operates a renal dialysis center, enter in column 2 the satellite number. Subscript this line for more than one satellite facility.

Line 17--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of your operations which generally cover a consecutive 12 month period of your operations. (See CMS Pub. 15-II, §§102.1-102.3 for situations where you may file a short period cost report.)

Line 18--Indicate the type of control or auspices under which the hospital is conducted as indicated.

- | | |
|---------------------------------|--------------------------------------|
| 1 = Voluntary Nonprofit, Church | 8 = Governmental, City-County |
| 2 = Voluntary Nonprofit, Other | 9 = Governmental, County |
| 3 = Proprietary, Individual | 10 = Governmental, State |
| 4 = Proprietary, Corporation | 11 = Governmental, Hospital District |
| 5 = Proprietary, Partnership | 12 = Governmental, City |
| 6 = Proprietary, Other | 13 = Governmental, Other |
| 7 = Governmental, Federal | |

Lines 19 and 20--Indicate in column 1, as applicable, the number listed below which best corresponds with the type of services provided. Subscript for lines as needed, i.e., line 20.01 for subprovider 2, etc.

- | | |
|---|----------------------|
| 3 = Cancer | 7 = Children |
| 4 = Psychiatric | 8 = Alcohol and Drug |
| 5 = Rehabilitation | 9 = Other |
| 6 = Religious Non-medical Health Care Institution | |

If your hospital services various types of patients, indicate "General - Short Term" or "General - Long Term," as appropriate.

NOTE: Long term care hospitals are hospitals organized to provide long term treatment programs with lengths of stay greater than 25 days. These hospitals may be identified in 2 ways:

- o Those hospitals properly identified by a distinct type of facility code in the third digit of the Medicare provider number; or
- o Those hospitals that are certified as other than long term care hospitals, but which have lengths of stay greater than 25 days.

If your hospital cares for only a special type of patient (such as cancer patients), indicate the special group served. If you are not one of the hospital types described in items 1 through 8 above, indicate 9 for "Other".

Line 21--Indicate if your hospital is either urban or rural. Enter 1 for urban or 2 for rural.

Line 21.01--Does your facility qualify and is currently receiving payments for disproportionate share in accordance with 42 CFR 412.106? Enter "Y" for yes and "N" for no.

Line 21.02--Has your facility received a geographic reclassification? Enter "Y" for yes and "N" for no. If yes report in column 2 the effective date. **If the effective date is after the beginning date of the provider's fiscal year, subscript Worksheet D, Part V, Worksheet E, Part A, and Worksheet E, Part B. No subscripting is required for a rural to urban reclassification relating to Worksheet E, Part B. For purposes of calculating the transitional corridor payment on Worksheet E, Part B, the provider can retain its rural status. (1/1/00s)**

Line 22--Are you classified as a referral center? Enter "Y" for yes and "N" for no.

Line 23--Does your facility operate a transplant center? **If yes, enter the certification dates below.**

Line 23.01--If this is a Medicare certified kidney transplant center, enter the certification date in column 2. Also complete Worksheet D-6.

Line 23.02--If this is a Medicare certified heart transplant center, enter the certification date in column 2. Also complete Worksheet D-6.

Line 23.03--If this is a Medicare certified liver transplant center, enter the certification date in column 2. Also complete Worksheet D-6.

Line 23.04--If this is a Medicare certified lung transplant center, enter the certification date in column 2. Also, complete Worksheet D-6.

Line 23.05--If Medicare **pancreas transplants are performed, enter the more recent date of July 1, 1999 (coverage of pancreas transplants) or the certification dates for kidney transplants.** Also, complete Worksheet D-6.

Line 23.06--If this is a Medicare certified intestinal transplant center, for services rendered on or after October 1, 2001, enter the certification date in column 2. Also, complete Worksheet D-6.

Line 24--If this is an organ procurement organization (OPO), enter the OPO number in column 2.

Line 25--Is this a teaching hospital or is your facility affiliated with a teaching hospital? Enter "Y" for yes and "N" for no.

Line 25.01--Is this a teaching program approved in accordance with CMS Pub. 15-I, chapter 4? Enter "Y" for yes and "N" for no.

Line 25.02--If line 25.01 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? Enter "Y" for yes and complete Worksheet E-3, Part IV or "N" for no and complete Worksheet D-2, Part II, if applicable.

Line 25.03--As a teaching hospital, did you elect cost reimbursement for teaching physicians as defined in CMS Pub. 15-I, §2148? Enter "Y" for yes and "N" for no. If yes, complete Worksheet D-9.

Line 25.04--Are you claiming costs on line 70, column 7, of Worksheet A? Enter "Y" for yes and "N" for no. If yes, complete worksheet D-2, Part I.

Line 26--If this is a sole community hospital(SCH), enter the number of periods within this cost reporting period that SCH status was in effect. Enter the beginning and ending dates of SCH status on line 26.01. Subscript line 26.01 if more than 1 period is identified for this cost reporting period and enter multiple dates. Note: Worksheet C Part II must be completed for the period not classified as SCH (9/96). **Multiple dates are created where there is a break in the date between SCH status, i.e., for calendar year provider SCH status dates are 1/1/00-6/30/00 and 9/1/00-12/31/00.**

Line 27--If this hospital has an agreement with CMS under either §1883 or §1913 of the Act for swing beds, enter "Y" for yes in column 1 and indicate the agreement date in column 2 (mm/dd/yy).

Line 28--If this facility contains a hospital-based SNF, which has been granted an exemption from the cost limits in accordance with 42 CFR 413.30(e), enter "Y" for yes and "N" for no (not applicable for cost reporting periods beginning on or after July 1, 1998). For cost reporting periods beginning on or after July 1, 1998 are all patients identified as managed care patients or did your facility fail to treat Medicare eligible patients (no utilization). Enter "Y" for yes or "N" for no. If no complete lines 28.01 and 28.02 and Worksheet S-7 (7/98).

Line 28.01--If this facility contains a hospital-based SNF, enter in column 1 the payment transition period of 1 = 25/75, 2 = 50/50, 3 = 75/25; or 100. Enter in columns 2 the wage adjustment factor in effect before October 1, and in column 3 the adjustment in effect on or after October 1. SNFs servicing immuno-deficient patients may continue 50/50 blend through September 30, 2001.

Line 28.02--Enter the updated hospital based SNF facility rate supplied by your fiscal intermediary. Enter in column 2 the classification of the SNF, either (1) for urban or (2) for rural. Enter in column 3 the SNF's MSA code. If you are located in a rural area enter your state code as your MSA code.

Line 29--Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional reimbursement method? Enter "Y" for yes and "N" for no.

Line 30--If this hospital qualifies as a rural primary care hospital (RPCH) or critical access hospital (CAH), enter "Y" for yes in column 1. Otherwise, enter "N" for no, and skip to line 31. (See 42 CFR 485.606ff.) For cost reporting periods beginning after October 1, 1997, the classification of rural primary care hospital is replaced by critical access hospitals (10/97).

Line 30.01--Is this cost reporting period the initial 12-month period for which the facility operated as an RPCH? Enter "Y" for yes and "N" for no. For cost reporting periods beginning after October 1,

1997 RPDHs are eliminated and critical access hospitals are established and paid on the basis of reasonable costs. This question does not apply to CAHs (10/97).

Line 30.02--If this facility qualifies as an RPDH/CAH, has it elected the all-inclusive method of payment for outpatient services? Enter "Y" for yes and "N" for no (10/97). For cost reporting periods beginning on or after October 1, 2000 CAHs can elect all inclusive payment for outpatient (10/00). An adjustment for the professional component is still required on Worksheet A-8-2 (10/97).

Line 30.03--If this facility qualifies as an CAH is it eligible for cost reimbursement for ambulance services (12/21/00s). Enter a "Y" for yes or a "N" for no. If yes, enter in column 2 the date eligibility determination was issued. (See 42 CFR 413.70(b)(5))

Line 31--Is this a rural hospital qualifying for an exception to the certified registered nurse anesthetist (CRNA) fee schedule? (See CFR 412.113(c).) Enter "Y" for yes in column 1. Otherwise, enter "N" for no. If you have a subprovider, subscript this line and respond accordingly (9/96) on line 31.01.

Line 32--If this is an all inclusive rate provider (see instructions in CMS Pub. 15-I, §2208), enter the applicable method in column 2.

Line 33--Is this a new hospital under 42 CFR 412.300 (PPS capital)? Enter "Y" for yes or "N" for no in column 1.

Line 34--Is this a new hospital under 42 CFR 413.40 (TEFRA)? Enter "Y" for yes or "N" for no in column 1.

Line 35--Have you established a new subprovider (excluded unit) under 42 CFR 413.40 (P)(f)(1)(I) (TEFRA)? Enter "Y" for yes or "N" for no in column 1. If there is more than one subprovider, subscript this line.

Line 36--Do you elect the fully prospective payment methodology for capital costs? (See 42 CFR 412.340.) Enter "Y" for yes or "N" for no in the applicable columns.

Line 36.01--Does your facility qualify and receive payments for disproportionate share in accordance with 42 CFR 412.320 Enter "Y" for yes and "N" for no. If you are eligible as a result of the Pickle amendment, enter "P" instead of "Y." Do not complete this line if you answered no on line 36.

Line 37--Do you elect the hold harmless payment methodology for capital costs? (See 42 CFR 412.344.) Enter "Y" for yes or "N" for no in the applicable columns.

Line 37.01--If you are a hold harmless provider, are you filing on the basis of 100 percent of the Federal rate even though payment on this basis may result in lower payment under the hold harmless blend? Enter "Y" for yes or "N" for no in the applicable columns.

Line 38--Do you have title XIX inpatient hospital services? Enter "Y" for yes or "N" for no in column 1.

Line 38.01--Is this hospital reimbursed for title XIX through the cost report in full or in part? Enter "Y" for yes or "N" for no in column 1.

Line 38.02--Does the title XIX program reduce capital in accordance with Medicare methodology? Enter "Y" for yes or "N" for no in column 1.

Line 38.03--If all of the nursing facility beds are certified for title XIX, and there are also title XVIII certified beds (dual certified) (9/96), are any of the title XVIII beds occupied by title XIX patients? Enter "Y" for yes and "N" for no. You must complete a separate Worksheet D-1 for title XIX for

each level of care.

Line 38.04--Do you operate an ICF/MR facility for purposes of title XIX? Enter "Y" for yes and "N" for no (9/96).

Line 39--Do not use this line.

Line 40--Are there any related organization or home office costs claimed? Enter "Y" for yes or "N" for no. If yes, complete Worksheet A-8-1. If you are claiming home office costs enter in column 2 the home office chain number (10/0).

Line 41--Are provider based physicians' costs included in Worksheet A? Enter "Y" for yes and "N" for no. If yes, complete Worksheet A-8-2.

Line 42--Are physical therapy services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, you may be required to complete A-8-3 and/or A-8-4 for services rendered before and on or after April 10, 1998, respectively (4/98).

Line 42.01--Are occupational therapy services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, you may be required to complete parts of Worksheet A-8-4 for services rendered on or after April 10, 1998 (4/98).

Line 42.02--Are speech pathology services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, complete all parts of Worksheet A-8-4 for services rendered on or after April 10, 1998 (4/98).

Line 43--Are respiratory therapy services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, you may be required to complete all parts of Worksheet A-8-3 and/or A-8-4 where applicable, for services rendered before and on or after April 10, 1998, respectively (4/98).

Line 44--If you are claiming costs for renal services on Worksheet A, are they inpatient services only? Enter "Y" for yes and "N" for no. If yes, do not complete Worksheet S-5 and the Worksheet I series.

Line 45--Have you changed your cost allocation methodology from the previously filed cost report? Enter "Y" for yes or "N" for no. If yes, enter the approval date in column 2.

Line 45.01--Was there a change in the statistical basis? Enter a "Y" for yes or an "N" for no.

Line 45.02--Was there a change in the order of allocation? Enter a "Y" for yes or an "N" for no.

Line 45.03--Was there a change to the simplified cost finding method? Enter a "Y" for yes and an "N" for no (9/96).

Line 46--If the provider-based SNF participates in the NHCMQ demonstration during this cost reporting period, identify the phase of the demonstration. If the SNF is participating, complete Worksheets S-7 and E-3, Part V. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration.

Lines 47 through 51--If you are a provider (public or non public) that qualifies for an exemption from the application of the lower of cost or charges as provided in 42 CFR 413.13, indicate the component and/or services that qualify for the exemption. Subscript as needed for additional components.

Line 52--Does this hospital claim expenditures for extraordinary circumstances in accordance with 42 CFR 412.348(e)? Enter "Y" for yes and "N" for no. If yes, complete Worksheet L-1.

Line 53--If this is a Medicare dependent hospital (MDH), enter the number of periods within this cost reporting period that MDH status was in effect. Enter the beginning and ending dates of MDH status on line 53.01. Subscript line 53.01 if more than 1 period is identified for this cost reporting period and enter multiple dates (10/97).

Line 54--Enter in the appropriate category your annual malpractice premiums. If malpractice costs are being reported in other than the Administrative and General cost center complete line 54.01, and submit supporting schedules listing the cost centers and the amounts contained therein (10/97).

Line 55--Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes and "N" for no (10/97).

Line 56--Are you claiming ambulance costs? Enter a "Y" for yes or a "N" for no. If yes, enter in column 2, for services rendered on and after October 1, 1997, the ambulance payment per trip limit provided by your intermediary. The per trip rate is updated October 1st of each year. For cost reporting periods which overlap October 1, report the payment rate prior to October 1, on line 56, column 2 and the payment rate applicable for services on October 1 to the end of the cost reporting period on line 56.01. For cost reporting periods beginning October 1st no subscribing is required. If this is your first year of providing and reporting ambulance services, you are not subject to the payment limit. Enter a "Y" for yes or an "N" for no in column 3 (10/97). **For services beginning on or after January 1, 2001 the limit will be changed to a calendar year basis.** There is an additional update established by regulation for July 1, 2001. Report your ambulance trip limits chronologically, in accordance with your fiscal year. **Applicable chronological dates should be 1/1/2001, 7/1/2001, 1/1/2002, 4/1/2002 (effective date of blend), 1/1/2003, 1/1/2004, 1/1/2005, and 1/1/2006.** For services rendered on or after 4/1/2002, enter in column 4 the gross fee schedule amounts (from the PS&R or your records) for the reporting period. For services on and after 4/1/2002 through 12/31/2005 ambulance services will be subject to a blend until 100% fee schedule amount is transitioned on 1/1/2006.

CAHs exempt from the limits (Worksheet S-2, line 30.03, column 1 equals "Y") complete columns 1 and 2 only. (10/1/97b) If you are eligible for cost reimbursement of ambulance services for the entire cost reporting period complete line 56 only, no subscripts are required.

Line 57--Are you claiming nursing and allied health costs? Enter "Y" for yes and "N" for no. If yes you must subscript column 2 of Worksheet D, Parts III and IV to separately identify nursing and allied health (paramedical education) from all other medical education costs (1/1/00s).

Line 58--If you are an Inpatient Rehabilitation Facility, have you made the election for 100% PPS reimbursement? Enter "Y" for yes and "N" for no. This option is only available for cost reporting period beginning on or after 1/1/2002 and before 10/1/2002.

3605. WORKSHEET S-3 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA AND HOSPITAL WAGE INDEX INFORMATION

This worksheet consists of three parts:

- Part I - Hospital and Hospital Health Care Complex Statistical Data
- Part II - Hospital Wage Index Information
- Part III - Overhead Cost - Direct Salaries

3605.1 Part I - Hospital and Hospital Health Care Complex Statistical Data.--This part collects statistical data regarding beds, days, FTEs, and discharges.

Column Descriptions

Column 1--Indicate the number of beds available for use by patients at the end of the cost reporting period.

A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes. (See CMS Pub. 15-I, §2205.)

Column 2--Enter the total bed days available. Bed days are computed by multiplying the number of beds available throughout the period in column 1 by the number of days in the reporting period. If there is an increase or decrease in the number of beds available during the period, multiply the number of beds available for each part of the cost reporting period by the number of days for which that number of beds was available. **For CAHs only, subscript column 2 to accumulate the aggregate number of hours CAH patients spend in each category on lines 1 and 6 through 10. This data is for informational purposes only. (10/1/97b)**

Columns 3 through 5--Enter the number of inpatient days or visits, where applicable, for each component by program. Do not include HMO except where required (line 2, columns 4 and 5) (10/97), organ acquisition, or observation bed days in these columns. Observation bed days are reported in column 6, line 26.

Report the program days for PPS providers in the cost reporting period in which the discharge is reported. TEFRA providers should report their program days in the reporting period in which they occur.

NOTE: Section 1886(d)(5)(F) of the Act provides for an additional Medicare payment for hospitals serving a disproportionate share of low income patients. A hospital's eligibility for these additional payments is partially based on its Medicaid utilization. The count of Medicaid days used in the Medicare disproportionate share adjustment computation includes days for Medicaid recipients who are members of an HMO as well as out of state days, Medicaid secondary payer patient days, Medicaid eligible days for which no payment was received, and baby days after mother's discharge. These days are reported on line 2 in accordance with CFR 412.106(b)(4)(ii). Therefore, Medicaid patient days reported on line 1, column 5 do not include days for Medicaid patients who are also members of an HMO.

Column 6--Enter the number of inpatient days for all classes of patients for each component. Include organ acquisition and HMO days in this column.

Column 7--Enter the number of intern and resident full time equivalents (FTEs) in an approved program determined in accordance with 42 CFR 412.105(g) for the indirect medical education

adjustment.

Column 8--When interns and residents are used by the hospital to perform the duties of an anesthetist, the related FTEs must be excluded from the interns and residents count in column 9. (See 42 CFR 412.105(g)). Enter the FTEs relating to the interns and residents performing in anesthesiology who are employed to replace anesthesiologists. Do not include interns and residents in an approved anesthesiology medical education program.

Column 9--Enter on each line the number of FTEs in column 7 less the FTEs in column 8.

Columns 10 and 11--The average number of FTE employees for the period may be determined either on a quarterly or semiannual basis. When quarterly data are used, add the total number of hours worked by all employees on the first week of the first payroll period at the beginning of each quarter, and divide the sum by 160 (4 times 40). When semiannual data are used, add the total number of paid hours on the first week of the first payroll period of the first and seventh months of the period. Divide this sum by 80 (2 times 40). Enter the average number of paid employees in column 10 and the average number of nonpaid workers in column 11 for each component, as applicable.

Columns 12 through 14--Enter the number of discharges including deaths (excluding newborn and DOAs) for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.)

Column 15--Enter the number of discharges including deaths (excluding newborn and DOAs) for all classes of patients for each component.

Line Descriptions

Line 1--In columns 3, 4, and 5, enter the number of adult and pediatric hospital days excluding the SNF and NF swing bed, observation, and HMO days. **Do not include in column 4 Medicare Secondary Payer/Lesser of Reasonable Cost (MSP/LCC) days.** Only include these days in column 6.

Line 2--Enter title XVIII and XIX HMO days and Medicaid days eligible for DSH. (10/97)

Line 3--Enter the SNF swing bed days for all programs where applicable.

Line 4--Enter the NF swing bed days unless state recognizes SNF care only.

Line 5--Enter the sum of lines 1, 3 and 4.

Lines 6 through 11--Enter the appropriate statistic applicable to each discipline for all programs.

Line 12--Enter the sum of lines 5 through 11 for columns 1 through 6, and for columns 12 through 15, enter the amount from line 1. For columns 7 through 11, enter the total for each from your records.

Line 13--Enter the number of outpatient visits for cost reporting periods beginning prior to October 1, 1997, for a rural primary care hospital by program and total. An outpatient RPCH visit is defined in 42 CFR 413.70(b)(3)(iii). Begin reporting visits for CAHs for cost reporting periods beginning on or after October 1, 2000.

Line 14--If you have more than one subprovider, subscript this line.

Line 15--If your state recognizes one level of care, complete this line for titles V, XVIII, and XIX. Do not complete line 16. If you answered yes to line 38.03 of Worksheet S-2, complete all columns. **Exclude NHCMQ days in column 4.**

Line 16--Enter nursing facility days if you have a separately certified nursing facility for Title XIX or you answered yes to line 38.03 of Worksheet S-2. Make no entry if your State recognizes only SNF level of care. If you operate an ICF/MR, subscript this line to 16.01 and enter the ICF/MR days. Do not report any nursing facility data on line 16.01 (9/96).

Line 17--If you have more than one hospital-based other long term care facility, subscript this line.

Line 18--If you have more than one hospital-based HHA, subscript this line.

Line 19--Do not use this line.

Line 20--Enter data for an ASC. If you have more than one ASC, subscript this line.

Line 21--Enter days applicable to hospice patients in a distinct part hospice.

Line 22--Do not use this line.

Line 23--Enter data for the outpatient rehabilitation providers. For reporting of multiple facilities follow the same format used on Worksheet S-2, line 15 (9/96). For CMHCs for services rendered on or after August 1, 2000, enter the number of partial hospitalization days (10/00).

Line 24--Enter the number of outpatient visits for FQHC and RHC. If you have both or multiples of one, subscript the line.

Line 26--Enter the total observation bed days in column 6. Subscript this line for the subprovider(9/96) when both providers are claiming observation bed costs. Divide the total number of observation bed hours by 24 and round up to the nearest whole day. These total hours should include the hours for observation of patients who are subsequently admitted but only the hours up to the time of admission. Observation bed days only need to be computed if the observation bed patients are placed in a routine patient care area. The bed days are needed to calculate the cost of observation beds since it cannot be separately costed when the routine patient care area is used. If, however, you have a distinct observation bed area, it must be separately costed (as are all other outpatient cost centers), and this computation is not needed.

Line 27--Enter in column 4 the number of ambulance trips, as defined by section 4531(a)(1) of the BBA, provided for Medicare patients for ambulance services on or after October 1, 1997. For cost reporting periods that overlap October 1 and July 1, 2001 see §3604, line 56 for proper subscripting (10/97). Effective for services rendered on or after December 21, 2000, ambulance costs for a CAH are reimbursed on costs if Worksheet S-2, column 1, line 30.03 is answered yes. If yes separate the trips in accordance with Worksheet S-2, line 56 and subscripts.

Line 28--Enter in column 6 the employee discount days if applicable. These days are used on Worksheet E, Part A, line 4.01 and Worksheet E-3, Part I, line 1.04.

3605.2 Part II - Hospital Wage Index Information--This worksheet provides for the collection of hospital wage data which is needed to update the hospital wage index applied to the labor-related portion of the national average standardized amounts of the prospective payment system. It is important for hospitals to ensure that the data reported on Worksheet S-3, Parts II and III are accurate. Beginning October 1, 1993, the wage index must be updated annually. (See §1886(d)(3)(E) of the Act.) Congress also indicated that any revised wage index must exclude data for wages incurred in furnishing SNF services. Complete this worksheet for §1886(d) hospitals, any hospital with a PPS subprovider, or any hospital that would be subject to PPS if not granted a waiver.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Column 1

Line 1--Enter from Worksheet A, column 1, line 101, the wages and salaries paid to hospital

employees increased by amounts paid for vacation, holiday, sick, paid-time-off, severance, and bonus pay if not reported in column 1.

NOTE: Bonus pay includes award pay and vacation, holiday, and sick pay conversion (pay in lieu of time off).

Lines 2 through 8.01--The amounts to be reported must be adjusted for vacation, holiday, sick, paid time off, severance, and bonus pay if not already included. Do not include in lines 2 through 6 the salaries for employees associated with excluded areas (report these costs on lines 8 and 8.01 (10/97)).

Line 2--Enter the salaries for directly-employed Part A, non-physician anesthetist salaries (for rural hospitals that have been granted CRNA pass through) to the extent these salaries are included in line 1. Add to this amount the costs for CRNA Part A services furnished under contract to the extent hours can be accurately determined. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 8 and 8.01. Additionally, contract CRNA cost must be included on line 9. Report in column 4 the hours that are associated with the costs in column 3 for directly employed and contract Part A CRNAs (10/97). Do not include nurse anesthetists, clinical nurse specialists, and nurse practitioner (10/00).

Line 3--Enter the non-physician anesthetist salaries included in line 1, subject to the fee schedule and paid under Part B by the carrier. Exclude nurse anesthetists, clinical nurse specialists, and nurse practitioners (10/99).

Line 4--Enter the physician Part A salaries, (excluding teaching physician salaries), which are included in line 1. Also do not include intern and resident (I & R) salary on this line. Report I & R salary on line 6. Subscript this line to 4.01 and report teaching physicians salaries, Part A included in line 1 above (10/97).

Line 5--Enter the total physician, physician assistant, nurse practitioner and clinical nurse specialist salaries billed under Part B that are included in line 1 (10/99). Under Medicare, these services are related to patient care and billed separately under Part B. Also include physician **salaries for patient care services** reported for rural health clinics and Federally qualified health clinics included on Worksheet A, column 1, line 63. Report on line 5.01 the non-physician **salaries for patient care services** reported for Hospital-based RHCs and FQHCs services included on Worksheet A, column 1, line 63 (10/99).

Line 6--For Cost reporting periods beginning before October 1, 2000, enter from Worksheet A the salaries reported in column 1 of line 22 for interns and residents. Add to this amount the costs for intern and resident services furnished under contract. For cost reporting periods beginning on or after October 1, 2000, **do not report contract services on line 6**; report contract services on line 6.01 only. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 8 and 8.01. Additionally, contract intern and resident costs must be included on line 9. DO NOT include contract intern and residents costs on line 10. Report in column 4 the hours that are associated with the costs in column 3 for directly employed and contract interns and residents.

Line 7--If you are a member of a chain or other related organization as defined in CMS Pub 15-I, §2150, enter, from your records, the wages and salaries for home office personnel that are included in line 1.

Lines 8 and 8.01--Enter the amount reported on Worksheet A, column 1 for line 34 for the SNF. On line 8.01, enter from Worksheet A, column 1, the sum of lines 21, 24, 31, 35, 35.01, 36, 64, 65, 68 through 71, 82 through 86, 89, 92 through 94, and 96 through 100 (10/00).

Line 9--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, and management services as defined below. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. Do not include costs applicable to excluded areas reported on line 8 and 8.01 Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and 6 respectively). For cost reporting periods beginning before October 1, 2000, DO NOT include costs for pharmacy and laboratory services furnished under contract. Subscript this line and report these costs on line 9.01 and 9.02 respectively (10/97). For cost reporting periods beginning on or after October 1, 2000 include on this line contract pharmacy and laboratory costs as defined below in lines 9.01 and 9.02

Direct patient care services include nursing, diagnostic, therapeutic, and rehabilitative services Report only personnel costs associated with these contracts. DO NOT apply the guidelines for contracted therapy services under §1861(v)(5) of the Act and 42 CFR 413.106. Eliminate all supplies, travel expenses, and other miscellaneous items. Direct patient care contracted labor, for purposes of this worksheet, DOES NOT include the following: services paid under Part B: (e.g., physician clinical services, physician assistant services), management and consultant contracts, billing services, legal and accounting services, clinical psychologist and clinical social worker services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care.

Include the amount paid for **management services**, as defined below, furnished under contract rather than by employees. Report only those personnel costs associated with the contract. Eliminate all supplies, travel expenses, and other miscellaneous items. Contract management is limited to the personnel costs for those individuals who are working at the hospital facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract management services DO NOT include the following: other management or administrative services, physician Part A services, consultative services, clerical and billing services, legal and accounting services, unmet physician guarantees, physician services, planning contracts, independent financial audits, or any services other than the management contracts listed above. Per instructions on the Form CMS-339, submit to your intermediary the following: for direct patient care, pharmacy and laboratory contracts, the types of services, wages, and associated hours; for management contracts, the aggregate wages and hours (10/00).

If you have no contracts for direct patient care or management services as defined above, enter a zero in column 1. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 1.

For cost reporting periods beginning on or after October 1, 2000, lines 9.01 and 9.02. are no longer required.

Line 9.01--Enter the amount paid for **pharmacy services** furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. Per instructions on Form CMS-339, submit to your fiscal intermediary the following for direct patient care pharmacy contracts: the types of services, wages, and associated hours (10/97).

Line 9.02--Enter the amount paid for **laboratory services** furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. Per instructions on Form CMS-339, submit to your fiscal intermediary the following for direct patient care laboratory contracts: the types of services, wages, and associated hours (10/97).

Line 10--Enter from your records the amount paid under contract (as defined on line 9) for Part A physician services, excluding teaching physician services. Subscript this line and report Part A teaching physicians under contract on line 10.01. DO NOT include contract I & R services (to be included on line 6) (10/97). DO NOT include the costs for Part A physician services from the home office allocation and/or from related organizations (to be reported on line 12). Also, DO NOT include Part A physician contracts for any of the management positions reported on line 9.

Line 11--Enter the salaries and wage-related costs (as defined on lines 13 and 14) paid to personnel who are affiliated with a home office, who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office salaries excluded on line 7 and the associated wage-related costs excluded on line 7. This figure must be based on recognized methods of allocating an individual's home office salary to the hospital. If no home office exists or if you cannot accurately determine the hours associated with the home office salaries that are allocated to the hospital, then enter a zero in column 1. All costs for any related organization must be shown as the cost to the related organization.

NOTE: Do not include any costs for Part A physician services from the home office allocation and/or related organizations. These amounts are reported on line 12.

If a wage related cost associated with the home office is not “core” (as described in Part I of Exhibit 7 of the Form-CMS -339) and is not a category included in “other” wage related costs on line 14 (see Part II of Exhibit 7 of Form CMS-339 and line 14 instructions below), the cost cannot be included on line 11. For example, if a hospital’s employee parking cost does not meet the criteria for inclusion as a wage-related cost on line 14, any parking cost associated with home office staff cannot be included on line 11 (10/97).

Line 12--Enter from your records the salaries and wage-related costs for Part A physician services, excluding teaching physician Part A services from the home office allocation and/or related organizations. Subscript this line and report separately on line 12.01 the salaries and wage-related costs for Part A teaching physicians from the home office allocation and/or related organizations (10/97).

Lines 13 through 20--For purposes of determining the wage related costs for the wage index, a hospital must use generally accepted accounting principles (GAAP).(Continue to use Medicare principles on all other areas to determine allowable fringe benefits.) Hospital are required to complete Form CMS-339, exhibit 7, section 3, a reconciliation worksheet to aid hospital and intermediaries in implementing GAAP when developing wage-related costs and Medicare principles when determining reimbursable costs. Additionally, upon request by the intermediary or CMS, hospitals must provide a copy of the GAAP pronouncement, or other documentation, showing that the reporting practice is widely accepted in the hospital industry and/or related field as support for the methodology used to develop the wage-related costs. If a hospital does not complete Form CMS-339, exhibit 7, section 3, or, the hospital is unable, when requested, to provide a copy of the standard used in developing the wage-related costs, the intermediary may remove the cost from the hospital’s Worksheet S-3 due to insufficient documentation. As an alternative the amount could be allowed based on the application of Medicare principles.

NOTE: Although GAAP allows hospitals to report their expenses at cost or at charge, for wage index purposes, hospitals must report their expenses at cost.

NOTE: All costs for any related organization must be shown as the cost to the related organization. (For Medicare cost reporting principles, see PRM 15-I, §1000. For GAAP, see FASB 57.) If a hospital's consolidation methodology is not in accordance with GAAP or if there are any amounts in the methodology that cannot be verified by the intermediary, the intermediary may apply the hospital's cost to charge ratio to reduce the related party expenses to cost.

Line 13--Enter the core wage-related costs as described in Exhibit 7 of the Form CMS-339. (See note below for costs that are not to be included on line 13). Only the wage-related costs reported on Part I of Exhibit 7 are reported on this line. (Wage-related costs are reported in column 2, not column 1, of Worksheet A.)

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 8 and 8.01. Instead, these costs are reported on line 15. Also, do not include the wage-related costs for physicians Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel. (See lines 11, 12, and 16 through 20.)

New Policy Regarding Health Insurance and Health-Related Wage Related Costs:

For cost reporting periods beginning on or after October 1, 1998, hospitals and fiscal intermediaries are no longer required to remove from domestic claims costs the personnel costs associated with hospital staff who deliver services to employees. Additionally, health related costs, **that is, costs for employee physicals and inpatient and outpatient services that are** not covered by health insurance but provided to employees at no cost or at a discount, are to be included as a core wage related cost. The 1 percent test no longer applies to health related costs for periods beginning on or after October 1, 1998.

Line 14--Enter the wage-related costs that are considered an exception to the core list. (See note below for costs that are not to be included on line 14.) A detailed list of each additional wage-related cost must be shown on Exhibit 7, Part II of Form CMS-339. In order for a wage-related cost to be considered an exception, it must meet all of the following tests:

- a. The cost is not listed on Exhibit 7, Part I of Form CMS-339,
- b. The wage-related cost has not been furnished for the convenience of the provider,
- c. The wage-related cost is a fringe benefit as defined by the Internal Revenue Service and, where required, has been reported as wages to IRS (e.g., the unrecovered cost of employee meals, education costs, auto allowances), and
- d. The total cost of the particular wage-related cost exceeds 1 percent of total salaries after the direct excluded salaries are removed (Worksheet S-3, Part III, column 3, line 3). Wage-related cost exceptions to the core list are not to include those wage-related costs that are required to be reported to the Internal Revenue Service as salary or wages (i.e., loan forgiveness, sick pay accruals). Include these costs in total salaries reported on line 1 of this worksheet.

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 8 and 8.01. Instead, these costs are reported on line 15. Also, do not include the wage-related costs for physician Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel.

Line 15--Enter the total (core and other) wage-related costs applicable to the excluded areas reported on lines 8 and 8.01.

Lines 16 through 20--Enter from your records the wage-related costs for each category of employee listed. The costs are the core wage related costs plus the other wage-related costs. Do not include wage-related costs for excluded areas reported on line 15. Do not include the wage related costs for Part A teaching physicians on line 18. These costs are reported separately on line 18.01 (10/97). **On line 19, do not include wage-related costs related to non-physician salaries for patient care services reported for Hospital-based RHCs and FQHCs services included on Worksheet A, column 1, line 63. These wage-related costs are reported separately on line 19.01 (10/99).**

Lines 21 through 35--Enter the direct wages and salaries from Worksheet A column 1 for the appropriate cost center identified on lines 21 through 35, respectively, increased by the amounts paid for vacation, holiday, sick, and paid-time-off if not reported in column 1 of these lines. These lines provide for the collection of hospital wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. These lines are completed by all hospitals if the ratio of Part II, column 4, sum of lines 8 and 8.01 divided by the result of column 4, line 1 minus the sum of lines 3, 5, and 7 equals or exceeds a threshold of 15 percent. For hospitals with less than 15 percent, these lines are optional. However, all hospitals with a ratio greater than 5 percent must complete line 13 of Part III for all columns. Calculate the percent to two decimal places for purposes of rounding.

NOTE: Do not include overhead costs on lines 8 and 8.01.

Column 2--Enter on each line, as appropriate, the **salary** portion of any reclassifications made on Worksheet A-6.

Column 3--Enter on each line the result of column 1 plus or minus column 2.

Column 4--Enter on each line the number of **paid** hours corresponding to the amounts reported in column 3. Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave hours, paid time-off hours, and hours associated with severance pay. For Part II, lines 1 through 12 (including subscripts) and Part III, line 13, if the hours cannot be determined, then the associated salaries must not be included in columns 1 through 3 (10/97).

NOTE: The hours must reflect any change reported in column 2; on call hours are not included in the total paid hours (on call hours should only relate to hours associated to a regular work schedule; and overtime hours are calculated as one hour when an employee is paid time and a half. No hours are required for bonus pay. The intern and resident hours associated with the salaries reported on line 6 must be based on 2080 hours per year for each full time intern and resident employee. The hours reported for salaried employees who are paid a fixed rate are recorded as 40 hours per week or the number of hours in your standard work week (10/97).

Column 5--Enter on all lines (except lines 13 through 20) the average hourly wage resulting from dividing column 3 by column 4.

Column 6--Enter on the appropriate lines the source used to determine the data entered in columns 1, 2, and 4, as applicable. If necessary, attach appropriate explanations. This column is used to provide information for future reference regarding the data sources and to assist intermediaries in verifying the data and method used to determine the data.

3605.3 Part III - Hospital Wage Index Summary--This worksheet provides for the calculation of the wage index update as well as analysis of the wage data.

Columns 1 through 5--Follow the same instructions discussed in Part II, except for column 5, line 5.

Line 1--From Part II, enter the result of line 1 minus the sum of lines 2, 3, 4.01, 5, 6, 6.01 (10/00), and 7 (10/97).

Line 2--From Part II, enter the sum of lines 8 and 8.01.

Line 3--Enter the result of line 1 minus line 2.

Line 4--From Part II, enter the sum of lines 9, 10, 11, and 12 and subscripts if applicable (10/97).

Line 5--From Part II, enter the sum of lines 13, 14, and 18. Enter on this line in column 5 the wage-related cost percentage computed by dividing Part III, column 3, line 5, by Part III, column 3, line 3. Round the result to 2 decimal places.

Line 6--Enter the sum of lines 3 through 5.

Lines 7 through 12--Do not complete these lines (10/97).

3606. WORKSHEET S-4 - HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under titles V, XVIII, and XIX.

The statistics required on this worksheet pertain to a hospital-based home health agency. The data maintained is dependent upon the services provided by the agency, number of program home health aide hours, total agency home health aide hours, program unduplicated census count, and total unduplicated census count. In addition, FTE data are required by employee staff, contracted staff, and total. Complete a separate S-4 for each hospital-based home health agency.

Line 1--Enter the number of hours applicable to home health aide services.

Line 2--Enter the unduplicated count of all individual patients and title XVIII patients receiving home visits or other care provided by employees of the agency or under contracted services during the reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count (column 5, line 2) may not equal the sum of columns 1 through 4, line 2. For purposes of calculating the unduplicated census, if a beneficiary has received healthcare in more than one MSA, you must prorate the count of that beneficiary so as not to exceed a total of (1). A provider is to also query the beneficiary to determine if he or she has received healthcare from another provider during the year, e.g., Maine versus Florida for beneficiaries with seasonal residence. For cost reports that overlap October 1, 2000, subscript line 2 and enter the census count before October 1, 2000 on line 2 and on and after October 1, 2000 on line 2.01. **For cost reporting periods that begin on or after October 1, 2000, no subscripting is required for line 2.**

Lines 3 through 18--Lines 3 through 18 provide statistical data related to the human resources of the HHA. The human resources statistics are required for each of the job categories specified in lines 3 through 18.

Enter the number of hours in your normal work week.

Report in column 1 the full time equivalent (FTE) employees on the HHA's payroll. These are staff for which an IRS Form W-2 is used.

Report in column 2 the FTE contracted and consultant staff of the HHA.

Compute staff FTEs for column 1 as follows. Add all hours for which employees were paid and divide by 2080 hours. Round to two decimal places, e.g., .04447 is rounded to .04. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked and divide by 2080 hours.

If employees are paid for unused vacation, unused sick leave, etc., exclude these paid hours from the numerator in the calculations.

Line 19--Enter the number of Metropolitan Statistical Areas you serviced during this cost reporting period (10/97).

Line 20--Identify each MSA where the reported HHA visits are performed. Subscript the lines to accommodate the number of MSA's you service (10/97).

PPS Activity Data—Applicable for Medicare services rendered on or after October 1, 2000.

In accordance with 42 CFR §413.20 and §1895 of the Social Security Act, home health agencies are mandated to transition from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

The statistics required on this worksheet pertain to home health services furnished on or after October 1, 2000. The data to be maintained, depending on the services provided by the agency, includes the number of aggregate program visits furnished in each episode of care payment category for each covered discipline, the corresponding aggregate program charges imposed in each episode of care payment category for each covered discipline, total visits and total charges for each episode of care payment category, total number of episodes and total number of outlier episodes for each episode of care payment category, and total medical supply charges for each episode of care payment category.

HHA Visits—See PRM II, chapter 32, §3205, page 32-13 for the definition of an HHA visit.

Episode of Care--Under home health PPS the 60 day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. Beneficiaries are covered for an unlimited number of non-overlapping episodes. The duration of a full length episode will be 60 days. An episode begins with the start of care date and must end by the 60th day from the start of care.

Less than a full Episode of Care--

When 4 or fewer visits are provided by the HHA in a 60 day episode period, the result is a low utilization payment adjustment (LUPA). In this instance the HHA will be reimbursed based on a standardized per visit payment.

An episode may end before the 60th day in the case of a beneficiary elected transfer, or a discharge and readmission to the same HHA (including for an intervening inpatient stay). This type of situation results in a partial episode payment (PEP) adjustment.

When a beneficiary experiences a significant change in condition (SCIC) and subsequently, but within the same 60 day episode, elects to transfer to another provider a SCIC within a PEP occurs.

A significant change in condition (SCIC) adjustment occurs when a beneficiary experiences a significant change in condition, either improving or deteriorating, during the 60 day episode that was not envisioned in the original plan of care. The SCIC adjustment reflects the proportional payment adjustment for the time both prior and after the beneficiary experienced the significant change in condition during the 60 day episode.

Use lines 21 through 32 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 33 and 35 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 36 identifies the total number of episodes completed for each episode payment category. Line 37 identifies the total number of outlier episodes completed for each episode payment category. Outlier episodes do

not apply to 1) Full Episodes without Outliers and 2) LUPA Episodes. Line 38 identifies the total medical supply charges incurred for each episode payment category. Column 7 displays the sum total of data for columns 1 through 6. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report and only pertain to services rendered on or after October 1, 2000.

When an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all statistical data (i.e., cost, charges, counts, etc...) associated with that episode of care will appear on the PS&R of the fiscal year in which the episode of care is concluded. Similarly, all data required in the cost report for a given fiscal year must only be associated with services rendered during episodes of care that conclude during the fiscal year. Title XVIII visits reported on this worksheet will not agree with the title XVIII visits reported on Worksheet H-6, sum of columns 6 and 7 line 14.

Columns 1 through 6--Enter data pertaining to title XVIII patients only for services furnished on or after October 1, 2000. Enter, as applicable, in the appropriate columns 1 through 6, lines 21 through 32, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episode of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only Episodes) will not include any visit counts and corresponding charges that appear in column 5 (SCIC within a PEP) and vice versa. This is true for all episode of care payment categories in columns 1 through 6.

Line 33--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visits from lines 21, 23, 25, 27, 29 and 31.

Line 34--Enter in columns 1 through 6 for each episode of care payment category, respectively, the charges for services paid under PPS and not identified on any previous lines.

Line 35--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visit charges from lines 22, 24, 26, 28, 30, 32 and 34.

Line 36--Enter in columns 1 through 6 for each episode of care payment category, respectively, the total number of episodes of care rendered and concluded in the provider's fiscal year.

Line 37--Enter in columns 2 and 4 through 6 for each episode of care payment category identified, respectively, the total number of episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

Line 38--Enter in columns 1 through 6 for each episode of care payment category, respectively, the total **non-routine medical supply charges** for services rendered and concluded in the provider's fiscal year.

Column 7--Enter on lines 21 through 37, respectively, the sum total of amounts from columns 1 through 6.

3608. STATISTICAL DATA OUTPATIENT PROVIDERS

3608.1 Worksheet S-6 - Hospital-Based Outpatient Rehabilitation Provider Data.--In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to hospital-based outpatient rehabilitation providers. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility. For cost reporting periods **beginning on or after April 1, 2001**, if all services provided by the CORF, OPPT, OSP, or OOT, are paid 100% from fee scheduled payments, **skip** lines 1 through 18 and enter an affirmative response on line 19 **of this worksheet and do not complete the corresponding J series worksheets**.

This worksheet provides statistical data related to the human resources of the outpatient rehabilitation provider. The data maintained depends on the services provided by the outpatient rehabilitation provider. FTE data is required by employee staff, contracted staff, and total. The human resources statistics are required for each of the job categories specified on lines 1 through 17. Enter any additional categories needed on line 18.

Line 19- Is this component paid 100 percent under established fee schedules? Enter a "Y" and a "N" for no.

Enter the number of hours in your normal work week in the space provided.

Report in column 1 the full time equivalent (FTE) employees on the outpatient rehabilitation provider's payroll. These are staff for which an IRS Form W-2 was issued.

Report in column 2 the FTE contracted and consultant staff of the outpatient rehabilitation provider.

Compute staff FTEs for column 1 as follows. Add hours for which employees were paid divided by 2080 hours, and round to two decimal places, e.g., round .04447 to .04. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked divided by 2080 hours, and round to two decimal places.

If employees are paid for unused vacation, unused sick leave, etc., exclude the paid hours from the numerator in the calculations.

3608.2 Worksheet S-8 - Provider-Based Rural Health Clinic/Federally Qualified Health Center Provider Statistical Data (1/98).--Effective with services rendered on and after January 1, 1998, in accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain separate statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based Federally qualified health centers (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility.

Lines 1 and 1.01--Enter the full address of the RHC/FQHC.

Line 2--For FQHCs only, enter your appropriate designation (urban or rural). See §505.2 of the RHC/FQHC Manual for information regarding urban and rural designations. If you are uncertain of your designation, contact your intermediary. RHCs do not complete this line.

Lines 3 through 8--In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 9--Subscript line 9 as needed to list all physicians furnishing services at the RHC/FQHC. Enter the physician's name in column 1, and the physician's Medicare billing number in column 2.

Line 10--Subscript line 10 as needed to list all supervisory physicians. Enter the physician's name in column 1, and the number of hours the physician spent in supervision in column 2.

Line 11--If the facility provides other than RHC or FQHC services (e.g., laboratory or physician services), answer "Yes" and enter the type of operation on subscripts of line 12 otherwise enter "N" for no.

Line 12 --Enter in columns 1 through 14 the starting and ending hours in the applicable columns for the days that the facility is available to provide RHC/FQHC services. Enter the starting and ending hours in the applicable columns 1 through 14 for the days that the facility is available to provide other than RHC/FQHC services. When entering time do so as military time, e.g., 2:00 p.m. is 1400.

Line 13--Have you received an approval for an exception to the productivity standards? Enter a "Y" for yes and an "N" for no.

Line 14--Is this a consolidated cost report as defined in the Rural Health Clinic Manual? If yes enter in column 2 the number of providers included in this report.

Line 15--Identify provider's name and number filing the consolidated cost report.

Line 16--Are you claiming allowable GME costs for services rendered on and after January 1, 1999, as a result of your substantial payment for interns and residents. If yes, enter the number of program visits in the appropriate column performed by interns and residents (1/99).

Line 17—If the bed size changed to below 50 beds during the year for services rendered on or after July 1, 2001, it will be necessary to subscript the columns on M-3 to accommodate the application or exemption of the payment limits. Enter a "Y" for yes an "N" for no.

3609. WORKSHEET S-7 - NHCMQ DEMONSTRATION STATISTICAL DATA AND PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES (July 1, 1998)

NOTE: Public Law 105-33 (Balanced Budget Act of 1997) requires that all SNFs be reimbursed under PPS for cost reporting periods beginning on and after July 1, 1998. Therefore, SNFs will not be reimbursed under demonstration procedures for cost reporting periods beginning on and after that date.

In accordance with 42 CFR 413.60(a), 42 CFR 413.24(a), and 42 CFR 413.40(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to hospital-based SNF facilities participating in the NHCMQ Demonstration, for cost reporting periods beginning prior to July 1, 1998. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ Demonstration.

Column Descriptions

Column 1--The case mix group designations are already entered in this column.

Column 2--The M3PI revenue code designations are already entered in this column.

Columns 3, 4, and 4.02--Enter the rate assigned to the provider for each applicable group. This rate is updated annually effective January 1. Providers with fiscal years other than a calendar year may have two rates to report. Enter the rate prior to January 1 in column 3 and the rate on or after January 1 in column 4 for the demonstration. Calendar year providers use column 4 only. For cost reporting periods beginning on or after July 1, 1998, no entry is required. The rate is automatically calculated when an entry is made on the appropriate lines of columns 3.01, 4.01, or 4.03 (10/00). This Federal rate is adjusted for the labor portion by the update factor specific to the provider's MSA plus applicable increase for the period. This update factor is reported on Worksheet S-2, line 28.01 columns 2 and 3.

For cost reporting periods beginning on or after July 1, 2001 **or for providers who have elected 100% federal rate** the only data required to be reported are the days associated with each RUG. Those days will be reported in column 3.01 regardless of the periods designated. The calculation of the total payment for each RUG is no longer required. All payment data will be reported as a total amount paid under the RUG PPS payment system on Worksheet E-3, Part III, line 24 and will be generated from the PS&R or your records.

Columns 3.01 and 4.01--Enter the number of demonstration inpatient days prior to January 1 and on or after January 1 respectively. If you are a calendar year provider, report all inpatient days in column 4.01 for each applicable group. For cost reporting periods beginning on or after July 1, 1998, enter in column 3.01 the days of the period before October 1 and in column 4.01 for the days on and after October 1. Enter on column 4.03 the days for the period April 1, 2001 through September 30, 2001. Enter the total on line 46.

Columns 4.02 and 4.03--For services rendered on and after April 1, 2001 through September 30, 2001 enter the appropriate rate and days respectively for the period.

Column 4.05--For cost reporting periods that end prior to April 1, 2000, do not complete this column. For services rendered on April 1, 2000 through September 30, 2000, enter the days associated with the high cost RUGS paid at an increase of 20 percent.

Column 5--Calculate the amount attributable to the demonstration for each revenue group by multiplying the rate in column 3 by the days in column 3.01 (rounded to zero) plus the rate in column 4 multiplied by the days in column 4.01 (rounded to zero) (Column 4 times column 4.01 for calendar year providers). Enter the total on line 46. Transfer this amount to Worksheet E-3, Part V, line 6. For cost reporting periods beginning on or after July 1, 1998, multiply columns 3, 4, and 4.02 times columns 3.01, 4.01, and 4.03 (columns 4 times column 4.01 for cost reporting periods beginning

October 1) respectively, rounded to zero and add the three results. This becomes the Federal amount. For services rendered on and after April 1 through September 30, 2000, increase the Federal rate by 20 percent for the following RUGs: RHC, RMC, RMB, SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, and CA1. Multiply the Federal amount by the appropriate transition period percentage, i.e., 25 percent, 50 percent, 75 percent, or 100 percent identified on worksheet S-2 line 28.01, column 1. Add to the Federal amount the result of the calculation of (total days from columns 3.01, 4.01 and 4.03 multiplied by the facility specific rate (that result rounded to zero) identified on worksheet S-2, line 28.02, column 1) times the reciprocal percentage applied to the Federal rate, i.e., 75 percent, 50 percent, 25 percent, or 0 percent. Enter the result on the appropriate line for each RUG. Enter the total of column 5 on line 46. Transfer this amount to Worksheet E-3, Part III, column 2, line 24.

NOTE: Columns 1 and 2 contain the days identified in columns 2 and 4. Columns 3 and 4 identify the SNF and NF days out of the total for title XVIII and XI

3609.1 Worksheet S-9 - Hospice Identification Data--In accordance with 42 CFR 418.310 hospice providers of service participating in the Medicare program are required to submit annual information for health care services rendered to Medicare beneficiaries. Also, 42 CFR 418.20 requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a hospital-based hospice. Complete a separate S-9 for each hospital-based hospice.

3609.2 Part 1-Enrollment Days Based on Level of Care--

NOTE: Columns 1 and 2 contain the days identified in column 3 and 4. Column 3 and 4 identify the SNF and NF days out of the total for title XVIII and XIX.

Lines 1-4--Enter on lines 1 through 4 the enrollment days applicable to each type of care. Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four types of care. Where a patient moves from one type of care to another, count only one day of care for that patient for the last type of care rendered. For line 4, an inpatient care day should be reported only where the hospice provides or arranges to provide the inpatient care.

Line 5--Enter the total of columns 1 through 6 for lines 1 through 4.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Continuous Home Care Day - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. **Note: Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.**

Routine Home Care Day - A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

Line 23--Enter the other costs applicable to interns and residents in an approved teaching program.

Line 24--This line is used for a hospital or subprovider which operates an approved paramedical education program that meets the criteria of 42 CFR 413.85 and 412.113(b). Establish a separate cost center for each paramedical education program (e.g., one for medical records or hospital administration). If additional lines are needed, subscript line 24. If the direct costs are included in the costs of an ancillary cost center, reclassify them on Worksheet A-6 to line 24. Appropriate statistics are required on Worksheet B-1 to ensure that overhead expenses are properly allocated to this cost center.

Lines 25 through 36--These lines are for the inpatient routine service cost centers.

Line 25--The purpose of this cost center is to accumulate the incurred routine service cost applicable to adults and pediatrics (general routine care) in a hospital. Do not include incurred costs applicable to subproviders or any other cost centers which are treated separately.

NOTE: If a rural hospital with a certified SNF which has less than 50 beds in the aggregate for both components (excluding intensive care type and newborn beds) has made an election to use swing bed optional method for the SNF, the SNF routine costs and patient days are treated as though they were hospital swing bed-SNF type costs and patient days and are combined with the hospital adults and pediatrics cost center on line 25. (See 42 CFR 413.24(d)(5) and CMS Pub. 15-1, §2230.5B.) The SNF direct costs are reclassified from line 34 to line 25 through Worksheet A-6. On Worksheet B-1, the statistics for line 25 include the statistics for line 34.

When the swing bed optional method is elected for the SNF, the SNF beds are not swing beds but are reimbursed as if they were swing beds.

SNF ancillary services are recorded on Worksheet D, Part III, and Worksheet D-4 as swing bed-SNF ancillary services and not as SNF ancillaries when the swing bed optional method is elected.

Lines 26 through 30--Use lines 26 through 29 to record the cost applicable to intensive care type inpatient hospital units. (See 42 CFR 413.53(b).) Label line 30 appropriately to indicate the purpose for which it is being used.

Line 31--Use this line to record the inpatient routine service costs of a subprovider. Hospital units that are excluded units from PPS are treated as subproviders for cost reporting purposes. If you have more than one subprovider, subscript line 31.

Line 34--Use this line to record the costs of SNFs certified for titles V, XVIII, or XIX if your state accepts one level of care.

Line 35--Use this line to record the cost of NFs certified for title V or title XIX but not certified as an SNF for title XVIII. Subscript this line to record the cost of ICF/MR. Do not report nursing facility costs on this subscripted line (9/96).

Line 36--Use this cost center to accumulate the direct costs incurred in maintaining long term care services not specifically required to be included in other cost centers. A long term care unit refers to a unit where the average length of stay for all patients is greater than 25 days. The beds in this unit are not certified for titles V, XVIII, or XIX.

Lines 37 through 59--Use for ancillary service cost centers.

Line 45--Use this line to record costs when a pathologist continues to bill non-program patients for clinical laboratory tests and is compensated by you for services related to such tests for program beneficiaries. When you pay the pathologist an amount for administrative and supervisory duties for the clinical laboratory for program beneficiaries only, include the cost in this cost center.

NOTE: No overhead expenses are allocated to this cost center since it relates to services for program beneficiaries only. The cost reporting treatment is similar to that of services furnished under arrangement to program beneficiaries only. (See CMS Pub. 15-I, §2314.)

These costs are apportioned among the various programs on the basis of program charges for provider clinical laboratory tests for all programs for which you reimburse the pathologist.

Line 46--Include the direct expenses incurred in obtaining blood directly from donors as well as whole blood and packed red blood cells from suppliers. Do not include in this cost center the processing fee charged by suppliers. The processing charge is included in the blood storing, processing, and transfusion cost center. **Subscript and identify this line with the appropriate cost center code (Table 5 - electronic reporting specifications) for the cost of administering blood clotting factors to hemophiliacs. (See §4452 of BBA 1997, OBRA 1989 & 1993.)**

Line 47--Include the direct expenses incurred for processing, storing, and transfusing whole blood, packed red blood cells, and blood derivatives. Also include the processing fee charged by suppliers.

Line 57--If you furnish renal dialysis treatments, account for such costs by establishing a separate ancillary service cost center. In accumulating costs applicable to this cost center, include no other ancillary services even though they are routinely administered during the course of the dialysis treatment. However, if you physically perform a few minor routine laboratory services associated with dialysis in the renal dialysis department, such costs remain in the renal dialysis cost center. Outpatient maintenance dialysis services rendered after July 31, 1983, are reimbursed under the composite rate reimbursement system. For purposes of determining overhead attributable to the drug Epoetin include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

NOTE: ESRD physician supervisory services rendered on or after August 1, 1983, (the effective date of the composite rate reimbursement system) are not included as your costs. Supervisory services are included in the physician's monthly capitation rate.

Line 58--Enter the cost of ASCs that are not separately certified as a distinct part but which have a separate surgical suite. Do not include the costs of the ancillary services provided to ASC patients. Include only the surgical suite costs (i.e., those used in lieu of operating or recovery rooms).

Lines 60 through 63--Use these lines for outpatient service cost centers.

Line 60--Enter the cost applicable to the clinic. If you have two or more clinics which are separately costed, separately report each such clinic. Subscript this line to report each clinic. Carry forward these subscripted lines to all applicable worksheets. If you do not separately cost each clinic, you may combine the cost of all clinics on the clinic line.

NOTE: For lines 60 and 63, any ancillary service billed as clinic, RHC, and FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.

o Reclassification of any direct expenses included in the central service and supply cost center which are directly applicable to other cost centers such as intern-resident service, intravenous therapy, and oxygen (inhalation) therapy.

o Reclassification of any direct expenses included in the laboratory cost center which are directly applicable to other cost centers such as whole blood and packed red blood cells or electrocardiology.

o Reclassification of any direct expenses included in the radiology-diagnostic cost center which are directly applicable to other cost centers such as radiology-therapeutic, radioisotope, or electrocardiology.

o When you purchase services (e.g., physical therapy) under arrangements for Medicare patients but do not purchase such services under arrangements for non-Medicare patients, your books reflect only the cost of the Medicare services. However, if you do not use the grossing up technique for purposes of allocating overhead and if you incur related direct costs applicable to both Medicare and non-Medicare patients (e.g., paramedics or aides who assist a physical therapist in performing physical therapy services), reclassify the related costs on Worksheet A-6 from the ancillary service cost center. Allocate them as part of A & G expense. However, when you purchase services that include performing administrative functions such as completion of medical records, training, etc. as described in CMS Pub. 15-1, §1412.5, the overall charge includes the provision of these services. Therefore, for cost reporting purposes, these related services are NOT reclassified to A & G.

o If a beneficiary receives outpatient renal dialysis for an extended period of time and you furnish a meal, the cost of this meal is not an allowable cost for Medicare. Make an adjustment on Worksheet A-8. However, the dietary counseling cost attributable to a dialysis patient is an allowable cost. Reclassify this cost from the dietary cost center, line 11, to the renal dialysis cost center, line 57.

o When interns and residents are employed to replace anesthetists, you must reclassify the related direct costs from the intern and resident cost center to the anesthesiology cost center. (See 42 CFR 413.85(d)(7) and 49 FR 296 dated January 3, 1984.)

NOTE: These interns and residents do not qualify for the indirect medical education adjustment and must be excluded for the intern and resident FTE for that purpose. (See 42 CFR 412.113(c).)

o If you incur costs for an unpaid guarantee for emergency room physician availability, attach a separate worksheet showing the computation of the necessary reclassification. (See CMS Pub. 15-I, §2109.)

o Reclassification of the costs of malpractice insurance premiums, self-insurance fund contributions, and uninsured malpractice losses incurred either through deductible or coinsurance provisions, as a result of an award in excess of reasonable coverage limits, or as a government provider to the A & G cost center.

3612. WORKSHEET A-7 - ANALYSIS OF CAPITAL ASSETS

This worksheet consists of three parts:

- Part I - Analysis of Changes in Old Capital Asset Balances
- Part II - Analysis of Changes in New Capital Asset Balances
- Part III - Computation of Old Capital for Insurance, Taxes, and Other Capital-Related Costs.

See the instructions for Worksheet A for a definition of old and new capital. **A non-PPS provider does not have to complete Part I.** For cost reporting periods beginning on and after October 1, 2001, hospitals receiving 100% Federal prospective payment for capital are no longer required to complete **Parts I through III of this Worksheet if worksheet S-2, column 2, line 36 = "Y"**.

NOTE: Include assets which are directly allocated to the provider from the home office or related organization and the related other capital costs in Parts I, II, and III of this worksheet.

The intent of Worksheet A-7, Parts I and II, is to reflect assets which relate to the hospital. However, examine the cost finding elections made at the time you submit the cost report to consider the cost finding treatment of SNF, HHA, hospice, subproviders, CORF, CMHC, the physician office building, and any other nonallowable cost centers.

Where you have elected to cost find any of these areas through the cost report, related assets must be included in Worksheet A-7, Parts I and II, as appropriate, to properly allocate the related insurance, taxes, etc. This cost finding treatment must comply with the consistency rule in 42 CFR 412.302(d).

3612.1 Part I - Analysis of Changes in Old Capital Asset Balances and Part II - Analysis of Changes in New Capital Asset Balances.--These parts enable the Medicare program to analyze the changes that occurred in your capital asset balances during the current reporting period. Complete this worksheet only once for the entire hospital complex (certified and non-certified components). However, only include in Parts I and II assets that relate to hospital services or are commingled and cannot be separated.

Columns 1 and 6--Enter the balance recorded in your books of accounts at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6). You must submit a reconciliation demonstrating that the sum of Parts I and II, column 6, line 9, agree with the total fixed assets on Worksheet G, plus any directly allocated assets from the home office or related organization, less any assets not allocated through the cost finding method on Worksheet B. Include fully depreciated assets still used for patient care.

Columns 2 through 4--Enter the cost of capital assets acquired by purchase in column 2 and the fair market value at date acquired of donated assets in column 3. Enter the sum of columns 2 and 3 in column 4.

NOTE: The amounts in Part I, column 2, represent transfers from obligated capital and/or a transfer of assets from a change of ownership.

Column 5--Enter the cost or other approved basis of all capital assets sold, retired, or disposed of in any other manner during your cost reporting period.

The sum of columns 1 and 4 minus column 5 equals column 6.

3615. WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 415.55, 42 CFR 415.60, 42 CFR 415.70, and 42 CFR 415.102(d), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider or which represent availability services in a hospital emergency room under specified conditions. (See 42 CFR 415.150 and 42 CFR 415.164 for an exception for teaching physicians under certain circumstances.) 42 CFR 415.70 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost you incur. 42 CFR 415.60 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services such as research. Only provider services are reimbursable to you through the cost report. This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 415.70. The methodology used in this worksheet applies the RCE limit to the total physician compensation attributable to provider services reimbursable on a reasonable cost basis. Enter the total provider-based physician adjustment for personal care services and RCE limitations applicable to the compensation of provider-based physicians directly assigned to or reclassified to general service cost centers. RCE limits are not applicable to a medical director, chief of medical staff, or to the compensation of a physician employed in a capacity not requiring the services of a physician, e.g., controller. **RCE limits also do not apply to critical access hospitals, however the professional component must still be removed on this worksheet. CAHs need only complete columns 1 through 5 and 18 (10/1/97b). Transfer for CAHs the amount from column 4 to column 18.**

NOTE: 42 CFR 415.70(a)(2) provides that limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services paid for under the prospective payment system implemented under 42 CFR Part 412.

Limits established under this section apply to inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40), outpatient services for all titles, and to title XVIII, Part B inpatient services.

Since the methodology used in this worksheet applies the RCE limit in total, make the adjustment required by 42 CFR 415.70(a)(2) on Worksheet C, Part I. Base this adjustment on the RCE disallowance amounts entered in column 17 of Worksheet A-8-2.

Where several physicians work in the same department, see CMS Pub. 15-I, §2182.6C for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

NOTE: The adjustments generated from this worksheet for physician compensation are limited to the cost centers on Worksheet A, lines 5-69, 82-86, and 92 and subscripts as allowed (9/96).

Column Descriptions

Columns 1 and 10--Enter the line numbers from Worksheet A for each cost center that contained compensation for physicians who are subject to RCE limits.

Columns 2 and 11--Enter the description of the cost center used on Worksheet A. When RCE limits are applied on an individual basis to each physician in a department, list each physician on successive lines directly under the cost center description line, or list the first physician on the same line as the cost center description line and then each successive line below for each additional physician in that cost center (10/97).

List each physician using an individual identifier (not necessarily either the name or social security number of the individual, e.g., Dr. A, Dr. B). However, the identity of the physician must be made available to your fiscal intermediary upon audit. When RCE limits are applied on a departmental basis, insert the word "aggregate" (instead of the physician identifiers) on the line below the cost center description.

Columns 3-9 and 12-18--When the aggregate method is used, enter the data for each of these columns on the aggregate line for each cost center. When the individual method is used, enter the data for each column on the individual physician identifier lines for each cost center.

Column 3--Enter the total physician compensation paid by you for each cost center. Physician compensation means monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services) that you or other organizations furnish a physician in return for the physician's services. (See 42 CFR 415.60(a).) Include the compensation in column 3 of Worksheet A or, if necessary, through appropriate reclassifications on Worksheet A-6 or as a cost paid by a related organization through Worksheet A-8-1.

Column 4--Enter the amount of total remuneration included in column 3 applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B carrier in accordance with 42 CFR 415.102(a). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 415.60(f).)

Column 5--Enter the amount of the total remuneration included in column 3, for each cost center, applicable to general services to you (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 415.60(f).)

NOTE: 42 CFR 405.481(b) requires that physician compensation be allocated between physician services to patients, the provider, and nonallowable services such as research. Physicians' nonallowable services must not be included in columns 4 or 5. The instructions for column 18 insures that the compensation for nonallowable services included in column 3 is correctly eliminated on Worksheet A-8.

Column 6--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the *Federal Register* before any allowable adjustments. The final notice on the annual update to RCE limits published in the *Federal Register*, Vol. 50, No. 34, February 20, 1985, on page 7126 contains Table 1, Estimates of FTE Annual Average Net Compensation Levels for 1984. An update was published in the *Federal Register* on May 5, 1997. Obtain the RCE applicable to the specialty from this table. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable: non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million.

Column 7--Enter for each line of data the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040 in this column. The hours entered are the actual hours for which the physician is compensated by you for furnishing services of a general benefit to your patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered. Time records or other documentation that supports this allocation must be

because of the prior elimination of cost centers that have been closed.

When closing the general service cost centers, first close the cost centers that render the most services to and receive the least services from other cost centers. List the cost centers in this sequence from left to right on the worksheets. However, your circumstances may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets. **NOTE** that the general service cost centers are not allocated to provider-based physician (PBP) clinical lab service (line 45) because this cost center is treated as a purchased service under arrangements provided only to program beneficiaries.

If the amount of any cost center on Worksheet A, column 7, has a credit balance, show this amount as a credit balance on Worksheet B, Part I, column O. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated, do not allocate the general service cost center. Rather, enter the credit balance in parentheses on line 102 as well as on the first line of the column and on line 103. This enables column 27, line 103, to crossfoot to columns 0 and 5A, line 103. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, Part I, column 27, do not carry forward a credit balance to any worksheet.

On Worksheet B-1, enter on the first line in the column of the cost center being allocated the total statistical base over which the expenses are allocated (e.g., in column 1, old capital-related cost - building and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating administrative and general expenses.

Do not include any statistics related to services furnished under arrangements except if:

- o Both Medicare and non-Medicare costs of arranged for services are recorded in your records; or
- o Your intermediary determines that you are able to (and do) gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if you had furnished such services directly to all patients. (See CMS Pub. 15-I, §2314.)

For all cost centers (below the first line) to which the capital-related cost is allocated, enter that portion of the total statistical base applicable to each. The sum of the statistical base applied to each cost center receiving the services rendered must equal the total base entered on the first line.

Enter on line 103 of Worksheet B-1 the total expenses of the cost center being allocated. Obtain this amount from Worksheet B, Part I from the same column and line number used to enter the statistical base on Worksheet B-1. (In the case of old capital-related costs - buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 1.)

Divide the amount entered on line 103 by the total statistics entered in the same column on the first

line. Enter the resulting unit cost multiplier on line 104. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B, Part I, in the corresponding column and line. (See §3600.1 for rounding standards.)

After applying the unit cost multiplier to all the cost centers receiving the services rendered, the total cost (line 103) of all the cost centers receiving the allocation on Worksheet B, Part I, must equal the amount entered on the first line. Perform the preceding procedures for each general service cost center. Complete the column for each cost center on both Worksheets B, Part I, and B-1 before proceeding to the column for the next cost center.

If a general service cost center has a credit balance at the point it is allocated on Worksheet B, Part I, do not allocate the general service cost centers. However, display the statistic departmentally, but do not calculate a unit cost multiplier for lines 104, 106, and 108 on Worksheet B-1. Use lines 105 and 106 of Worksheet B-1 in conjunction with the allocation of old capital-related costs on Worksheet B, Part II. Use lines 105 and 106 of Worksheet B-1 in conjunction with the allocation of new capital-related costs on Worksheet B, Part III. Complete lines 105 and 107 for all columns after Worksheets B, Part I, and B-1 are completed and the amount of direct and indirect capital-related cost is determined on Worksheet B, Parts II and III, column 4a. Use lines 106 and 108 for all columns in allocating the direct and indirect capital-related cost on Worksheet B, Parts II and III, respectively. Compute the unit cost multiplier (after the amounts entered on lines 105 and 107 have been determined) by dividing the capital-related costs recorded on lines 105 and 107 by the total statistics entered in the same column on the first line. Round the unit cost multipliers to six decimal places. (See instructions for Worksheet B, Parts II and III, for the complete methodology and exceptions.)

Since capital-related cost, non-physician anesthetists, and approved education programs are not included in the operating cost per discharge, columns 20 through 24 are shaded on Worksheet B, Parts II and III, for all lines except 20 through 24, 101, 102, and 103. These are the only lines and columns where an approved educational cost center can be shown. Use line 101 of Worksheet B-1, columns 20 through 24, for this purpose in the allocation of capital-related cost on Worksheet B, Parts II and III. Use the statistic on line 101 together with the statistics on lines 20 through 24 of Worksheet B-1 to allocate columns 20 through 24 of Worksheet B, Parts II and III. (Do not use line 101 to allocate costs on Worksheet B, Part I.) The statistic for line 101 is the sum of the statistics on lines 25 through 71 and 82 through 100 on Worksheet B-1 for the same column.

Since intern and resident costs are segregated into two cost centers, properly allocate general service costs applicable to each center. A listing of general service cost centers which may be applicable and the appropriate allocation to the separate cost centers for the intern and resident costs is presented below.

<u>Cost Center</u>	<u>Salary & Salary Related Fringe Benefits</u>	<u>Other</u>
Old Capital Related Costs - Bldgs. & Fixtures		X
Old Capital Related Costs - Movable Equipment		X
New Capital Related Costs - Bldgs. & Fixtures		X
New Capital Related Costs - Movable Equipment		X

Employee Benefits	X	X
Administrative and General	X	X
Maintenance and Repair		X
Operation of Plant		X
Housekeeping		X
Cafeteria	X	X
Maintenance of Personnel		X

After the costs of the general service cost center have been allocated on Worksheet B, Part I, enter in column 25 the sum of the costs in columns 5a through 24 for lines 25 through 102. Once overhead is allocated to these cost centers, they are closed and the costs are not further allocated to the revenue producing cost centers.

Since costs applicable to direct graduate medical education costs (inpatient and outpatient in approved programs) are reimbursed based on a specific amount per resident, exclude these costs from the total costs in column 27. Enter on each line in column 26 the sum of the amounts shown on each line in columns 22 and 23. If you qualify for the exception, enter only the amounts from Worksheet B-2.

In addition, when an adjustment to expenses is required after cost allocation, enter the amount applicable to each cost center in column 26 of Worksheet B, Part I. Corresponding adjustments to Worksheet B, Parts II and III, may be applicable for capital-related cost adjustments. However, if a capital-related cost adjustment was not made prior to October 1, 1991, then the rules of capital consistency prohibit an adjustment during the transition period. (See 42 CFR 412.302(d).) Submit a supporting worksheet showing the computation of the adjustments in addition to completing Worksheet B-2.

NOTE: The amount reported in column 26 must equal both the sum of the amounts shown in columns 22 and 23 and the amount on Worksheet B-2, unless you qualify for the exception. See the instructions for column 26 for a more detailed explanation.

Other examples of adjustments to expenses which may be required after cost allocation are (1) the allocation of available costs between the certified portion and the non-certified portion of a distinct part provider, and (2) costs attributable to unoccupied beds in a hospital with a restrictive admission policy. (See CMS Pub. 15-I, §§2342-2344.3.)

After the adjustments have been made on Worksheet B, Part I, column 26, adjust the amounts in column 25 by the amounts in column 26, and extend the net balances to column 27 for each line. The total costs entered in column 27, line 103 must equal the total costs entered in column 0, line 103.

Transfer the totals in column 27, lines 25 through 36 (inpatient routine service cost centers), lines 37 through 59 (ancillary service cost centers), lines 60 through 63 (outpatient service cost centers), and lines 64 through 68 (other reimbursable cost centers) to Worksheet C, Parts I and II, column I, lines 25 through 68. (9/96) For provider based RHC/FQHCs with cost reporting periods that overlap January 1, 1998, transfer the total costs to Worksheets C, Parts I and II and M-2 for the same amount. For cost reporting periods beginning on or after January 1, 1998, transfer the total costs to Worksheet M-2 only.

NOTE: If you are a rural hospital with a certified SNF with less than 50 beds in the aggregate for both components (excluding intensive care type and newborn beds) and have made an election to use the swing bed optional reimbursement method for the SNF, the SNF costs and patient days are treated as though they were hospital swing bed-SNF type costs and patient days and are combined with the hospital adults and pediatrics

cost center on line 25. (See 42 CFR 413.24(d)(5) and CMS Pub. 15-I, §2230.9B.) Reclassify the SNF direct costs from line 34 to line 25 through Worksheet A-6. On Worksheet B-1, the statistics for line 25 must include the statistics for line 34. On Worksheet D, Part III, and Worksheet D-4, record the SNF ancillary services as swing bed-SNF ancillary services.

Transfer the direct hospital-based HHA costs in column 27, line 71, to Worksheet H-4, Part I, column 1, lines as indicated. If you have multiple HHAs, line 71 must be subscripted and transferred to a separate Worksheet H-4 for each HHA.

Only approved certified transplant centers transfer the amount in column 27, lines 73 through 76 to Worksheet D-6, Part III, column 1, line 50. If you are not certified as a transplant center, do not carry forward lines 73 through 76, column 27. Do not carry forward column 27, line 77, as Medicare either does not reimburse for these services or does not reimburse for these services as a pass through cost.

Transfer the total cost in column 27, line 70 (intern/resident services not in approved teaching program) to Worksheet D-2, Part I, column 2, line 1.

The total outpatient rehabilitation costs in column 27, line 69 and subscripts, must agree with Worksheet J-1, Part I, column 27, line 12, for each provider type.

Do not transfer ASC costs from column 27, line 92. Do not transfer the nonreimbursable cost center totals (lines 96 through 99).

NOTE: Do not transfer negative numbers.

Column Descriptions

Column 1--Include only old capital costs. See the instructions for Worksheet A, lines 1 and 2, for a discussion of old capital-related costs.

Column 2--Include only old capital costs. See the instructions for Worksheet A, lines 1 and 2, for a discussion of old capital-related costs.

Column 3--Include only new capital costs. See the instructions for Worksheet A, lines 3 and 4, for a discussion of new capital-related costs.

Column 4--Include only new capital costs. See the instructions for Worksheet A, lines 3 and 4, for a discussion of new capital-related costs.

Worksheet B, Part I, Column 26--Accumulate in this column the costs for interns and residents and post step down adjustments. The costs of interns and residents (direct graduate medical education costs for inpatient and outpatient in approved programs) are paid on a per resident amount. The intern and resident costs are paid through Worksheet E-3, Part IV. In order to avoid duplicate payments, enter the sum of the amounts reported on each line in columns 22 and 23 in the appropriate line of column 26. In addition, enter the amounts from Worksheet B-2, lines as appropriate. The total of columns 22 and 23 and the appropriate lines on Worksheet B-2 must equal the total of column 26.

NOTE: 42 CFR 413.86(e)(4)(I) provides for an exception to the base period for certain hospitals. If you did not have an approved medical residency

Line 34 - SNF

Sum of lines 34 and 35

Lines 37-59 - Ancillary Services

Lines 60, 61, subscripts of 62,
and 63 - Outpatient Service Cost

Lines 64, 65, and 68 - Other
Reimbursable Cost Centers

Lines 37-68

To Worksheet D-1, Part III

Line 71 for the SNF

Line 71 for the NF

To Worksheet D, Part II

Column 2, lines 37-59

Column 2, lines 60, 61, subscripts
of 62, and 63

Column 2, lines 64, 65, and 68

To Worksheet C, Part II, Column 2

Lines 37-68

3619. WORKSHEET B-2 - POST STEP DOWN ADJUSTMENTS

This worksheet provides an explanation of the post step down adjustments reported in column 26 of Worksheets B, Parts I through III, and L-1.

Column Descriptions

Column 1--Enter a brief description of the post step down adjustment.

Column 2--Make post step down adjustments on Worksheets B, Parts I through III, and L-1. Enter the worksheet part to which the post step down adjustment applies. For lines 57 and/or 64 remove the amount for epoietin reported on Worksheet S-5 lines 13 and 13.01.

Use the codes below to identify the worksheet in which the adjustment applies:

<u>Code</u>	<u>Worksheet</u>
1	B, Part I
2	B, Part II
3	B, Part III
4	L-1, Part I

Column 3--Enter the worksheet line number to which the adjustment applies.

Column 4--Enter the amount of the adjustment. Transfer these amounts to the appropriate lines on Worksheets B, Parts I, II, and III, or L-1, column 26.

NOTE: If you qualify for the exception in 42 CFR 413.86(e)(4), all direct graduate medical education costs are reimbursed as a pass through based on reasonable cost. Enter the amount from Worksheet B, Part I, sum of columns 21 through 24 plus or minus post step down adjustments (reported on Worksheet B-2) applicable to medical education costs.

If you answered yes to question 57 on Worksheet S-2 subscript this column and report in column 2 nursing school, column 2.01 allied health costs (paramedical education) and column 2.02 all other medical education costs.

Column 3--Compute the amount of the swing bed adjustment. If you have a swing bed agreement or have elected the swing bed optional method of reimbursement, determine the amount for the cost center in which the swing beds are located by multiplying the sum of the amounts in columns 1 and 2 by the ratio of the amount entered on Worksheet D-1, line 26 to the amount entered on Worksheet D-1, line 21.

Column 4--Enter the sum of columns 1 and 2 minus column 3.

Column 5--Enter on each line the total patient days, excluding swing bed days, for that cost center. Transfer these amounts from the appropriate Worksheet D, Part I, column 7. For SNF cost reporting periods beginning on or after July 1, 1998, enter the program days from worksheet S-3, Part I, column 6, line 15.

Column 6--Divide the cost of each cost center in column 4 by the total patient days in column 5 for each line to determine the pass through cost. Enter the resultant per diem cost in column 6.

Column 7--Enter the program inpatient days for the applicable cost centers. Transfer these amounts from the appropriate Worksheet D, Part I, column 8. For SNF cost reporting periods beginning on or after July 1, 1998, enter the program days from worksheet S-3, Part I, column 4, line 15.

Column 8--Multiply the per diem cost in column 6 by the inpatient program days in column 7 to determine the program's share of pass through costs applicable to inpatient routine services, as applicable. Transfer the sum of the amounts on lines 25 through 30 and 33 to Worksheet D-1, line 50 for the hospital. Transfer the amount on line 31 to the appropriate Worksheet D-1, line 50 for the subprovider. If you are a title XVIII hospital or subprovider paid under PPS, also transfer these amounts to the appropriate Worksheet E, Part A, line 14. For SNF, NF or ICF/MR that follow Medicare principles for cost reporting periods beginning on or after July 1, 1998, transfer the amount on column 8, line 34 to Worksheet E-3, Part III, line 28.

3621.4 Part IV - Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs--The TEFRA rate of increase limitation applies to inpatient operating costs. In order to determine inpatient operating costs, it is necessary to exclude capital-related and medical education costs as these costs are reimbursed separately. Hospitals and subprovider components subject to PPS must also exclude nonphysician anesthetist and direct medical education costs as these costs are reimbursed separately. Determine capital-related inpatient ancillary costs on Worksheet D, Part II. For cost reporting periods beginning on or after July 1, 1998, SNFs are required to report medical education costs as a pass through cost. Prepare a separate Worksheet D, Part IV for the SNF and NF/ICFMR (if applicable). Beginning August 1, 2000, hospital payment for outpatient services will be made prospectively with the exception of certain pass through costs identified on this worksheet.

This worksheet is provided to compute the amount of pass through costs other than capital applicable to hospital inpatient and outpatient ancillary services for titles V, XVIII, Part A, and XIX. Complete a separate copy of this worksheet for each subprovider for titles V, XVIII, Part A, and XIX, as applicable. In this case, enter the subprovider component number in addition to showing the provider number.

Make no entries on this worksheet for any costs centers with a negative balance on Worksheet B, Part I, column 27.

Column 1--Enter on each line (after any adjustments made after cost finding) the nonphysician anesthetist cost for hospitals and components qualifying for the exception to the CRNA fee schedule. (See §3610, line 20 description for more information.) Obtain this amount from Worksheet B, Part I, column 20 plus or minus any adjustments reported on Worksheet B, Part I, column 26 for nonphysician anesthetist. For the hospital and subprovider (if applicable) components only, enter on line 62, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 88.

Column 2--Enter on each line (after taking into consideration any adjustments made in column 26 of Worksheet B, Part I) the direct medical education costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part I, sum of columns 21 and 24 plus or minus post step down adjustments made on Worksheet B, Part I, column 26 applicable to direct medical education costs. For SNFs enter the sum of columns 21 through 24 unless the hospital is receiving graduate medical education payments reported on worksheet E-3, Part IV (Worksheet S-2, line 25.02 with a yes response); then report the sum of columns 21 and 24 only (7/98). For the hospital and subprovider (if applicable) components only, enter on line 62, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 89.

NOTE: If you qualify for the exception in 42 CFR 413.86(e)(4), all direct graduate medical education costs for interns and residents in approved programs are reimbursed as a pass through based on reasonable cost. Enter the amount from Worksheet B, Part I, sum of columns 21 through 24 plus or minus post step down adjustments (reported on Worksheet B-2) applicable to medical education costs.

If you answered yes to question 57 on Worksheet S-2, subscript this column and report in column 2 nursing school, column 2.01 allied health costs (paramedical education) and column 2.02 all other medical education costs.

Enter the costs of administering blood clotting factors to hemophiliacs in column 2.03 from Worksheet B, column 27, subscript of line 46 containing the corresponding costs. Complete only columns 2.03 and 3 through 7 for this entry. (see §4452 of BBA 1997)

Column 3--Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 1 and 2.

Column 4--Enter on each line the charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 5--Divide the cost of each cost center in column 3 by the charges in column 4 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to .032151. Enter the resultant departmental ratio in column 5.

Column 6--Enter on each line titles V, XVIII, Part A, or XIX inpatient charges from Worksheet D-4. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 7--Multiply the ratio in column 5 by the charges in column 6 to determine the program's share of pass through costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

Column 8--Enter on each line titles XVIII, Part B, V or XIX (if applicable) outpatient charges from Worksheet D, Part V, column 5.01. Do not include in Medicare charges any charges identified as MSP/LCC (8/00).

Column 9--Multiply the ratio in column 5 by the charges in column 8 to determine the program's share of pass through costs applicable to titles XVIII, Part B, V or XIX (if applicable) outpatient ancillary services, as appropriate (8/00).

For hospitals and subproviders transfer column 7, line 101 to Worksheet D-1, Part II, column 1, line 51. If you are a PPS hospital or subprovider, also transfer this amount to Worksheet E, Part A, line 15. For SNFs, NFs, and ICF/MRs for titles XVIII and XIX, for cost reporting periods beginning on or after July 1, 1998, transfer the amount on line 101 to Worksheet E-3, Part III, line 29 (7/98).

3621.5 Part V - Apportionment of Medical and Other Health Services Costs.--This worksheet provides for the apportionment of costs applicable to hospital outpatient services reimbursable under titles V, XVIII, and XIX, as well as inpatient services reimbursable under title XVIII, Part B. Title XVIII is reimbursed in accordance with 42 CFR 413.53. Do not complete this worksheet for an RPCH component that has elected the all-inclusive payment method for outpatient services. (See Worksheet S-2, lines 30 through 30.02.) Payment under the all-inclusive payment method for outpatient services is computed on Worksheet C, Part V. Critical access hospitals do not complete columns 2 through 4 and 6 through 8 of this worksheet. **Providers exempt from outpatient PPS (i.e., SNFs, CAHs, & swing bed SNFs), complete columns 5 and 9. All other providers subscript columns 5 and 9 as necessary.**

NOTE: Do not enter CORF, OPT, OSP, OOT, or CMHC charges on Worksheet D, Part V. Report those charges on Worksheet J-2.

For title XVIII, complete a separate Worksheet D, Part V, for each provider component as applicable. Enter the applicable component number in addition to the hospital provider number. Make no entries in columns 6 through 9 of this worksheet for any cost centers with a negative balance on Worksheet B, Part I, column 27. However, complete columns 2 through 5 for such cost centers.

For cost reporting periods that end on or after October 1, 1997, and before September 30, 1998, subscript columns 2 through 4 and 6 through 8 and report the charges and cost during the period for services prior to October 1, 1997, in columns 2 through 4 and 6 through 8 and report the charges and costs for the periods on or after October 1, 1997, and before September 30, 1998 in columns 2.01 through 4.01 and 6.01 through 8.01. The subscripting is required as a result of the change in calculating the different payment methodologies on Worksheet E, Parts C, D, and E regarding the application of deductibles and coinsurance. Subscripting is not required for cost reporting periods ending on or after September 30, 1998. Revert back to reporting the charges and costs for these services in columns 2 through 4 and 6 through 8. For services rendered on and after August 1, 2000, outpatient services are subject to prospective payment. For cost reporting periods that overlap the effective date, subscript the columns to accommodate the proper reporting of cost reimbursement prior to August 1, 2000, and prospective payment on and after August 1, 2000.

Columns 1, 1.01 and 1.02--Enter on each line in column 1 and 1.02, for hospital and subprovider components, the ratio from the corresponding line on Worksheet C, Part II, columns 8 and 9, respectively, for services rendered prior to August 1, 2000. For SCH (full cost reporting period), RPCH/CAH, SNF, NF, and swing bed services, enter on each line in **column 1** the ratio from the corresponding line on Worksheet C, Part I, column 9. Enter in column 1.01 the ratio from the corresponding line on Worksheet C, Part I, column 9 for services on and after August 1, 2000.

Columns 2 and 2.01--Enter on the appropriate line the charges (per your records or the PS&R ASC segment) for outpatient ambulatory surgical services through July 31, 2000.

Columns 3 and 3.01--Enter on the appropriate line the outpatient radiology charges per your records or the PS&R outpatient radiology segment through July 31, 2000.

Columns 4 and 4.01--Enter on the appropriate line the other outpatient diagnostic procedure charges per your records or the PS&R other diagnostic segment through July 31, 2000.

Columns 5, 5.01 and 5.02--For title XVIII, enter the charges for outpatient services not included in

any other column in Part V. For SNFs for services rendered which overlap the effective date of January 1, 1998, for physical, occupational and speech therapy (lines 50 through 52) subscript this column and report charges before January 1, 1998, in column 5 and on and after January 1, 1998, in column 5.01. Subscribing is not required for cost reporting periods beginning on or after January 1, 1998. For hospitals claiming ambulance services for cost reporting periods which overlap October 1, 1997, subscript column 5. Enter on line 65, column 5 the charges relating to the period on or after October 1, 1997, and in column 5.01 the charges relating to prior to October 1, 1997. For cost reporting periods beginning on or after October 1, 1997, do not complete column 5.01 for ambulance. Exclude charges for which costs were excluded on Worksheet A-8. For example, CRNA costs reimbursed on a fee schedule are excluded from total cost on Worksheet A-8. For titles V and XIX, enter the appropriate outpatient service charges. Do not include charges for vaccine, i.e., pneumococcal, flu, hepatitis, and osteoporosis. These charges are reported on Worksheet D, Part VI. Do not include in Medicare charges any charges identified as MSP/LCC. Effective August 1, 2000, enter in column 5 the services prior to August 1, 2000, paid based on cost. In column 5.01 enter the charges for services rendered on or after August 1, 2000, paid subject to the prospective payment system. **These charges should not include services paid under the fee schedule such as physical therapy, speech pathology or occupational therapy.** Create separate subscripted column (e.g. 5.03, 5.04) when a cost reporting period overlaps the effective dates for the various transitional corridor payments and **when a provider experiences a geographic reclassification from urban to rural. However, no subscribing is required when a provider geographically reclassifies from rural to urban.** In column 5.02 enter the charges for services rendered on and after August 1, 2000, e.g., for drugs and supplies related to ESRD dialysis (excluding EPO, and any drugs or supplies paid under the composite rate), and corneal tissue. For cost reporting periods which overlap August 1, 2000, report ambulance service charges prior to August 1st, in column 5 and services on and after August 1st in column 5.02. Do not include in any column services excluded from OPPS because they are paid under another fee schedule, e.g., rehabilitation services and clinical diagnostic lab. **Hospitals with cost reporting periods which overlap August 1, 2000, report in columns 1.02 through 5 the applicable amounts for services render prior to August 1, 2000, report in column 5.01 the applicable PPS amounts for services on or after August 1, 2000, and report in column 5.02 the cost of services on or after August 1, 2000 which were erroneously paid at cost.**

For cost reporting periods beginning on or after January 1, 1999, for SNF, CAHs, and title XIX services not paid under PPS no subscribing is required. Report all charges in column 5.

For CAHs (BIPA §205), enter the charges for the period you are subject to the limit and/or blend and the subscripted line the charges for which you are exempt from the limit and/or blend (see Worksheet S-2, line 30.03). If you are exempt for the full cost reporting period only complete line 65, no subscripts are required.

For cost reporting periods overlapping 4/1/2002 and after subscript line 65 for ambulance services in accordance with the subscripts on Worksheet S-2, line 56 and report charges separately on line 65 and subscripts for the applicable periods.

Columns 6 and 6.01--Multiply the charges in column 2 and 2.01 by the ratios in column 1, and enter the result. Line 101 equals the sum of lines 37 through 68.

Columns 7 and 7.01--Multiply the charges in column 3 and 3.01 by the ratios in column 1, and enter the result.

Columns 8 and 8.01--Multiply the charges in column 4 and 4.01 by the ratios in column 1, and enter the result.

Columns 9, 9.01, and 9.02--Multiply the charges in column 5 by the ratios in column 1, and enter the result. For hospitals subject to outpatient prospective payment, multiply the charges in column 5.01 and 5.02, or any additional subscripted column of column 5 by the ratios in column 1.01, and

enter the result in columns 9.01 and 9.02 or additional subscripts, respectively. For SNFs subscript this column and report the result of multiplying the ratio in column 1 by the charges in columns 5 and 5.01 for physical and occupational therapies, and speech pathology. For lines 50 through 52 only, for services rendered on and after January 1, 1998, enter in column 9.01, 90 percent of the result of multiplying the ratio in column 1 by the charges in column 5.01. For SNF services rendered on and after January 1, 1999, make no entry for therapy services paid under a fees schedule for lines

50 through 52. The amount entered on line 65 of this column, Ambulance, for all providers, cannot exceed the payment limit calculated from Worksheet S-2, column 2, lines 56 and 56.01 (if applicable), times the amount on Worksheet S-3, Part I, column 4, line 27 and 27.01 (if applicable) respectively, for ambulance services on or after October 1, 1997. For cost reporting periods which overlap the October 1, 1997, effective date, enter in column 9 the lower of the cost (column 1 times column 5, rounded to zero, or the limit (Worksheet S-2, Column 2, line 56, times, Worksheet S-3, Part I, column 4, line 27, rounded to zero), added to column 1 times column 5.01 rounded to zero).

Hospitals with cost reporting periods that overlap August 1, 2000, subscript column 9 in accordance with column 5 instructions.

For cost reporting periods beginning on or after October 1, 1997, costs for ambulance services are calculated from column 5 charges only. For cost reporting periods which overlap August 1, 2000, to calculate the ambulance costs, multiply the charges reported in columns 5 and 5.02 by the appropriate ratio on Worksheet C, Part II and add the result. Compare that to the limit amount calculated as indicated above and enter the lesser of the two in column 9.02.

Ambulance services on after 4/1/2002 through 12/31/2005 are reimbursed on a blend of the lesser of the cost or limit times 80 percent plus the fee schedule amounts (from Worksheet S-2, line 56 and subscripts, column 4) times 20 percent for the calendar year services beginning 4/1/2002. Subsequent dates and blends are: Calendar year 2003 is 60/40, 2004 is 40/60, 2005 is 20/80, and 2006 and after is 100% fee schedule amounts.

For CAHs follow the instructions for ambulance services subject to the limit (10/1/97b) and/or the blend (4/1/02s). For ambulance services eligible for cost reimbursement (Worksheet S-2, line 30.03, column 1 = "Yes") multiple column 1 times column 5 and enter the result. (12/21/00s)

Column 10--Enter in this column the hospital inpatient Part B charges for services rendered prior to August 1, 2000 (10/1/90s).

Column 11--Enter in this column the hospital inpatient Part B costs computed by multiplying the charges in column 10 times the cost to charge ratio reported in column 1.02 (10/1/90s).

Line Descriptions

Line 44--For title XVIII, do not include charges for outpatient clinical diagnostic laboratory services. For titles V and XIX purposes, follow applicable State program instructions.

Line 45--Enter the program charges for provider clinical laboratory tests for which the provider reimburses the pathologist. See §3610 for a more complete description on the use of this cost center. For title XVIII, do not include charges for outpatient clinical diagnostic laboratory services. For titles V and XIX purposes, follow applicable State program instructions.

NOTE: Since the charges on line 45 are also included on line 44, laboratory, reduce the total charges to prevent double counting. Make this adjustment on line 103.

Line 55--Enter in columns 2 through 5 the charges for medical supplies charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics.

Line 56--Enter the program charges for drugs charged to patients that are not paid a predetermined price. Do not include vaccine charges for pneumococcal, hepatitis B, influenza, and osteoporosis. These charges are reported on Worksheet D, Part VI.

Line 57--The only renal dialysis services entered on this line are for inpatients who are not reimbursed under the composite rate regulations. (See 42 CFR 413.170.) Therefore, include only inpatient Part B charges on this line in column 5. Enter the related costs in column 9.

Line 58--Enter in columns 2 and 2.01 the outpatient ASC facility charges for the hospital nondistinct part ambulatory surgery center. These charges represent the ASC facility charge only (i.e., in lieu of operating or recovery room charges), and do not include charges for the ancillary services provided to the patient. Enter in column 5 all other Part B charges applicable to services performed in the nondistinct ASC.

Lines 60 through 63--Use these lines for outpatient service cost centers.

NOTE: For lines 60 and 63, any ancillary service billed as clinic, RHC, or FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.

Line 62--Enter in columns 2 through 5 the title XVIII Part B charges for observation beds. These are the charges for patients who were treated in the nondistinct observation beds and released. These patients were not admitted as inpatients.

Line 64--The only home program dialysis services which are cost reimbursed are those rendered to beneficiaries who have elected the option to deal directly with Medicare. Home program dialysis services reimbursed under the composite rate regulation (see 42 CFR 413.170) are not included on this line. This line includes costs applicable to equipment-related expenses only.

Line 65--Enter in column 5.02 the total ambulance charges for PPS hospital providers (column 5 for non PPS hospitals). (8/2000)

Line 66 and 67--For title XVIII, DME is paid on a fee schedule through the carrier and, therefore, is not paid through the cost report.

Line 101--Enter the sum of lines 37 through 68.

Line 102--Generally, nonphysician anesthetist services are not subject to the ASC payment methodology for outpatient ambulatory surgical procedures performed in hospitals and as such are not reported on this worksheet unless you meet the exception described in §3610. Do not complete this line if you do not qualify for the exception. If the services meet the criteria for continued cost reimbursement, exclude nonphysician anesthetist charges from ASC charges in columns 2 and 2.01, line 102 and add these charges to column 5, line 102. Do not reduce the charges reported in columns 2 and 2.01, lines 37 through 68 (nor do you increase the charges in column 5) for CRNA charges. The reduction and addition are done in total on line 102. However, if you have separate charges for nonphysician anesthetists reported in the ancillary service cost centers where the services were performed, and the apportionment between ASC and all other Part B is not necessary, enter those charges directly in column 5, line 102. For services rendered on or after August 1, 2000, do not report CRNA charges or cost on this worksheet. These costs are pass through costs when eligible for the exception and are reported on Worksheet D, Part IV.

EXAMPLE: If nonphysician anesthetist charges are included in operating room and anesthesiology charges reported on Worksheet D, Part V, column 2, lines 37 and 40,

respectively, eliminate the charges from columns 2 and 2.01 and report them in column 5. This is accomplished by developing a ratio of each affected cost center's nonphysician anesthetist cost allocated on Worksheet B, Part I, column 20, lines 37 and 40 to the total cost reported on Worksheet B, Part I, column 27, lines 37 and 40. Each ratio is then multiplied by the charges applicable to Worksheet D, Part V, columns 2 and 2.01, lines 37 and 40. The result represents the CRNA charges for operating room and anesthesiology. These charges are added together and reported on line 102 as a decrease in columns 2 and 2.01 and an increase to column 5. Attach a separate reconciliation to the cost report showing this computation.

Step Instructions

- 1 $\frac{\text{Worksheet B, Part I, column 20, line 37}}{\text{Worksheet B, Part I, column 27, line 37}} = \text{ratio (six decimal places)}$
- 2 $\frac{\text{Worksheet B, Part I, column 20, line 40}}{\text{Worksheet B, Part I, column 27, line 40}} = \text{ratio (six decimal places)}$
- 3 The ratio in step 1 multiplied by the charges reported on Worksheet D, Part V, columns 2 and 2.01, line 37 equals the CRNA operating room charges.
- 4 The ratio in step 2 multiplied by the charges reported on Worksheet D, Part V, columns 2 and 2.01, line 40 equals the CRNA anesthesiology charges.
- 5 Add the amounts in steps 3 and 4. Enter the total on line 102 as a decrease in columns 2 and 2.01 and as an increase in column 5, line 102.
- 6 To determine the costs reported in columns 6 and 9, line 102, multiply the ratio on Worksheet C, Part II, column 8, as applicable for each cost center (lines 37 and 40), by the charges computed in steps 3 and 4. Add these two costs together, and report the total as a decrease to columns 6 and 6.01 and an increase to column 9.

Line 103--Enter in column 5 program charges for provider clinical laboratory tests where the physician bills the provider for program patients only. Obtain this amount from line 45. Do not complete this line for column 9.

Line 104--Enter in columns 5 and 9, and subscripts, the amount on line 101 plus or minus the amounts on lines 102 and 103 if applicable.

Transfer Referencing: For title XVIII, transfer the sum of the amounts in columns 5 and subscripts and column 10, line 104 to Worksheet E, Part B, line 6. Make no transfers of swing bed charges to Worksheet E-2 since no LCC comparison is made.

For titles V and XIX (other than PPS), transfer the sum of the amounts in columns 5 and subscripts and column 10, line 104 plus the amount from Worksheet D-4, column 2, line 103 to the appropriate Worksheet E-3, Part III, column 1, line 11.

For titles V and XIX (under PPS), transfer the amount in column 5, line 104 to the appropriate Worksheet E-3, Part III, column 1, line 11.

NOTE: If the amount on line 104 includes charges for professional patient care services of provider-based physicians, eliminate the amount of the professional component charges from the total charges, and transfer the net amount as indicated. Submit a schedule showing these computations with the cost report.

Transfer References

<u>From Wkst. D, Part V</u>	Title XVIII, Part B <u>Swing Bed</u> To	Titles V or XIX or Title XVIII, Part B
Columns 6 & 6.01, line 104	N/A	Wkst. E, Part C, col. 1& 1.01, line 6
Columns 2 & 2.01, line 104	N/A	Wkst. E, Part C, col. 1& 1.01, line 7
Columns 7 & 7.01, line 104	N/A	Wkst. E, Part D, col. 1& 1.01, line 6
Columns 3 & 3.01, line 104	N/A	Wkst. E, Part D, col. 1& 1.01, line 7
Columns 8 & 8.01, line 104	N/A	Wkst. E, Part E, col. 1 & 1.01, line 6
Columns 4 & 4.01, line 104	N/A	Wkst. E, Part E, col. 1 & 1.01, line 7
Columns 9 and subscripts & column 11, Line 104	N/A	Wkst. E, Part B, col. 1 (& subscripts), line 1 & 1.01
Sum of columns 5, 5.01 (SNF only) and 5.02, line 104	N/A	Wkst. E, Part B, line 6 or Wkst. E-3, Part III, col. 1, line 11 for titles V or XIX
Sum of columns 9 and 9.01 (SNF only) through 12/31/98 line 104	Wkst E-2 col. 2, line 3	Wkst. E, Part B, line 1 or Wkst. E-3, Part III, col. 1, line 2 for titles V or XIX

3621.6 Part VI - Vaccine Cost Apportionment.--This worksheet provides for the apportionment of costs applicable to the administration and cost of the drug for the following vaccines: Pneumococcal, Hepatitis B (subject to deductibles and coinsurance), Influenza, and Osteoporosis. These charges include, if applicable, vaccine services provided by hospital based RHC/FQHC which cannot be reported on Worksheet M-3 and M-4 (1/98). For services rendered on and after August 1, 2000 for vaccines provided by a RHC/FQHC will be reported on Worksheets M-3 and M-4.

Line 1--Enter the cost to charge ratio from Worksheet C, Part I, column 9, line 56.

Line 2--Enter the program charges from the PS&R or from provider records. Effective for services rendered on or after **April 1, 2001**, subscript this line and report charges prior to **April 1, 2001**, on line 2 and on line 2.01 charges on or after **April 1, 2001**. For cost reporting periods beginning on or after August 1, 2000, no subscripting is required.

For CAHs effective for services rendered on or after November 29, 1999, enter on line 2 the program charges for pneumococcal, influenza, and osteoporosis vaccines and on line 2.01 the charges for hepatitis B vaccines. Hepatitis B vaccine charges are subject to deductibles and coinsurance.

Line 3--Multiply line 1 times line 2, for hospital services rendered prior to **April 1, 2001**, and enter the result on line 3. For services rendered on or after **April 1, 2001**, subscript this line and enter on line 3.01 the result of line 1 times line 2.01. For cost reporting periods beginning on or after **April 1, 2001**, no subscripting is required. For hospitals for title XVIII, transfer the amount on line 3 to Worksheet E, Part B, line 1 for services rendered prior to **April 1, 2001**. The amount on line 3.01 is added to the amount reported on Worksheet D, Part V, column 9.01, line 104 and transferred to Worksheet E, Part B, line 1.01 for services rendered on or after **April 1, 2001**. **For SNFs transfer to Worksheet E, Part B, line 1, the sum of lines 3 and 3.01, but for reporting periods beginning on or after April 1, 2001, transfer the amount from line 3 only. For swing bed SNFs transfer the amount from line 3 to Worksheet E-2, column 2, line 3 and for NFs to Worksheet E-3, Part III, column 1, line 2, for titles V and XIX.**

For CAHs effective for services rendered on or after November 29, 1999, enter on line 2 the program charges for pneumococcal, influenza, and osteoporosis vaccines and on line 2.01 the charges for Hepatitis B vaccines. Transfer the sum lines 3 and 3.01 to Worksheet E, Part B, line 1.

3622. WORKSHEET D-1 - COMPUTATION OF INPATIENT OPERATING COST

This worksheet provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment). All providers must complete this worksheet.

Complete a separate copy of this worksheet for the hospital, each subprovider, hospital-based SNF, and hospital-based other nursing facility. Also, complete a separate copy of this worksheet for each health care program under which inpatient operating costs are computed. When this worksheet is completed for a component, show both the hospital and component numbers.

At the top of each page, indicate by checking the appropriate line the health care program, provider component, and the payment system for which the page is prepared.

Worksheet D-1 consists of the following four parts:

- Part I - All Provider Components
- Part II - Hospital and Subproviders Only
- Part III - Skilled Nursing Facility and Other Nursing Facility Only
- Part IV - Computation of Observation Bed Cost

NOTE: If you have made a swing bed election for your certified SNF, treat the SNF costs and patient days as though they were hospital swing bed-SNF type costs and patient days on Parts I and II of this worksheet. Do not complete Part III for the SNF. (See CMS Pub. 15-I, §2230.9B.)

Definitions

The following definitions apply to days used on this worksheet.

Inpatient Day--The number of days of care charged to a beneficiary for inpatient hospital services is always in documented units of full days. A day begins at midnight and ends 24 hours later. Use the midnight to midnight method in reporting the days of care for beneficiaries even if the hospital uses a different definition for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. However, do not count the day of discharge or death, or a day on which a patient begins a leave of absence, as a day. If both admission and discharge or death occur on the same day, consider the day a day of admission and count it as one inpatient day.

Include a maternity patient in the labor/delivery room ancillary area at midnight in the census of the inpatient routine (general or intensive) care area only if the patient has occupied an inpatient routine bed at some time since admission. Count no days of inpatient routine care for a maternity inpatient who is discharged (or dies) without ever occupying an inpatient routine bed. However, once a maternity patient has occupied an inpatient routine bed, at each subsequent census include the patient

in the census of the inpatient routine care area to which she is assigned, even if the patient is located in an ancillary area (labor/delivery room or another ancillary area) at midnight. In some cases, a maternity patient may occupy an inpatient bed only on the day of discharge if the day of discharge differs from the day of admission. For purposes of apportioning the cost of inpatient routine care, count this single day of routine care as the day of admission (to routine care) and discharge. This day is considered as one day of inpatient routine care. (See CMS Pub. 15-I, §2205.2.)

When an inpatient is occupying any other ancillary area (e.g., surgery or radiology) at the census taking hour prior to occupying an inpatient bed, do not record the patient's occupancy in the ancillary area as an inpatient day in the ancillary area. However, include the patient in the inpatient census of the routine care area.

When the patient occupies a bed in more than one patient care area in one day, count the inpatient day only in the patient care area in which the patient was located at the census taking hour.

Newborn Inpatient Day--Newborn inpatient days are the days that an infant occupies a newborn bed in the nursery. Include an infant remaining in the hospital after the mother is discharged who does not occupy a newborn bed in the nursery, an infant delivered outside the hospital and later admitted to the hospital but not occupying a newborn bed in the nursery, or an infant admitted or transferred out of the nursery for an illness in inpatient days. Also, include an infant born in and remaining in the hospital and occupying a newborn bed in the nursery after the mother is discharged in newborn inpatient days.

Private Room Inpatient Day--Private room inpatient days are the days that an inpatient occupies a private room. If you have only private rooms, report your days statistic as general inpatient days. Inpatient private room days are used for computing any private room differential adjustment on Worksheet D-1, Part I if you have a mixture of different type rooms to accommodate patients. Do not count swing bed-SNF or swing bed-NF type services rendered in a private room as private room days.

Inpatient Swing Bed Days--Inpatient swing bed days are the days applicable to swing bed-SNF or swing bed-NF type services. If the state recognizes only SNF level of care, do not use the NF lines.

Intensive Care Type Inpatient Days--Intensive care type inpatient days are those days applicable to services rendered in intensive care type inpatient hospital units. These units must meet the requirements specified in CMS Pub. 15-I, §2202.7.II.A.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type inpatient hospital days for purposes of computing the intensive care type inpatient hospital unit per diem. However, count the program days as general routine days in computing program reimbursement. (See CMS Pub. 15-I, §2217.)

Observation Beds--Observation beds, for purposes of this worksheet, are those beds in general routine areas of the hospital or subprovider which are not organized as a distinct, separately staffed observation area and which are used to house patients for observation. These beds need not be used full time for observation patients. These beds are not to be confused with a subintensive care unit (i.e., definitive observation unit, a stepdown from intensive care reported as an inpatient cost center following surgical intensive care (line 29)). If you have a distinct observation bed unit (an outpatient cost center), report the costs of this unit on the subscripted line 62.01 on Worksheet A.

3622.1 Part I - All Provider Components.--This part provides for the computation of the total general inpatient routine service cost net of swing bed cost and private room cost differential for each separate provider component. When this worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

Lines 1 through 16--Inpatient days reported, unless specifically stated, exclude days applicable to newborn and intensive care type patient stays. Report separately the required statistics for the hospital, each subprovider, hospital-based SNF, hospital-based other nursing facility and ICF/MR. Obtain the information from your records and/or Worksheet S-3, Part I, columns and lines as indicated.

Line 1--Enter the total general routine inpatient days, including private room days, swing bed days, observation bed days, and hospice days, as applicable. Do not include routine care days rendered in an intensive care type inpatient hospital unit. Enter the total days from Worksheet S-3, Part I, column 6 for the component and lines as indicated: hospitals from lines 5 and 26; subproviders from lines 14 and 26.01, if applicable; SNFs from line 15; and NFs from line 16. If you answered yes to line 38.03 of Worksheet S-2, the NF days come from line 15 for the SNF level of care and line 16 for the NF level of care, and you will need to prepare a separate Worksheet D-1 for each level of care for title XIX.

NOTE: If you are a rural hospital with a certified SNF, have less than 50 beds in the aggregate for both components (excluding intensive care type and newborn beds), and have made an election to be reimbursed as though you were a swing bed hospital, treat the SNF total and SNF program patient days as though they were hospital swing bed-SNF days. Report them on lines 1, 5, 6, 10, and 11, as appropriate. (See 42 CFR 413.24(d)(5) and CMS Pub. 15-I, §2230.9.B.)

Line 2--Enter the total general routine inpatient days. Include private room days and exclude swing bed and newborn days. Hospitals and enter the sum of the days entered on Worksheet S-3, Part I, column 6, lines 1 and 26. Subproviders, SNFs, and NFs enter the days from line 1 of this worksheet.

Line 3--Enter the total private room days excluding swing bed private room days.

Line 4--Enter the number of days reported on line 2 less the number of days reported on line 3.

NOTE: For purposes of this computation, the program does not distinguish between semi-private and ward accommodations. (See CMS Pub. 15-I, §2207.3.)

Line 5--Enter the total swing bed-SNF type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all swing bed-SNF type inpatient days.

Line 6--Enter the total swing bed-SNF type inpatient days, including private room days, after December 31 of your cost reporting period. If you are on a calendar year end, enter zero. The sum of lines 5 and 6 equals Worksheet S-3 Part I, line 3, column 6.

Line 7--Enter the total swing bed-NF type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all swing bed-NF type inpatient days. This line includes title V, title XIX, and all other payers.

Line 8--Enter the total swing bed-NF type inpatient days, including private room days, after December 31 of your cost reporting period. If you are on a calendar year end, enter zero. This line includes title V, title XIX, and all other payers. The sum of lines 7 and 8 equals Worksheet S-3, Part I, line 4, column 6.

NOTE: Obtain the amounts entered on lines 5 and 7 from your records.

Line 9--Enter the total program general routine inpatient days as follows:

<u>Type of Provider</u>	<u>From</u>
Hospital	Wkst. S-3, Part I, cols. 3, 4, or 5, line 1
Subprovider	Wkst. S-3, Part I, cols. 3, 4, or 5, line 14
SNF	Wkst. S-3, Part I, cols. 3, 4, or 5, line 15
NF	Wkst. S-3, Part I, cols. 3, 4, or 5, for SNF only level of care; line 15. If line 38.03 of Wkst S-2 is a "Y", two D-1s must be completed for title XIX using line 15 for SNF level of care and line 16 for the NF level of care; or line 16 only for NF level of care.

Include private room days and exclude swing bed and newborn days for each provider component. Add any program days for general care patients of the component who temporarily occupied beds in an intensive care or other special care unit. (See CMS Pub. 15-I, §2217.)

Line 10--Enter the title XVIII swing bed-SNF type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all program swing bed-SNF type inpatient days. Combine titles V and XIX for all SNF lines if your state recognizes only SNF level of care.

Line 11--Enter the title XVIII swing bed-SNF type inpatient days, including private room days, after December 31 of your cost reporting period. If you are on a calendar year end, enter zero.

Line 12--Enter the total titles V or XIX swing bed-NF type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all program swing bed-NF type inpatient days.

Line 13--Enter the total titles V or XIX swing bed-NF type inpatient days, including private room days, after December 31 of your reporting period. If you are on a calendar year end, enter zero.

NOTE: If you are participating in both titles XVIII and XIX, complete, at a minimum, a separate Worksheet D-1, Part I, for title XIX, lines 9, 12, and 13. If these data are not supplied, the cost report is considered incomplete and is rejected.

Line 14--Enter the total medically necessary private room days applicable to the program, excluding swing bed days, for each provider component.

Line 15--Enter, for titles V or XIX only, the total nursery inpatient days from Worksheet S-3, Part I, column 6, line 11.

Line 16--Enter, for titles V or XIX only, the total nursery inpatient days applicable to the program from Worksheet S-3, Part I, columns 3 and 5, respectively, line 11.

Lines 17 through 27--These lines provide for the carve out of reasonable cost of extended care services furnished by a swing bed hospital. Under the carve out method, the total costs attributable

to SNF type and NF type routine services furnished to all classes of patients are subtracted from total general inpatient routine service costs before computing the average cost per diem for general routine hospital care. The rates on lines 17 through 20 are supplied by your intermediary.

Line 17--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 5 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-I, §2230ff.) Critical access hospitals do not complete this line (12/00).

Line 18--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 6 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-I, §2230ff.) Critical access hospitals do not complete this line (12/00).

Line 19--Enter the average Statewide rate per patient day paid under the State Medicaid plan for routine services furnished by nursing facilities (other than NFs for the mentally retarded) in that State in the calendar year preceding the calendar year in which inpatient days on line 7 occurred.

Line 20--Enter the average Statewide rate per patient day paid under the State Medicaid plan for routine services furnished by nursing facilities (other than NFs for the mentally retarded) in that State in the calendar year preceding the calendar year in which inpatient days on line 8 occurred.

Line 21--Enter the total general inpatient routine service costs for the applicable provider component.

For titles V, XVIII, and XIX, enter the amounts from Worksheet C, Part I, line 25 for adults and pediatrics or line 31 for the subprovider, as appropriate:

COST or OTHER	Inpatient	Column 1
TEFRA	Inpatient	Column 3
PPS	Inpatient	Column 5

SNF/NF Inpatient Routine--For title XVIII, transfer this amount from Worksheet C, Part I, column 5, line 34 (SNF) (7/1/98b). For titles V and XIX, transfer this amount from Worksheet B, Part I, column 27, line 35 (NF) or 35.01 ICF/MR.

Line 22--Enter the product of the days on line 5 multiplied by the amount on line 17.

Line 23--Enter the product of the days on line 6 multiplied by the amount on line 18.

Line 24--Enter the product of the days on line 7 multiplied by the amount on line 19.

Line 25--Enter the product of the days on line 8 multiplied by the amount on line 20.

Line 26--Enter the sum of the amounts on lines 22 through 25. This amount represents the total reasonable cost for swing bed-SNF type and NF type inpatient services.

For critical access hospitals, for cost reporting periods beginning on or after December 21, 2000, subtract the sum of lines 24 and 25 from the amount reported on line 21. Divide that result by the patient days equal to lines 2, 5, and 6 above to arrive at a per diem (Retain this amount for the calculation required on lines 38, 60 and 61). Multiply the per diem by the total days reported on lines 5 and 6. Add that result to the amounts reported on lines 24 and 25.

Line 27--Subtract the amount on line 26 from the amount on line 21. This amount represents the general inpatient routine service cost net of swing bed-SNF type and NF type inpatient costs.

Lines 28 through 36--All providers must complete lines 28 through 36. PPS providers complete these lines for data purposes only. However, if line 3 equals line 2 above you are not to complete these lines.

Line 28--Enter the total charges for general inpatient routine services, excluding charges for swing bed-SNF type and NF type inpatient services (from your records).

Line 29--Enter the total charges for private room accommodations, excluding charges for private room accommodations for swing bed-SNF type and NF type inpatient services (from your records).

Line 30--Enter the total charges for semi-private room and ward accommodations, excluding semi-private room accommodation charges for swing bed-SNF type and NF type services (from your records).

Line 31--Enter the general inpatient routine cost to charge ratio (rounded to six decimal places) by dividing the total inpatient general routine service costs (line 27) by the total inpatient general routine service charges (line 28).

Line 32--Enter the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the amount on line 29 by the days on line 3.

Line 33--Enter the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the amount on line 30 by the days on line 4.

Line 34--Subtract the average per diem charge for all semi-private accommodations (line 33) from the average per diem charge for all private room accommodations (line 32) to determine the average per diem private room charge differential. If a negative amount results from this computation, enter zero on line 34.

Line 35--Multiply the average per diem private room charge differential (line 34) by the inpatient general routine cost to charge ratio (line 31) to determine the average per diem private room cost differential (rounded to two decimal places).

Line 36--Multiply the average per diem private room cost differential (line 35) by the private room accommodation days (excluding private room accommodation days applicable to swing bed-SNF type and NF type services) (line 3) to determine the total private room accommodation cost differential adjustment.

Line 37--Subtract the private room cost differential adjustment (line 36) from the general inpatient routine service cost net of swing bed-SNF type and NF type costs (line 27) to determine the adjusted general inpatient routine service cost net of swing bed-SNF type service costs, NF type service costs, and the private room accommodation cost differential adjustment. **If line 3 equals line 2, enter the amount from line 27 above.**

3622.2 Part II - Hospital and Subproviders Only.--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX and the calculation of program excludable cost for all hospitals and subproviders. For hospitals reimbursed under TEFRA, it provides for the application of a ceiling on the rate of cost increase for the hospital and subproviders. When the worksheet is completed for a component, show both the hospital and component numbers.

NOTE: This is not completed for RPCH providers. (See Worksheet S-2, line 31ff.) RPCH providers complete Worksheet C, Part IV, in lieu of this part. For cost reporting periods beginning after October 1, 1997 CAHs will complete this worksheet.

Line Descriptions

Line 38--For non-PPS providers, divide the adjusted general inpatient routine service cost (line 37) by the total general inpatient routine service days including private room (excluding swing bed and newborn) days (line 2) to determine the general inpatient routine service average cost per diem (rounded to two decimal places). For PPS providers, divide the sum of lines 36 and 37 by the inpatient days reported on line 2. **For CAHs the per diem, unless there is an adjustment for private room differential, should be equal to the per diem calculated in the formula on line 26.**

Line 39--Multiply the total program inpatient days including private room (excluding swing bed and newborn) days (line 9) by the adjusted general inpatient routine service average cost per diem (line 38) to determine the general inpatient service cost applicable to the program.

Line 40--Multiply the medically necessary private room (excluding swing bed) days applicable to the program (line 14) by the average per diem private room cost differential (line 35) to determine the reimbursable medically necessary private room cost applicable to the program. PPS providers enter zero.

Line 41--Add lines 39 and 40 to determine the total general inpatient routine service cost applicable to the program.

Line 42--This line is for titles V and XIX only and provides for the apportionment of your inpatient routine service cost of the nursery, as appropriate.

Column 1--Enter the total inpatient cost applicable to the nursery from Worksheet C, Part I, line 33.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient	Column 5

Column 2--Enter the total inpatient days applicable to the nursery from line 15.

Column 3--Divide the total inpatient cost in column 1 by the total inpatient days in column 2 (rounded to two decimal places).

Column 4--Enter the program nursery days from line 16.

Column 5--Multiply the average per diem cost in column 3 by the program nursery days in column 4.

Lines 43 through 47--These lines provide for the apportionment of the hospital inpatient routine service cost of intensive care type inpatient hospital units (excluding nursery) to the program.

Column 1--Enter on the appropriate line the total inpatient routine cost applicable to each of the indicated intensive care type inpatient hospital units from Worksheet C, Part I, lines 26 through 30, as appropriate.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient	Column 5

Column 2--Enter on the appropriate line the total inpatient days applicable to each of the indicated intensive care type inpatient units. Transfer these inpatient days from Worksheet S-3, Part I, column 6, lines 6 through 10, as appropriate.

Column 3--For each line, divide the total inpatient cost in column 1 by the total inpatient days in column 2 (rounded to two decimal places).

Column 4--Enter on the appropriate line the program days applicable to each of the indicated intensive care type inpatient hospital units. Transfer these inpatient days from Worksheet S-3, Part I, columns 3, 4, or 5, as appropriate, lines 6 through 10.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type unit days for the purpose of computing the intensive care type unit per diem. The days are included in column 2. However, count the program days as general routine days in computing program reimbursement. Enter the program days on line 9 and not in column 4, lines 43 through 47, as applicable. (See CMS Pub. 15-I, §2217.)

Column 5--Multiply the average cost per diem in column 3 by the program days in column 4.

Line 48--Enter the total program inpatient ancillary service cost from the appropriate Worksheet D-4, column 3, line 101.

Line 49--Enter the sum of the amounts on lines 41 through 48. When this worksheet is completed for components, neither subject to prospective payment, nor subject to the target rate of increase ceiling (i.e., "Other" box is checked), transfer this amount to Worksheet E-3, Part II, line 1 or Part III, column 1, line 1, as appropriate. Do not complete lines 50-59. **For all inclusive rate providers (Method E) apply the percentage to the sum of the aforementioned lines based on the provider type designated on Worksheet S-2, line 19 (see PRM 15-I, section 2208).** Lines 50-53--These lines compute total program inpatient operating cost less program capital-related, nonphysician anesthetists, and approved medical education costs. Complete these lines for all provider components.

Line 50--Enter on the appropriate worksheet the total pass through costs including capital-related costs applicable to program inpatient routine services. Transfer capital-related inpatient routine cost from Worksheet D, Part I, columns 10 and 12, sum of lines 25 through 30 and line 33 for the hospital, and line 31 for the subprovider. Add that amount to the other pass through costs from Worksheet D, Part III, column 8, sum of lines 25 through 30 and line 33 for the hospital, and line 31 for the subprovider.

Line 51--Enter the total pass through costs including capital-related costs applicable to program inpatient ancillary services. Transfer capital-related inpatient ancillary costs from Worksheet D, Part II, sum of columns 6 and 8, line 101. Add that amount to the other pass through costs from Worksheet D, Part IV, column 7, line 101.

Line 52--Enter the sum of lines 50 and 51.

Line 53--Enter total program inpatient operating cost (line 49) less program capital-related, nonphysician anesthetists (if appropriate), and approved medical education costs (line 52).

Lines 54 through 59--Except for those hospitals specified below, all hospitals (and distinct part hospital units) excluded from prospective payment are reimbursed under cost reimbursement principles and are subject to the ceiling on the rate of hospital cost increases (TEFRA). (See 42 CFR 413.40.) The following hospitals are reimbursed under special provisions and, therefore, are not generally subject to TEFRA or prospective payment:

- o Hospitals reimbursed under approved State cost control systems (see 42 CFR 403.205 through 403.258);
- o Hospitals reimbursed in accordance with demonstration projects authorized under §402(a) of the Social Security Amendments of 1967 or §222(a) of the Social Security Amendments of 1972; and
- o Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

For your components subject to the prospective payment system or not otherwise subject to the rate of increase ceiling as specified above, make no entries on lines 54 through 59.

NOTE: A new non-PPS hospital or subprovider (Lines 34 and/or 35 of Worksheet S-2 with a “Y” response) is cost reimbursed for all cost reporting periods through the end of its first 12 month cost reporting period. The 12 month cost reporting period also becomes the TEFRA base period unless an exemption under 42 CFR 413.40 (f) is granted. If such an exemption is granted, cost reimbursement continues through the end of the exemption period. The last 12 month period of the exemption is the TEFRA base period. For cost reporting periods beginning on or after October 1, 1997, new providers will be paid the lower of their inpatient operating costs per case or 110 percent of the national median of the target amounts for similar provider types.

Line 54--Enter the number of program discharges including deaths (excluding newborn and DOAs) for the component from Worksheet S-3, Part I, columns 12 through 14 (as appropriate), lines 12 and 14 (as appropriate). A patient discharge, including death, is a formal release of a patient.

Line 55--Enter the target amount per discharge as obtained from your intermediary. The target amount establishes a limitation on allowable rates of increase for hospital inpatient operating cost. The rate of increase ceiling limits the amount by which your inpatient operating cost may increase from one cost reporting period to the next. (See 42 CFR 413.40.)

Line 56--Multiply the number of discharges on line 54 by the target amount per discharge on line 55 to determine the rate of increase ceiling.

Line 57--Subtract line 53 from line 56 to determine the difference between adjusted inpatient operating cost and the target amount.

Line 58 through 58.04--This line provides incentive payments when your cost per discharge for the cost reporting period subject to the ceiling is less than the applicable target amount per discharge. In addition, for cost reporting periods beginning on or after October 1, 1997, bonus payments are provided for hospitals who have received PPS exempt payments for three or more previous cost reporting periods and whose operating costs are less than the target amount, expected costs (lesser of actual costs or the target amount for the previous year), or trended costs (lesser of actual operating costs or the target amount in 1996; or for hospitals where its third full cost reporting period was after 1996 the inpatient operating cost per discharge), updated and compounded by the market basket. It also provides for an adjustment when the cost per discharge exceeds the applicable target amount per discharge. If line 57 is zero, enter zero on lines 58 through 58.04. New providers skip lines 58 through 58.04 and go to line 59.

Line 58--If line 57 is a positive amount (actual inpatient operating cost is less than the target amount), enter on line 58 the lesser of 50 percent of line 57 or 5 percent of line 56. For cost reporting periods beginning on or after October 1, 1997, the percentages are 15 percent and 2 percent (3 percent for cost reporting periods beginning on or after October 1, 2000 **for psychiatric hospital/subprovider only (see BIPA §306)**) respectively. If line 57 is a negative amount (actual inpatient operating cost is greater than the target amount) for cost reporting periods beginning prior to October 1, 1997, enter on line 58, the lesser of 50 percent of the absolute value of line 57 or 10 percent of line 56. For cost reporting periods beginning on or after October 1, 1997, do not complete

line 58 (leave blank) and complete line 58.04 for calculation of any adjustments to the operating costs when line 57 is negative.

Line 58.01--Starting with the first full cost reporting period and counting forward, enter from the third full cost reporting period the lesser of the hospital's inpatient operating cost per discharge (line 53/line 54) or line 55, updated and compounded by the market basket for each year through the current reporting year. If the third full cost reporting period ended during or before the Federal fiscal year 1996 use the amounts from fiscal year 1996. For hospitals where its third full cost reporting period ended in the Federal fiscal year 1997 or subsequent fiscal period enter the inpatient operating cost per discharge updated and compounded by the market basket for each year through the current reporting year.

Line 58.02--Enter from the prior year cost report, the lesser of the hospital's inpatient operating cost per discharge (line 53/line 54) or line 55, updated by the market basket.

Line 58.03--If (line 53/line 54) is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50 percent of the amount by which operating costs (line 53) are less than expected costs (line 54 times line 58.02), or 1 percent of the target amount (line 56); otherwise enter zero.

Line 58.04--If line 57 is a negative amount (actual inpatient operating cost is greater than the target amount) and line 53 is greater than 110 percent of line 56, enter on this line the lesser of (1) or (2): (1) 50 percent of the result of (line 53 minus 110 percent of line 56) or (2) 10 percent of line 56; otherwise enter zero.

Line 59--For cost reporting periods beginning prior to October 1, 1997, enter the sum of lines 52 and 58 plus the lesser of line 53 or line 56. For cost reporting periods beginning on or after October 1, 1997, if line 57 is a positive amount, enter the sum of lines 52, 53, 58 and 58.03 (if applicable). If line 57 is a negative amount enter the sum of lines 52, 56, and 58.04. If line 57 is zero, enter the sum of lines 52 and 56. New providers enter the lesser of lines 53 or 56 plus line 52. TEFRA providers, except cancer and children's hospitals, for services rendered on and after October 1, 1997, are required to reduce capital to 85 percent of reported costs. To recalculate line 52, for cost reporting periods that overlap the October 1, 1997 effective date, multiply the capital pass through costs included on lines 50 and 51 of Worksheet D, **Parts I and II**, by the ratio of days on and after October 1, 1997, to total days for the period. Multiply that result by 85 percent and add to that 100 percent of the ratio of days prior to October 1, 1997, to total days applied to the capital pass through amount. For cost reporting periods beginning on or after October 1, 1997, multiply the capital amount reported on lines 50 and 51 by 85 percent. Add the result of the 85 percent of capital to the non capital pass through costs included on lines 50 and 51 (10/97).

Line 60--Enter the amount of Medicare swing bed-SNF type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-SNF type inpatient days on line 10 by the rate used on line 17. For CAH multiply line 10 times the per diem calculated on line **38 (12/21/00b)**.

Line 61--Enter the amount of Medicare swing bed-SNF type inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-SNF type inpatient days on line 11 by the rate used on line 18. For CAH multiply line **11** times the per diem calculated on line **38 (12/21/00b)**.

Line 62--Enter the sum of lines 60 and 61. Transfer this amount to the appropriate Worksheet E-2, column 1, line 1.

Line 63--Enter the amount of titles V or XIX swing bed-NF type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-NF type inpatient days on line 12 by the rate used on line 19.

Line 64--Enter the amount of titles V or XIX swing bed-NF type inpatient routine cost for the period

after December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-NF type inpatient days on line 13 by the rate used on line 20.

Line 65--Enter the sum of lines 63 and 64. Transfer this amount to the appropriate Worksheet E-2, column 1, line 2. **If your state recognizes only one level of care obtain the amount from line 62.**

3622.3 Part III - Skilled Nursing Facility, Other Nursing Facility, and Intermediate Care Facility/Mental Retardation Only--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX and the application of a limitation on reimbursable cost for these provider components. If the hospital-based SNF elects reimbursement under PPS for cost reporting periods beginning prior to July 1, 1998, complete lines 66 through 70 for data purposes only. For cost reporting periods beginning on or after July 1, 1998, complete lines 66 through 82 for data purposes only. When this worksheet is completed for a component, show both the hospital and component numbers. Any reference to the nursing facility will also apply to the intermediate care facility/mental retardation unit.

NOTE: If you have made a swing bed election for your certified SNF and hospital complex, do not complete this part for the SNF (Worksheet S-2, line 29 response is "Y"). Treat all the days and costs as swing bed days and costs and include them with the hospital. (See CMS Pub. 15-I, §2230.9B.)

Line Descriptions

Line 66--Enter the SNF or other nursing facility routine service cost from Part I, line 37.

Line 67--Determine the adjusted general inpatient routine service cost per diem by dividing the amount on line 66 by inpatient days, including private room days, shown on Part I, line 2.

Line 68--Determine the routine service cost by multiplying the program inpatient days, including the private room days in Part I, line 9, by the per diem amount on line 67.

Line 69--Determine the medically necessary private room cost applicable to the program by multiplying the days shown in Part I, line 14 by the per diem in Part I, line 35.

Line 70--Add lines 68 and 69 to determine the total program general inpatient routine service cost.

Line 71--Enter the capital-related cost allocated to the general inpatient routine service cost center. For title XVIII, transfer this amount from Worksheet B, sum of Parts II and III, column 27, line 34 (SNF). For titles V and XIX, transfer this amount from Worksheet B, sum of Parts II and III, column 27, line 35 (NF).

Line 72--Determine the per diem capital-related cost by dividing the amount on line 71 by the days in Part I, line 2.

Line 73--Determine the program capital-related cost by multiplying line 72 by the days in Part I, line 9.

Line 74--Determine the inpatient routine service cost by subtracting line 73 from line 70.

Line 75--Enter the aggregate charges to beneficiaries for excess costs obtained from your records.

Line 76--Enter the total program routine service cost for comparison to the cost limitation. Obtain this amount by subtracting line 75 from line 74.

NOTE: If you are a new provider not subject to the inpatient routine service cost per diem limitation, do not complete lines 77 and 78. (See 42 CFR 413.30(e)(2).)

Line 77--Enter the inpatient routine service cost per diem limitation. This amount is provided by your intermediary. This information is no longer required for cost reporting periods beginning on or after July 1, 1998.

Line 78--Enter the inpatient routine service cost limitation. Obtain this amount by multiplying the number of inpatient days shown on Part I, line 9 by the cost per diem limitation on line 77. This computation is no longer required for cost reporting periods beginning on or after July 1, 1998.

Line 79--Enter the amount of reimbursable inpatient routine service cost determined by adding line 73 to the lesser of line 76 or line 78. If you are a new provider not subject to the inpatient routine service cost limit, enter the sum of lines 73 and 76. For title XVIII, for cost reporting periods beginning on or after July 1, 1998, enter the amount from line 70.

Line 80-- Enter the program ancillary service amount from Worksheet D-4, column 3, line 101.

Line 81--Enter (only when Worksheet D-1 is used for a hospital-based SNF and NF) the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees to an SNF and/or NF. Include the amount eliminated from total costs on Worksheet A-8. If the utilization review costs are for more than one program, the sum of all the Worksheet D-1 amounts reported on this line must equal the amount adjusted on Worksheet A-8.

Line 82--Enter the total program inpatient operating cost by adding the amounts on lines 79 through 81. Transfer this amount to the appropriate Worksheet E-3, Part II, line 1 except for SNFs participating in the NHCQM demonstration and SNFs with cost reporting periods beginning on or after July 1, 1998. For NF and ICF/MR, transfer this amount to Worksheet E-3, Part III, column 1, line 1 for titles V and XIX.

3622.4 Part IV - Computation of Observation Bed Pass Through Cost--This part provides for the computation of the total observation bed costs and the portion of costs subject to reimbursement as a pass through cost for observation beds that are in the general acute care routine area of the hospital and/or subprovider. A separate computation must be made if a subprovider is claiming observation bed costs. For title XIX, insert the amount calculated for title XVIII for the hospital and subprovider, if applicable. To avoid duplication of reporting observation bed costs, do not transfer the title XIX amount to Worksheet C.

Line 83--Enter the total observation bed days from your records. Total observation days for the hospital and subprovider (if applicable) should equal the days computed on Worksheet S-3, Part I, column 6, line 26.

Line 84--Enter the result of general inpatient routine cost on line 27 divided by line 2.

Line 85--Multiply the number of days on line 83 by the cost on line 84 and enter the result. Transfer this amount to Worksheet C, Parts I and II, column 1, line 62. When transferring the amount to Worksheet C, be sure to combine with the subprovider if applicable.

Lines 86 through 89--These lines compute the observation bed costs used to apportion the routine pass through costs and capital-related costs associated with observation beds for PPS and TEFRA providers.

Column 1--For line 86, transfer the amount from Worksheet D, Part I, column 1, line 25 for the hospital and line 31 for the subprovider, if applicable. For line 87, transfer the amount from Worksheet D, Part I, column 4, line 25 or line 31. For lines 88 and 89, enter on each line the cost from Worksheet D, Part III, columns 1 and 2 and subscripts respectively, line 25 or line 31. Subscript line 89 to agree with Worksheet D, Part III, columns 2, 2.01 and 2.02 (01/00).

Column 2--Enter on each line the general inpatient routine cost from line 27. Enter the same amount on each line.

Column 3--Divide column 1 by column 2 for each line, and enter the result. If there are no costs in column 1, enter 0 in column 3.

Column 4--Enter the total observation cost from line 85 on each line. Enter the same amount on each line.

Column 5--Multiply the ratio in column 3 by the amount in column 4. Use this cost to apportion routine pass through costs associated with observation beds on Worksheet D, Parts II and IV.

Transfer the amount in column 5:

<u>From</u>	<u>To</u>	<u>To</u>
<u>Wkst. D-1, Part IV</u>	<u>Wkst. D, Part II</u>	<u>Wkst D, Part IV</u>
Col. 5, line 86	Col. 1, line 62	
Col. 5, line 87	Col. 2, line 62	
Col. 5, line 88		Col. 1, line 62
Col. 5, line 89 and subscripts		Col. 2, line 62 and subscripts

Columns 8, 9, and 10--Multiply the average cost per day in column 4 by the health care program days in columns 5, 6, and 7, respectively. Enter the resulting amounts in columns 8, 9, and 10, as appropriate, for each cost center.

Outpatient

Column 3--Enter the total charges applicable to each outpatient service area. Obtain the total charges from Worksheet C, Part I, column 8, lines 60 through 63.

Column 4--Compute the total outpatient cost to charge ratio by dividing costs in column 2 by charges in column 3 for each cost center.

Columns 5, 6, and 7--Enter in these columns program charges for outpatient services. Do not include in Medicare charges any charges identified as MSP/LCC.

Titles V and XIX

<u>Description</u>	Enter in col. 5 for title V or col. 7 for title XIX	<u>Sum of</u>	
		<u>Worksheet D-4, col. 2</u>	<u>Worksheet D, Part V, sum of cols. 2-5 & 5.02</u>
Clinic	line 20	line 60	line 60
Emergency	line 21	line 61	line 61
Observation Beds	line 22	line 62	line 62
Other Outpatient	line 23	line 63	line 63

Title XVIII

<u>Description</u>	<u>From</u>		<u>Less Part A Only Charges</u>
	<u>Worksheet D-4, Column 6, col. 2</u>	<u>Worksheet D, Part V, cols. 2-5 & 5.02</u>	
Clinic	line 20	line 60	plusline 60 minus From
Emergency	line 21	line 61	plusline 61 minus Provider
Observation Beds	line 22	line 62	plusline 62 minus Records
Other Outpatient	line 23	line 63	plusline 63 minus

NOTE: Submit a reconciliation worksheet with the cost report showing the computations used for the charges for column 6.

If you have subproviders, the amounts entered in these columns are the sum of the hospital and subprovider Worksheets D-4 and D, Part V.

Columns 8, 9, and 10--Compute program outpatient costs for titles V and XIX and title XVIII, Part B cost by multiplying the cost to charge ratio in column 4 by the program outpatient charges in columns 5, 6, and 7. Enter the resulting amounts in columns 8, 9, and 10, as appropriate, for each cost center.

Transfer program expenses.

From Title V (Column 8)/Title XIX (Column 10)

Hospital: Sum of lines 9 and 24 TO Worksheet E-3, Part III, line 3

Subprovider: line 10 TO Worksheet E-3, Part III, line 3

Other Nursing Facility: line 13 TO Worksheet E-3, Part III, line 3

From Title XVIII (Column 9) (only if Part II is not utilized)

Hospital: Sum of lines 9 and 24 TO Worksheet E, Part B, line 2

Subprovider: line 10 TO Worksheet E, Part B, line 2

Skilled Nursing Facility: line 12 TO Worksheet E, Part B, line 2

3623.2 Part II - In Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only).--Do not complete this section unless you qualify for the exception for graduate medical education payments in 42 CFR 413.86(e)(4)(I). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicare beneficiaries who have Part B coverage and are not entitled to benefits under Part A. (See CMS Pub. 15-I, chapter 4, and §2120.)

Column 1--Enter the amounts allocated in the cost finding process to the indicated cost centers. Obtain these amounts from Worksheet B, Part I, sum of the amounts in columns 22 and 23, as adjusted for any post stepdown adjustments applicable to interns and residents in approved teaching programs.

Column 2--Enter the adjustment for interns and residents costs applicable to swing bed services but allocated to hospital routine cost. Compute these amounts as follows:

Swing Inpatient = Bed Amount	Interns and Residents Costs Allocated to Adults & Pediatrics	Total Swing Bed Divided Days By	Total Days
For line 27 (SNF)	Wkst. D-2, col. 1, line 26	Wkst. D-1, sum of lines 5 and 6	Wkst. D-1, line 1
For line 28 (NF)	Wkst. D-2, col. 1, line 26	Wkst. D-1, sum of lines 7 and 8	Wkst. D-1, line 1

The amount subtracted from line 26 must equal the sum of the amounts computed for lines 27 and 28.

If you have swing beds in your subprovider, subscript line 35 into 35.01 and 35.02 to adjust for swing bed costs. Compute the swing bed amounts as explained above except that the interns and residents costs allocated to adults and pediatrics (line 35) comes from Worksheet D-2, column 1, line 35. The amount subtracted from line 35 must equal the sum of the subscripted lines (35.01 and 35.02).

on a reasonable cost basis. Other hospitals that excise organs for transplant are no longer paid for this activity directly by Medicare. They must receive payment from the organ procurement organization (OPO) or CTC. Therefore, hospitals which are not CTCs do not have any program reimbursable costs or charges for organ acquisition services. CTCs complete Worksheet D-6 for all organ acquisition costs.

Line 45--Enter the program charges for your clinical laboratory tests for which you reimburse the pathologist. See the instructions for Worksheet A (see §3610) for a more complete discussion on the use of this cost center.

NOTE: Since the charges on line 45 are also included on line 44, laboratory, you must reduce total charges to prevent double counting. Make this adjustment on line 102.

Line 56--Enter only the program charges for drugs charged to patients that are not paid a predetermined amount.

Lines 60 through 63--Use these lines for outpatient service cost centers.

NOTE: For lines 60 and 63, any ancillary service billed as clinic, RHC, or FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology - diagnostic, PBP clinical lab services - program only.

Lines 62 and/or 62.01, observation beds, are completed for services received subsequent to admission, where applicable, for all hospitals, i.e., acute care hospitals, freestanding rehabilitation hospitals, psychiatric hospitals, etc. In a complex comprised of an acute care hospital with an excluded unit, the acute care hospital reports the observation bed costs. Subproviders with separate provider numbers from the main hospital (no alpha character in the provider number) may report observation bed costs if a separate outpatient department is maintained within the subprovider unit.

Lines 66 and 67--Do not enter program charges for oxygen rented or sold, because, effective with services rendered on or after June 1, 1989, the fee schedule applies.

Line 102--Enter in column 2 program charges for your clinical laboratory tests when the physician bills you for program patients only. Obtain this amount from line 45.

Line 103--Enter in column 2 the amount on line 101 less the amount on line 102.

Transfer the amount in column 2, line 103, as follows.

For title XVIII, Part A (other reimbursement), transfer the amount to Worksheet E-3, Part II, line 8. Do not transfer this amount if you are reimbursed under PPS or TEFRA. No transfers of swing bed charges are made to Worksheet E-2 since no LCC comparison is made. For titles V and XIX (if not a PPS provider), transfer the amount plus the amount from Worksheet D, Part V, column 5, line 103, to Worksheet E-3, Part III, column 1, line 11.

NOTE: If the amount on line 103 includes charges for professional patient care services of provider-based physicians, eliminate the amount of the professional component charges from the total charges and transfer the net amount as indicated. Submit a schedule showing these computations with the cost report.

Column 3--Multiply the indicated program charges in column 2 by the ratio in column 1 to determine the program inpatient expenses.

Transfer column 3, line 101, as follows:

Type of Provider

TO

Hospital

Wkst. D-1, Part II, col. 1, line 48

Subprovider

Wkst. D-1, Part II, col. 1, line 48

SNF

Wkst. D-1, Part III, col. 1, line 80

NF

Wkst. D-1, Part III, col. 1, line 80

Swing Bed-SNF

Wkst. E-2, col. 1, line 3

Swing Bed-NF

Wkst. E-2, col. 1, line 3

3625. WORKSHEET D-6 - COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS

Only certified transplant centers (CTCs) are reimbursed directly by the Medicare program for organ acquisition cost. This worksheet provides for the computation and accumulation of organ acquisition costs and charges for CTCs. Check the appropriate box to determine which organ acquisition cost is being computed. Use a separate worksheet for each type of organ.

Hospitals that are not CTCs are not reimbursed by the Medicare program for organ acquisition costs and do not complete this worksheet. Such hospitals have to obtain revenue by the sale of any organs excised to an organ procurement organization (OPO) or CTC.

Worksheet D-6 consists of the following four parts:

- Part I - Computation of Organ Acquisition Cost (Inpatient Routine and Ancillary Services)
- Part II - Computation of Organ Acquisition Cost (Other than Inpatient Routine and Ancillary Service Costs)
- Part III - Summary of Costs and Charges
- Part IV - Statistics

3625.1 Part I - Computation of Organ Acquisition Costs (Inpatient Routine and Ancillary Services).--

Lines 1 through 7--These lines provide for the computation of inpatient routine service costs applicable to organ acquisition and for the accumulation of inpatient routine service charges for organ acquisition.

Column 1--Enter on lines 1 through 6, as appropriate, the inpatient routine charges applicable to organ acquisition. Enter on line 7 the sum of the amounts reported on lines 1 through 6.

Column 2--Enter on lines 1 through 6, as appropriate, the average per diem cost from Worksheet D-1:

<u>Description</u>	<u>To Worksheet D-6, Part I, Col. 2</u>	<u>From Worksheet D-1, Part II</u>
Adults & Pediatrics	line 1	col. 1, line 38
Intensive Care	line 2	col. 3, line 43
Coronary Care	line 3	col. 3, line 44
Burn Intensive Care Type Unit	line 4	col. 3, line 45
Surgical Intensive Care Type Unit	line 5	col. 3, line 46
Other Intensive Care Type Unit	line 6	col. 3, line 47

Column 3--Enter from your records on lines 1 through 6, as appropriate, total organ acquisition days (Medicare and non-Medicare). An organ acquisition day is an inpatient day of care rendered to an organ donor patient who is hospitalized for the surgical removal of an organ for transplant or a day of care rendered to a cadaver in an inpatient routine service area for the purpose of surgical removal of its organs for transplant. Enter on line 7 the sum of the days on lines 1 through 6.

Column 4--Enter on lines 1 through 6, as appropriate, the amount in column 2 multiplied by the amount in column 3. Enter on line 7 the sum of lines 1 through 6.

Lines 8 through 34--These lines provide for the computation of ancillary service cost applicable to organ acquisition. These lines also provide for the accumulation of inpatient and outpatient organ acquisition ancillary charges.

Column 1--Enter on lines 8 through 34 the "cost or other" cost to charges ratio from Worksheet C, Part I, column 9.

Column 2--Enter from your records inpatient and outpatient organ acquisition ancillary charges. Enter on line 35 the sum of lines 8 through 34.

Column 3--Enter on lines 8 through 34 the organ acquisition costs. Compute this amount by multiplying the ratio in column 1 by the amount in column 2 for each cost center. Enter on line 35 the sum of lines 8 through 34.

3625.2 Part II - Computation of Organ Acquisition Costs (Other Than Inpatient Routine and Ancillary Service Costs).--

Lines 36 through 41--Use these lines to apportion the cost of inpatient services attributable to organ acquisitions rendered in each of the inpatient routine areas by interns and residents not in an approved teaching program.

Column 1--Enter on the appropriate lines the average per diem cost of interns and residents not in an approved teaching program in each of the inpatient routine areas. Obtain these amounts from Worksheet D-2, Part I, column 4, lines as indicated.

Column 2--Enter the number of organ acquisition days in each of the inpatient routine areas from Part I, column 3, lines 1 through 6, as appropriate.

Column 3--Multiply the per diem amount in column 1 by the number of days in column 2 for each cost center.

Line 42--For columns 2 and 3, enter the sum of lines 36 through 41.

Lines 43 through 46--These lines provide for the computation of the cost of outpatient services attributable to organ acquisitions rendered in each of the outpatient service areas by interns and residents not in an approved teaching program.

Column 1--Enter on the appropriate lines the organ acquisition charges in each of the outpatient service areas. Obtain these amounts from Part I, column 2, lines 31 through 34, as appropriate.

Column 2--Enter the ratio of the outpatient costs of interns and residents not in an approved teaching program to the hospital outpatient service charges in each of the outpatient service areas. Obtain these ratios from Worksheet D-2, Part I, column 4, lines as indicated.

Column 3--Multiply the charges in column 1 by the ratios in column 2 for each cost center. Enter the sum of lines 43 through 46 on line 47.

Compute the average cost of organ acquisition by dividing the total cost of organ acquisition (including the inpatient routine service costs and the inpatient ancillary service costs applicable to organ acquisition) by the total number of organ transplanted into all patients and furnished to others. If the average cost cannot be determined in the manner described, then use the appropriate standard organ acquisition charge in lieu of the average cost.

Line 59--Enter line 53 minus line 58.

For All Organ Acquisitions

Line 60--Enter in all columns the total amount of organ acquisition charges billed to Medicare under Part B. This occurs when organs are transplanted into Medicare beneficiaries who, on the day of transplantation, are not entitled to Part A benefits. This computation reflects an adjustment between Medicare Part A and Part B costs and charges so that the amount added under Part B is the same amount subtracted under Part A.

Line 61--For columns 1 and 3 subtract line 60 from line 59. For columns 2 and 4 transfer that amount from line 60.

3625.4 Part IV - Statistics--

Lines 62 through 76--The data entered are data applicable to living donors (column 1) and cadaveric donors (column 2). Use column 1 (living related) for kidney, partial liver, and partial lung transplants. If you complete this worksheet for hearts, pancreases, intestines, whole livers, or whole lungs do not complete column 1.

Line 66--Enter the sum of lines 62 through 65.

Lines 67 through 74--Enter in columns 1 and 2 the appropriate number of organs sold (or transplanted). Enter in column 3 the revenue applicable to organs furnished to other providers, organ procurement organizations and others, and for organs transplanted into non-Medicare patients. Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicare patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered on these lines must also include an amount representing the acquisition cost of the organs transplanted into such patients. Determine this amount by multiplying the average cost of organ acquisition by the number of organs transplanted into non-Medicare patients not liable for payment on a charge basis.

Compute the average cost of organ acquisition by dividing the total cost of organ acquisition (including the inpatient routine service costs and the inpatient ancillary service costs applicable to organ acquisitions) by the total number of organs transplanted into all patients and furnished to others. If the average cost cannot be determined in the manner described, then use the appropriate standard organ acquisition charge in lieu of the average cost.

Line 75--Enter in columns 1 and 2 the applicable number of unusable organs.

Line 76--Enter the sum of lines 67 through 75. These totals equal the totals on line 66, columns 1 and 2.

3626. WORKSHEET D-9 - APPORTIONMENT OF COST FOR SERVICES OF TEACHING PHYSICIANS

This worksheet provides for the computation of the RCE limit by medical specialty and for the apportionment of reimbursable adjusted cost to titles V, XVIII, and XIX for the direct medical and surgical services, including the supervision of interns and residents, rendered by physicians to patients in a teaching hospital which makes the election described in CMS Pub. 15-I, §2148.

NOTE: Do not complete this worksheet for an RPCH/CAH component.

If such election is made, direct medical and surgical services to program patients, including supervision of interns and residents, rendered in a teaching hospital by physicians on the hospital staff are reimbursable as provider services on a reasonable cost basis. In addition, certain medical school costs may be reimbursed. Payments for services donated by volunteer physicians to program patients are made to a fund designated by the organized medical staff the teaching hospital or medical school.

Limits on the amount of physician compensation which may be recognized as a reasonable provider cost are imposed in accordance with 42 CFR 405.482.

Worksheet D-9 consists of two parts:

- Part I - Reasonable Compensation Equivalent Computation
- Part II - Apportionment of Cost for the Services of Teaching Physicians

3626.1 Part I - Reasonable Compensation Equivalent Computation--This part provides for the computation of the RCE limit by medical specialty of the physician on the hospital staff or physician on the medical school faculty. Complete separate parts for the hospital staff physicians and for physicians on the medical staff faculty. This part must be completed by applicable hospitals.

42 CFR 405.482(a)(2) provides that limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services paid for under the prospective payment system. (See 42 CFR Part 412.)

Limits established under this section apply to inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40), outpatient services for all titles, and to title XVIII, Part B inpatient services.

42 CFR 405.465 provides for the reimbursement of direct medical and surgical services to patients, including supervision of interns and residents, rendered in a teaching hospital by physicians on the faculty of a medical school where the hospital exercises the election as provided in 42 CFR 405.521.

Where several physicians work in the same specialty, see CMS Pub. 15-I, §2182.6C for a discussion of applying the RCE limit in the aggregate for the specialty versus on an individual basis to each of the physicians in the specialty.

When RCE limits are applied on an individual basis to each physician in a medical specialty, prepare a supporting worksheet identical in columnar format to Worksheet D-9, Part I, for each medical specialty. Enter on the first line under columns 1 and 9 the line number applicable to the medical specialty (as displayed on Worksheet D-9, Part I). Enter the name of the medical specialty.

Line 3--Enter the result obtained by dividing the cost of services on line 1 by the sum of the days on line 2 for each category of physicians.

Lines 4 through 13--Enter in column 1, on the appropriate line, the reimbursable days and outpatient visit days for titles V, XVIII, and XIX for the applicable component of the health care complex. Lines 10, 11, 12, and 13 contain the total of the title XVIII organ acquisition days and outpatient visit days. Enter in column 2 the same number of days as entered in column 1. Compute these days from your records in the manner described in CMS Pub. 15-I, §2218.C.

Lines 14 through 23--Enter on the appropriate line the result of multiplying the days entered on lines 4 through 13 by the average cost per diem from line 3. Enter the total of columns 1 and 2 in column 3 for each line. The total becomes a part of the reimbursement settlement through the transfers denoted on this worksheet.

Worksheet E, Parts A and B, calculate title XVIII settlement for inpatient hospital services under PPS and title XVIII (Part B) settlement for medical and other health services. Worksheet E, Parts C, D, and E, calculate (for titles V, XVIII, and XIX) settlement for outpatient ambulatory surgery, radiology, and other diagnostic procedures. Worksheet E-3 computes title XVIII, Part A settlement for non-PPS hospitals, settlements under titles V and XIX, and settlements for title XVIII SNFs reimbursed under a prospective payment system.

Worksheet E consists of the following five parts:

- Part A - Inpatient Hospital Services Under PPS
- Part B - Medical and Other Health Services
- Part C - Outpatient Ambulatory Surgical Center
- Part D - Outpatient Radiology Services
- Part E - Other Outpatient Diagnostic Procedures

Application of Lesser of Reasonable Cost or Customary Charges.--Worksheet E, Parts B, C, D, and E, allow for the computation of the lesser of reasonable costs or customary charges (LCC) for services covered under Part B. Make a separate computation on each of these worksheets. In addition, make separate computations to determine whether the services on any or all of these worksheets are exempt from LCC. For example, the provider may meet the nominality test for the services on Worksheet E, Parts B and C only and, therefore, be exempt from LCC only for these services.

For those provider Part B services exempt from LCC for this reason, reimbursement for the affected services is based on 80 percent of reasonable cost net of the Part B deductible amounts.

3630.1 Part A - Inpatient Hospital Services Under PPS.--

NOTE: For SCH/MDH status change and/or geographical reclassification (see 42 CFR 412.102/103) subscript column 1 for lines 1-2, 3.21-3.24, 4.03-4.04, and 5-6. (9/30/96)

Enter on lines 1 through 5 in column 1 the applicable payment data for the period applicable to SCH status. Enter on lines 1 through 5 in column 1.01 the payment data for the period in which the provider did not retain SCH status. The data for lines 1 through 5 must be obtained from the provider's records or the PS&R. Enter on line 7, column 1, hospital-specific rate payments. (See instructions for line 7.) Enter on line 8, column 1, the greater of the amounts from column 1, line 6 or line 7, plus the amount in column 1.01, line 6.

Line Descriptions

Line 1--The amount entered on this line is computed as the sum of the Federal portion (DRG payment) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. Beginning October 1, 1997, the formula for calculating indirect medical education will be modified annually beginning October 1 of each year through October 1, 2001. To accommodate the change in the formula it is necessary to subscript line 1. On line 1 enter the payments for discharges occurring prior to October 1. (See the asterisks (*) below for any exceptions to the reporting of these payments.) If you answered yes to question

21.02 on Worksheet S-2, subscript column 1 and report the payments before the reclassification in column 1.01 and on or after the reclassification in column 1. For discharges occurring on or after

April 1, 2001 through September 30, 2001 a modification has been made to the IME formula. See line 1.07 and 1.08 for identifying payments made on or after that date.

Line 1.01--Enter the payment for discharges occurring on or after October 1 and before January 1.

Line 1.02--Enter the payments for discharges occurring on or after January 1.

The chart below provides guidance for reporting the payments for each of the lines identified above for each fiscal year including the potential for a 13 month cost report:

Cost reporting ending month	Line 1	Line 1.01	Line 1.02	Line 1.07
October *	10/1-10/31	11/1-12/31	1/1-(3/31)(9/30)	4/1-9/30
November*	10/1-11/30	12/1-12/31	1/1-(3/31)(9/30)	4/1-9/30
December**	1/1-(3/31)(9/30)	10/1-12/31		4/1-9/30
January	2/1-(3/31)(9/30)	10/1-12/31	1/1-1/31	4/1-9/30
February	3/1-(3/31)(9/30)	10/1-12/31	1/1-2/28/29	4/1-9/30
March		10/1-12/31	1/1-3/31	4/1-9/30
April	5/1-9/30	10/1-12/31	1/1-(3/31)(4/30)	4/1-4/30
May	6/1-9/30	10/1-12/31	1/1-(3/31)(5/31)	4/1-5/31
June	7/1-9/30	10/1-12/31	1/1-(3/31)(6/30)	4/1-6/30
July	8/1-9/30	10/1-12/31	1/1-(3/31)(7/31)	4/1-7/31
August	9/1-9/30	10/1-12/31	1/1-(3/31)(8/31)	4/1-8/31
September*		10/1-12/31	1/1-(3/31)(9/30)	4/1-9/30

* Twelve month cost reporting periods that end in October and November or a 13 month cost reporting period which ends on these months must report payments for the ending months of October and November on line 1.

** A 13 month cost report that ends January 31 must report the payments for the 13th month (January 1- January 31) on line 1.02.

For short period cost reports, base the input of payment as if it was a 12 month cost report from the beginning date. Be sure lines 1 through 1.02, 1.03 through 1.05, and 3.21 through 3.23 reflect the same time period and the appropriate adjustment factor (10/97).

Hospitals receive payments for indirect medical education for managed care patients beginning January 1, 1998. Therefore, further subscripts are required to report the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture in conjunction with the PPS PRICER the simulated payments. Only a specified percentage of the simulated payment is allowed to be included, i.e., 20 percent for January 1, 1998, 40 percent for January 1, 1999, 60 percent for January 1, 2000, 80 percent for January 1, 2001, and 100 percent thereafter. (See the chart and exceptions identified with asterisks (*) (**)) above before reporting these payments on the lines below.)

Line 1.03--Enter the total managed care "simulated payments" from the PS&R prior to March 31 or October 1. Complete line 1.08 for cost reports that overlap April 1, 2001.

Line 1.04--Enter the total managed care "simulated payments" from the PS&R from October 1 and before January 1.

Line 1.05--Enter the total managed care "simulated payments" from the PS&R on or after January 1 but before April 1/October 1. Complete line 1.08 for cost reports that overlap April 1, 2001.

Line 1.06--If you answered "yes" to line 55 of Worksheet S-2, and you did not receive the add-on payment during the year, report the additional amount eligible in accordance with CFR 412.107 on line 1.06 by multiplying the sum of lines 1 through 2.01 by .5 percent for fiscal years ending in the government's fiscal year end 1998 and .3 percent for 1999. If lines 1 through 2.01 reflect payment and you are no longer eligible, multiply that amount by .995025 for 1998 and .997024 for 1999 and subtract that result from the sum of lines 1 through 2.01 and enter the result as a negative.

Line 1.07--Enter the payment for discharges occurring on or after April 1, 2001 and before October 1, 2001.

Line 1.08--Enter the total managed care "simulated payments" from the PS&R on or after April 1, 2001 through September 30, 2001.

Line 2--Enter the amount of outlier payments made for PPS discharges during the period. See 42 CFR 412, Subpart F for a discussion of these items. Report only the outlier payments attributable to discharges occurring prior to October 1, 1997. Report on line 2.01 the outlier payments received for discharges occurring on and after October 1, 1997.

Indirect Medical Educational Adjustment--Calculate the amount of the additional payment relating to indirect medical education on lines 3 to 3.03. (See 42 CFR 412.105.) Calculate the IME adjustment only if you answered "yes" to line 25.01 on Worksheet S-2. For cost reporting periods ending on or before September 30, 1997, complete lines 3 to 3.03. For cost reporting periods which overlap October 1, 1997, and thereafter, skip lines 3.01 to 3.03 and complete lines 3, 3.04 to 3.24.

Line 3--Enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 2, line 12) by the number of days in the cost reporting period (365 or 366 in case of leap year). Do not include statistics associated with an excluded unit (subprovider).

NOTE: Reduce the bed days available by nursery days (Worksheet S-3, Part I, column 2, line 11), swing bed days (Worksheet S-3, Part I, column 6, sum of lines 3 and 4), and the number of observation days (Worksheet S-3, Part I, column 6, line 26).

Line 3.01--Enter the number of interns and residents from Worksheet S-3, Part I, column 9, line 12. (See 42 CFR 412.105(f) for counting FTE.)

Line 3.02--Enter the indirect medical education percentage ($1.89 \times \{(1 + \text{line } 3.01 / \text{line } 3)\}^{\text{line } 3.02}$ to the .405 power - 1).

Line 3.03--Multiply the percentage calculated on line 3.02 by the sum of lines 1 and 2 and subscripts.

Calculation of the adjusted cap in accordance with 42 CFR 412.105(f):

Line 3.04--Enter the FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. 42 CFR 412.105(f)(iv) Effective for discharges occurring on or after April 1, 2000, adjust this count for the 30 percent increase for qualified rural hospitals. For cost reporting periods beginning on or after November 29, 1999, adjust for any increases due to primary care residents that were on approved leaves of absence. (42 CFR 412.105(f)(1)(iv) and (xi) respectively)

Line 3.05--Enter the FTE count for allopathic and osteopathic programs which meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.86(g)(6). For hospitals qualifying for a cap adjustment under 42 CFR 413.86(g)(6)(i), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995. For hospitals qualifying for a cap adjustment under 42 CFR 413.86(g)(6)(ii), the cap for each new program accredited or begun on or after January 1, 1995 and before August 6, 1997, is effective in the fourth program year of each of those new programs (see 66 FR, August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTE's that were already included in the cap on line 3.04. Also enter here the allopathic or osteopathic FTE count for residents in all years of a rural track program that meet the criteria for an add-on to the cap under 42 CFR 412.105(f)(1)(x). (If the rural track program is a new program under 42 CFR 413.86(g)(12) and qualifies for a cap adjustment under 42 CFR 413.86(g)(6)(i) or (iii), do not report FTE residents in the rural track program on this line until the fourth program year. Report these FTEs on line 3.17).

Line 3.06--Enter the adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.86(b), (g)(4)(iv) and Vol. 64 *Federal Register*, page 26336, May 12, 1998.

Line 3.07--Enter the sum of lines 3.04 through 3.06. This is the adjusted cap.

Calculation of the allowable current year FTEs:

Line 3.08--Enter the FTE count for allopathic and osteopathic programs in the current year from your records for cost reporting periods beginning on or after October 1, 1997. Do not include residents in the initial years of the program. (42 CFR 412.105(f)(1)(iv) and/or (f)(1)(v).)

Lines 3.09 through 3.12 apply only to providers with cost reporting periods that overlap the October 1, 1997 effective date. Complete these lines in lieu of line 3.08. **For cost reporting periods beginning on or after October 1, 1997, do not complete these lines.** Do not include residents in the initial years of the program.

Line 3.09--For cost reporting periods beginning before October 1, enter the percentage of discharges to total discharges occurring prior to October 1. (10/97)

Line 3.10--For cost reporting periods beginning before October 1, 1997, enter the percentage of discharges to total discharges occurring on and after October 1. (10/97)

Line 3.11--Enter the FTE count net of dental and podiatry for the period identified in line 3.09. Use the actual count as if counting for the entire year, or what would have been reported on line 3.08. Do not include intern and residents in the initial years of the program 42 CFR 413.86(g)(5).

Line 3.12--Enter the FTE count net of dental and podiatry for the period identified in line 3.10. Use the actual count as if counting for the entire year, or what would have been reported on line 3.08. Do not include intern and residents in the initial years of the program 42 CFR 413.86(g)(5).

Line 3.13--Enter the FTE count for residents in dental and podiatric programs.

Line 3.14--Enter the result of the lesser of lines 3.07 or 3.08 added to line 3.13. If lines 3.09 through 3.12 are completed, enter the sum of (line 3.09 times line 3.11) plus the lesser of (line 3.10 times line 3.12) or (line 3.10 times line 3.07). Add that result to the amount on line 3.13.

Calculate the rolling average count for cost reporting periods beginning on or after October 1, 1997.

Line 3.15--Enter the total allowable FTE count from line 3.14 or line 3.01 of the prior year. Do not include residents in the initial years of the program. If you did not have any FTE's reported for this period but you did have an approved teaching program, enter a (1) in column 0. If you had no approved teaching program make no entry (10/97).

Line 3.16--Enter the total allowable FTE count for the penultimate year from line 3.14 if that year ended on or after September 30, 1997. If you did not have any FTE's reported for this period but you did have an approved teaching program, enter a (1) in column 0. If you had no approved teaching program make no entry. Do not include residents in the initial years of the program (42 CFR 413.86(g)(5)(v)). (10/97)

Line 3.17--Enter the sum of lines 3.14 through 3.16 and divide by the number of these lines greater than zero, unless a 1 is entered in column zero on lines 3.15 and 3.16 then count those lines. (See 42 CFR 413.86(g)(5).) Add to that result the number of FTE residents in the initial years of the program that meet the exception in 42 CFR 413.86(g)(5)(v) and (g)(6). Add to this amount any temporary adjustments for FTE residents that were displaced by program or hospital closure (42 CFR 412.105(f)(1)(ix)).

Line 3.18--Enter the current year resident to bed ratio. Line 3.17 divided by line 3.

Line 3.19--Enter from the prior year cost report the intern and resident to bed ratio (if the allopathic and osteopathic FTE residents were subject to the FTE cap in the prior year, add to the numerator the FTE residents in the initial years of the program from line 3.17 of that year) adjusted for the number of current year residents that meet the exception for new programs and affiliations in 42CFR413.86(g)(6) and (g)(4)(iv) respectively. **If the current year is the first cost reporting period in which a receiving hospital trains FTE residents displaced by the closure of another hospital or program, then also adjust the numerator of the prior year ratio for the number of current year FTE residents that meet the exception for residents that were displaced by hospital or program closure.** If no intern and resident to bed ratio was reported in the prior year, calculate the ratio using the FTE count for residents in the initial years of the new program. For prior year cost reporting periods ending prior to October 1, 1997, compute the ratio by dividing line 3.01 by line 3. For cost reporting periods beginning on or after October 1, 1997, compute the ratio by dividing line 3.14 by line 3.

Line 3.20--For cost reporting periods beginning on or after October 1, 1997, enter the lesser of lines 3.18 or 3.19.

IME adjustment calculation for hospitals with cost reporting periods beginning prior to October 1. The multiplier of the adjustment factor defined in 42 CFR 412.105(d) is changed every October 1st for discharges occurring on and after: October 1, 1996 - 1.89; October 1, 1997 - 1.72; October 1, 1998 - 1.6; October 1, 1999 - 1.60; October 1, 2000 – through March 31, 2001 - 1.54, April 1, 2001 through September 30, 2001 – 1.66; and, on or after October 1, 2001 through September 30, 2002 – 1.6; and on or after October 1, 2002 – 1.35.

For cost reporting periods that overlap April 1, 2001, an additional computation will be required for discharges occurring on or after April 1, 2001 through September 30, 2001. See line 3.24 below and the revised payment chart on page 36-137 for completion of line 3.24.

Line 3.21--For payments reported on lines 1 and 1.03, enter the result of the following: The appropriate multiplier of the adjustment factor for the payment period identified on line 1 times $\{(1 + \text{line 3.14}/\text{line 3}^*) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{sum of (the amount on line 1) + (line 1.03 times the appropriate percentage identified in the paragraph prior to line 1.03) + Line 2.}^{**}\}$

Line 3.22--For payments reported on lines 1.01 and 1.04, enter the result of the following: The appropriate adjustment factor for the payment period identified on line 1.01 times $\{(1 + \text{line 3.14}/\text{line 3}^*) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{line 1.01} + (\text{line 1.04 times the appropriate percentage identified in the paragraph prior to line 1.03})\}$.

Line 3.23--For payments reported on lines 1.02 and 1.05, enter the result of the following: The appropriate multiplier of the adjustment factor for the payment period identified on line 1.02 times $\{(1 + \text{line 3.14}/\text{line 3}^*) \text{ to the } .405 \text{ power} - 1\}$ times $(\text{line 1.02} + \text{line 1.05 times the appropriate percentage identified in the paragraph prior to line 1.03})$.

* For cost reporting periods beginning on or after October 1, 1997, replace $\{(\text{line 3.14 divided by line 3})(\text{adjust line 3.14 by the interns and residents in the initial years of the program})\}$ with the ratio reported on line 3.20. ** For discharges prior to October 1, 1997, only; do not include outliers for purposes of the IME calculation for discharges occurring on and after October 1, 1997.

Line 3.24--Enter the sum of lines 3.21 through 3.23. For cost reporting periods which overlap April 1, 2001 add to this result, the appropriate multiplier of the adjustment factor for the payment period identified on line 1.07 times $\{(1 + \text{line 3.14}/\text{line 3}^*) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{the sum of line 1.07} + (\text{line 1.08 times the appropriate percentage identified in the paragraph prior to line 1.03})\}$.

Disproportionate Share Adjustment.--Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on lines 4 through 4.04. Complete this portion only if you answered yes to line 21.01 of Worksheet S-2. For cost reporting periods which overlap January 20, 2000, do not complete lines 4 through 4.03 and enter on line 4.04 the manually calculated DSH payment adjusted by the appropriate reduction. **(See intermediary PM A-99-62 for proper determination of DSH adjustment.)** For those hospitals experiencing a change in the DSH percentage as a result of the application of the BIPA provisions effective for services on and after April 1, 2001, i.e., **geographic reclassification subscript column 1 for lines 1, 1.01, 1.02, 1.07, 4.03 and 4.04** apply the appropriate percentage for the DSH payment and reduction in accordance with the payment dates prescribed above. Review the payment chart on page 137 and lines 1, 1.01, 1.02 and 1.07 for proper reporting of payments. **Do not subscript the column for lines 4.03 and 4.04, except as applicable for geographic reclassification.**

Line 4--Enter the percentage of SSI recipient patient days to Medicare Part A patient days. (Obtain the percentage from your intermediary.)

Line 4.01--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12 minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

Line 4.02--Add lines 4 and 4.01 to equal the hospital's DSH patient percentage.

Line 4.03--Compare the percentage on line 4.02 with the criteria described in 42 CFR 412.106(c) and (d). Enter the percentage identified in the CFR to be applied against PPS payments.

Line 4.04--Multiply line 4.03 by the sum of lines 1, 1.01, 1.02 and 2 and enter the result. For discharges occurring on or after October 1, 1997, multiply line 4.03 by the sum of lines 1, 1.01, 1.02, and 1.07 only. Reduce that amount for discharges occurring on or after October 1, 1997, by 1 percent; 2 percent for October 1, 1998, 3 percent for October 1, 1999; **3 percent for October 1, 2000 through March 31, 2001**; 1 percent for April 1, 2001 through September 30, 2001; **3 percent for October 1, 2001 through September 30, 2002**; and **0 (zero) percent thereafter**. Review the payment chart on page 137 for the proper splitting of payments before and on or after October 1 and April 1 for those cost reports that overlap these dates in order to properly calculate the reduction.

High Percentage of ESRD Beneficiary Discharges Adjustment--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104.

Line 5--Enter total Medicare discharges reported on Worksheet S-3 excluding discharges for DRGs 302, 316, and 317 as reported on the PS&R or your records.

Line 5.01--Enter total ESRD Medicare discharges excluding DRGs 302, 316, and 317.

Line 5.02--Divide line 5.01 by line 5. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

Line 5.03--Enter the total Medicare ESRD inpatient days excluding DRGs 302, 316, and 317.

Line 5.04--Enter the average length of stay expressed as a ratio to 7 days. Divide line 5.03 by line 5.01 and divide the result by 7 days.

Line 5.05--Enter the average cost per dialysis treatment of \$335 (\$111.67 times the average number of treatments (3)).

Line 5.06--Enter the ESRD payment adjustment (line 5.04 times line 5.05 times line 5.01).

Line 6--Enter the sum of lines 1, 1.01, 1.02, **1.07**, 2, 2.01, 3.03 (for cost reporting periods which overlap October 1, 1997, and thereafter, substitute line 3.24 for line 3.03), 4.04 (subscripted columns), and 5.06. For cost reporting periods ending in the government's fiscal year ending in 1998 and 1999 and you answered yes to line 55 of Worksheet S-2, add to this sum the amount on line 1.06, if applicable.

Line 7--Sole community hospitals are paid the highest rate of the Federal payment rate, the hospital-specific rate determined based on a Federal fiscal year 1982 base period (see 42 CFR 412.73), or the hospital-specific rate determined based on a Federal fiscal year 1987 base period. (See 42 CFR 412.75.) Medicare dependent hospitals are paid the highest of the Federal payment rate, or the Federal rate plus 50 percent of the amount of the excess over the Federal rate of the higher of either the 1982 base period, or the 1987 base period hospital specific rate. For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments

For sole community hospitals only, the hospital-specific payment amount entered on this line is supplied by your fiscal intermediary. Calculate it by multiplying the sum of the DRG weights for the period (per the PS&R) by the final per discharge hospital-specific rate for the period. For new hospital providers established after 1987, do not complete this line. Use the higher of the hospital-specific rate based on cost reporting periods beginning in FY 1982 or FY 1987. Use the hospital-specific rate (operating cost per discharge divided by the case mix index for 1982 or 1987, as applicable) updated to the beginning of the cost reporting period and adjusted for budget neutrality, if applicable, in this calculation. For cost reporting periods beginning on or after October 1, 2000, in addition to the comparison of 1982 and 1987, hospitals can compare the hospital specific rate for cost reporting 2000, **with the hospital specific rate** for cost reporting periods beginning in FY 1996. The transition into 1996 is actually a blend **based on discharges** for FY 2001 (10/1/2000-9/30/2001) of 75 percent of either 1982, 1987, or PPS and 25 percent of 1996. For FY 2002 (10/1/2001-9/30/2002), the blend is 50/50 and for FY 2003 (10/1/2002-9/30/2003) the blend is 25/75. For **discharges** on and after FY2003 (10/1/2002) the comparison then becomes 1982, 1987, or 1996 compared to the Federal PPS rate. (42 CFR 412.92)

Line 8--For SCHs, enter the greater of line 6 or 7. For MDHs (for discharges occurring on or after 10/1/1997 and before 10/1/2006), enter the greater of line 6, column 1.01 or line 7, column 1 minus line 6, column 1 with that result multiplied by 50 % and added to the amount on line 6, column 1. For hospitals subscribing column 1 of line 6 due to a change in geographic location, enter the greater of line 6, sum columns 1 and 1.01 or line 7, column 1 minus line 6, column 1 with that result multiplied by 50% and added to the amount reported on line 6, columns 1 and 1.01.

Line 9--Enter the payment for inpatient program capital costs from Worksheet L, Part I, line 6; Part II, line 10; or Part III, line 5, as applicable.

Line 10--Enter the exception payment for inpatient program capital, if applicable, from Worksheet L, Part IV, line 13.

Line 11--Enter the amount from Worksheet E-3, Part IV, line 24. Complete this line only for the hospital component.

Line 11.01--Enter the amount of Nursing and Allied Health Managed Care if applicable.

Line 12--Enter the net organ acquisition cost from Worksheet(s) D-6, Part III, column 1, line 61.

Line 13--Enter the cost of teaching physicians from Worksheet D-9, Part II, column 3, line 16.

Line 14--Enter on the appropriate Worksheet E, Part A, the routine service other pass through costs from Worksheet D, Part III, column 8, lines 25 through 30 for the hospital and line 31 for the subproviders.

Line 15--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101.

Line 16--Enter the sum of lines 8 through 15

Line 17--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- o Workmens' compensation,
- o No fault coverage,
- o General liability coverage,
- o Working aged provisions,
- o Disability provisions, and
- o Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, treat the services as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted by you in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 12. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 17 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductible and coinsurance on line 17.

Enter the primary payer amounts applicable to organ transplants. However, do not enter the primary payer amounts applicable to organ acquisitions. Report these amounts on Worksheet D-6, Part III, line 58.

If you are subject to PPS, include the covered days and charges in the program days and charges, and include the total days and charges in the total days and charges for inpatient and pass through cost apportionment. Furthermore, include the DRG amounts applicable to the patient stay on line 1. Enter the primary payer payment on line 17 to the extent that the primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductibles.

Line 19--Enter from the PS&R or your records the deductibles billed to program patients.

Line 20--Enter from the PS&R or your records the coinsurance billed to program patients.

Line 21--Enter the program reimbursable bad debts, reduced by the bad debt recoveries.

Line 21.01--Enter line 21 times 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999, and 70 percent for October 1, 2000 and thereafter. If line 21 is a negative (recoveries exceeded bad debts) enter that amount with no reduction.

Line 22--Enter the sum of lines 18 and 21.01 minus the sum of lines 19 and 20.

Line 23--Enter the programs share of any recovery of accelerated depreciation applicable to prior periods paid under reasonable cost or the hold harmless methodology under capital PPS resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, §§136 - 136.16.)

Line 24--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

Line 25--If you are filing under the fully prospective payment methodology for capital costs or on the basis of 100 percent of the Federal rate under the hold harmless methodology, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. For providers paid under the hold harmless reasonable cost methodology, compute gains or losses on the disposal of old assets in accordance with CMS Pub. 15-1, §§132-134.4. For gains or losses on new capital, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment.

NOTE: Section 1861 (v) (1) (O) of the Act sets a limit on the valuation of a depreciable asset that may be recognized in establishing an appropriate allowance for depreciation, and for interest on capital indebtedness after a change of ownership that occurs on or after December 1, 1997, and restricts the gain or loss on the sale or scrapping of assets.

Enter the amount of any excess depreciation taken as a negative amount.

Line 26--Enter the amount due you (i.e., the sum of the amounts on line 22 plus or minus lines 24 and 25 minus line 23).

Line 27--Enter the sequestration adjustment amount, if applicable.

Line 28--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 28.01. Include in interim payment the amount received as the estimated nursing and allied health managed care payments.

Line 29--Enter line 26 minus the sum of lines 27 and 28 or 27 and 28.01 for intermediaries. Transfer to Worksheet S, Part II.

Line 30--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.

3630.2 Part B - Medical and Other Health Services--Use Worksheet E, Part B, to calculate reimbursement settlement for hospitals, subproviders, and SNFs.

Use a separate copy of Worksheet E, Part B, for each of these reporting situations. If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. Enter check marks in the appropriate spaces at the top of each page of Worksheet E to indicate the component program for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers. **OPD PPS services furnished on or after 8/1/2000 is only applicable for hospital title XVIII providers. (See BBRA §202)** For services rendered on or after August 1, 2000, for purposes of prospective payment for outpatient services, if the cost reporting periods overlap any of the effective dates, **complete subscripted column 1.01 for lines 1.01 through 1.06 only** and make a separate transitional corridor or **geographic reclassification (urban to rural only) (42 CFR 412.103 and 412.230)** payment calculation for the appropriate periods. This may result in **multiple subscripted columns**. Order the subscripted columns chronologically as the transition dates or **geographic reclassification** relate to your fiscal year. The dates should also agree with the format on Worksheet D, Part V, columns 9, 9.01, 9.02 and 9.03, **etcetera**.

Line Descriptions

Line 1--Enter the cost of medical and other health services for title XVIII, Part B. This amount also includes the cost of ancillary services furnished to inpatients under the medical and other health services benefit of Medicare Part B. These services are covered in this manner for Medicare beneficiaries with Part B coverage only when Part A benefits are not available. Obtain this amount from Worksheet D, Part V, line 104, columns 9, 9.02 and 11, for hospitals and enter in column 1. Add to the amount reported in column 1 the amount from Worksheet D, VI, line 3 for services rendered through **March 31, 2001**. For SNFs transfer the amount **from Worksheet D, Part V, column 9 plus Worksheet D, Part VI, lines 3**. For RPCH/CAH providers electing the all-inclusive method of payment for outpatient services prior to October 1, 1997 (see Worksheet S-2, lines 30 through 30.02), obtain this amount from Worksheet C, Part V, column 7, line 108.

CAHs are not subject to transitional corridor payments, therefore lines 1.01 through 1.07 do not apply to CAHs. Transfer Worksheet D, Part V, column 9, line 104 and Worksheet D, Part VI, lines 3 and 3.01.

Line 1.01--Enter the medical and other health services for services rendered on or after **April 1, 2001**, from Worksheet D, Part V, column 9.01, line 104 added to the amount reported on Worksheet D, Part VI, line 3.01; line 3 for cost reporting periods beginning on or after **April 1, 2001**.

Line 1.02--Enter the gross PPS payments received including payment for drugs, device pass through payments, and outliers.

Line 1.03--Enter the hospital specific payment to cost ratio provided by your intermediary.

Line 1.04--Line 1.01 times line 1.03.

If line 1.02 is < line 1.04 complete lines 1.05 and 1.06. Otherwise do not complete lines 1.05 and 1.06.

Line 1.05--Line 1.02 divided by line 1.04.

Line 1.06--Enter the transitional corridor payment amount calculated based on the following:

For services rendered August 1, 2000 through December 31, 2001:

- a. Worksheet S-2, line 21 response is 2 (rural hospitals) **or if 21.02 equals "Y"**, and Worksheet S-3, **Part I**, column 1, line 1 is ≤ 100 , enter the difference of line 1.04 minus

line 1.02; or

- b. Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the difference of line 1.04 minus line 1.02.

For all other hospitals enter one of the following:

- c. If line 1.05 is ≥ 90 percent but < 100 percent, enter 80 percent of (line 1.04 minus line 1.02).
- d. If line 1.05 is ≥ 80 percent but < 90 percent, enter the result of 71 percent of (line 1.04) minus 70 percent of (line 1.02).
- e. If line 1.05 is ≥ 70 percent but < 80 percent, enter the result of 63 percent of (line 1.04) minus 60 percent of (line 1.02).
- f. If line 1.05 is < 70 percent, enter 21 percent of line 1.04

For services rendered January 1, 2002, through December 31, 2002:

- a. If line 1.02 is $<$ line 1.04, Worksheet S-2, line 21 response is 2 (rural hospital) or if 21.02 equals "Y", and Worksheet S-3, Part I, column 1, line 1 is ≤ 100 , enter the result of line 1.04 minus line 1.02; or.
- b. If line 1.02 is $<$ line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the difference of line 1.04 minus line 1.02.

For all other hospitals enter one of the following:

- c. If line 1.05 is ≥ 90 percent but < 100 percent, enter 70 percent of the result of line 1.04 minus line 1.02.
- d. If line 1.05 is ≥ 80 percent but < 90 percent, enter the result of 61 percent of (line 1.04) minus 60 percent of (line 1.02).
- e. If line 1.05 is < 80 percent, enter 13 percent of line 1.04 .

For services rendered January 1, 2003, through December 31, 2003:

- a. If line 1.02 is $<$ line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y" and Worksheet S-3, Part I, column 1, line 1 is ≤ 100 enter the result of line 1.04 minus line 1.02; or
- b. If line 1.02 is $<$ line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the result of line 1.04 minus line 1.02.

For all other hospital enter one of the following:

- c. If line 1.05 is ≥ 90 percent but < 100 percent, enter 60 percent of the result of line 1.04 minus line 1.02.
- d. If line 1.05 is < 90 percent, enter 6 percent of line 1.04.

Line 1.07--Enter the pass through amount from worksheet D, Part IV, column 9, line 101.

Line 2--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

<u>Provider/Component</u>	<u>Title XVIII Hospital</u>	<u>Title XVIII Subprovider</u>	<u>Title XVIII Skilled Nursing Facility</u>
Hospital	Part I, col. 9, line 9 plus line 24; or Part II, col. 7, line 34; or Part III, col. 6, line 41	Part I, col. 9, line 10; or Part II, col. 7, line 35, or Part III, col. 6, line 42	Part I, col. 9, line 12; or Part II, col. 7, line 37; or Part III, col. 6, line 44

Line 3--If you are an approved CTC, enter the cost of organ acquisition from Worksheet D-6, Part III, column 2, line 61 when Worksheet E is completed for the hospital or the hospital component of a health care complex. Make no entry on line 3 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 4--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost (see CMS Pub. 15-I, §2148), enter the amount from Worksheet D-9, Part II, column 3, line 17.

Line 5--Enter the sum of lines 1 through 4 **excluding subscripts in column 1**.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e).

NOTE: RPCHs/CAHs are not subject to the computation of the lesser of reasonable costs or customary charges. If the component is an RPCH/CAH, do not complete lines 6 through 16. Instead, enter on line 17 the amount computed on line 5.

Line Descriptions

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter the total reasonable cost from line 5 directly on line 17. Still complete lines 6 through 16 to insure that you meet one of the criteria for this exemption.

Lines 6 through 10--These lines provide for the accumulation of charges which relate to the reasonable cost on line 5.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-I, §2104.3) and (2) charges to beneficiaries for excess costs. (See CMS Pub. 15-I, §§2570-2577.)

Line 6--For total charges for medical and other services, enter the sum of Worksheet D, Part V, columns 5 and 5.01 (for hospitals and subproviders with cost reporting periods which overlap October 1, 1997, for ambulance services, and SNFs with cost reporting periods beginning prior to January 1, 1998), line 104 and Worksheet D, Part VI, line 2. For cost reporting periods overlapping 8/1/2000 **and after**, for hospital and subprovider services, enter the sum of D, Part V, columns 5, 5.02, and 10, line 104, plus D, Part VI, line 2.

For cost reporting periods beginning 1/1/99 for SNF services enter the sum of Worksheet D, Part V, column 5, line 104 and D, Part VI, line 2.

NOTE: If the amounts on Worksheet D, Part V include charges for professional services, eliminate the amount of the professional component from the charges entered on line 6. Submit a schedule showing these computations with the cost report.

Line 7--Enter from your records the total billed charges for services of interns and residents not in an approved program furnished to program beneficiaries.

Line 8--When Worksheet E is completed for a CTC hospital component for title XVIII, enter the organ acquisition charges from Worksheet D-6, Part III, column 4, line 61.

Line 9--Enter your charges for the services for which the cost is entered on line 4.

Line 10--Enter the sum of lines 6 through 9.

Lines 11 through 14--These lines provide for the reduction of program charges when you do not actually impose such charges in the case of most patients liable for payment for services on a charge basis or fail to make reasonable efforts to collect such charges from those patients. If line 13 is greater than zero, multiply line 10 by line 13, and enter the result on line 14. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 11 through 13. Enter on line 14 the amount from line 10. In no instance may the customary charges on line 14 exceed the actual charges on line 10. (See 42 CFR 413.13(e).)

Line 15--Enter the excess of the customary charges over the reasonable cost. If line 14 exceeds line 5, enter the difference.

Line 16--Enter the excess of reasonable cost over the customary charges. If line 5 exceeds line 14, enter the difference.

Line 17-- Enter the lesser of the reasonable cost on line 5 or the customary charges on line 14.

Line 17.01-- Enter the sum of lines 1.02, 1.06, and 1.07, all columns.

NOTE: If these services are exempt from LCC, i.e., **CAH or charges are equal to or less than 60% of cost, (refer to Worksheet S-2, lines 47-51, columns 1-5, as applicable)**, enter on line 17 the reasonable costs from line 5.

Line 18--Enter the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries. **DO NOT INCLUDE** deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for coinsurance enter on this line the full coinsurance amount not the discounted amount.

Line 18.01--Enter the deductible and coinsurance relating to the amounts reported on line 17.01.

NOTE: If these services are exempt from LCC as a result of **charges being equal to or less than 60% of cost (refer to Worksheet S-2, lines 47-51, columns 1-5, as applicable)**, enter the Part B deductibles billed to program beneficiaries only. Do not enter any Part B coinsurance. **For CAHs with cost reporting periods beginning on or after 7/1/2002, enter the deductibles on line 18 and the coinsurance on line 18.01.**

Line 19--Subtract line 18 and 18.01 from line 17 and 17.01 respectively.

NOTE: If these services are exempt from LCC, line 17 minus line 18 times 80 percent. **Add to that result line 17.01 minus line 18.01.**

For critical access hospitals, exempt from LCC, multiply **80% times** the result of line 17 minus (sum of line 18 plus Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus Worksheet D, Part VI, line 3). **Add back** Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus Worksheet D, Part VI, line 3. **Prorate on a days to days basis lab services for cost reporting periods overlapping 11/29/99. For cost reporting periods beginning on or after 11/29/99, no proration is required. (11/29/99s)**

For CAHs with cost reporting periods beginning on or after July 1, 2002, enter the lesser of (line 17 minus the sum of lines 18 and 18.01) or 80% times the result of (line 17 minus line 18 minus lab cost (Worksheet D, Part V, column 9, lines 44, 45, and subscripts) minus vaccine cost (Worksheet D, Part VI, line 3)). **Add back the aforementioned lab and vaccine cost). (7/1/02b)**

Line 20--This line is used to combine the amounts for medical and other health services, outpatient ambulatory services, outpatient radiology services, and other outpatient diagnostic procedures, for services rendered prior to August 1, 2000. Enter in column 1 only the sum of the amounts from Worksheet E, Part C, columns 1 plus 1.01, line 21; Part D, columns 1 plus 1.01, line 21; and Part E, columns 1 plus 1.01, line 21. For services after August 1, 2000, make no entry.

Line 21—Enter in column 1 the amount from Worksheet E-3, Part IV, line 25. Complete this line for the hospital component only.

Line 22--Enter in column 1 the amount from Worksheet E-3, Part IV, line 11. Complete this line for the hospital component only.

Line 23—Enter in column 1 the sum of columns 1 and 1.01, lines 19 through 22 .

Line 24--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- o Workmens' compensation,
- o No fault coverage,
- o General liability coverage,
- o Working aged provisions,
- o Disability provisions, and
- o Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, the services are treated as if they were non-program services for cost reporting purposes only. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient charges in total charges but not in program charges. In this situation, enter no primary payer payment on line 26. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered charges in program charges, and include the charges in charges for cost apportionment purposes. Enter the primary payer payment on line 26 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 26.

Line 25--Enter line 23 minus line 24.

Line 26--Enter the amount of reimbursable bad debts for deductibles and coinsurance for ESRD services reimbursed under the composite rate system from Worksheet I-5, line 9.

Line 27--Enter reimbursable bad debts for deductibles and coinsurance for other services (from your records), excluding professional services, net of recoveries. Do not include ESRD bad debts. These are reported on line 26.

Line 27.01--Multiply reimbursable bad debts on line 27 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; and 55 percent for October 1, 1999; 70 percent for October 1, 2000 and thereafter (hospitals and subproviders only). The reduction does not apply to Critical Access Hospitals. If line 27 is a negative (recoveries exceeded bad debts) enter that amount with no reduction.

Line 28--Enter the sum of lines 25, 26 and 27 or 27.01 (hospitals and subproviders only).

Line 29--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 30--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 31--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.) Enter the amount of any excess depreciation taken as a negative amount in parentheses ().

Line 32--Enter the result of line 28, plus or minus lines 30 and 31 minus line 29.

Line 33--Enter the sequestration adjustment amount, if applicable.

Line 34--Enter interim payments from Worksheet E-1, column 4, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 34.01. For intermediary purposes it will be necessary to make a reclassification of the bi-weekly pass through payments from Part A to Part B and report that Part B portion on line 34.01. Maintain the necessary documentation to support the amount of the reclassification.

Line 35--Enter line 32 minus the sum of lines 33 and 34. Transfer this amount to Worksheet S, Part II, column 3, line as appropriate.

Line 36--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.

3630.3 Part C - Outpatient Ambulatory Surgical Center--Use this worksheet to calculate reimbursement settlement for outpatient ambulatory surgery for titles V, XVIII, and XIX for the hospital and/or subprovider for services rendered prior to August 1, 2000; otherwise do not complete.

NOTE: Rural primary care hospitals that have elected the all-inclusive method for payment of outpatient services (see Worksheet S-2, lines 30 through 30.02), and CAHs do not complete this worksheet.

As required by §§1833(a)(4), 1832(a)(2)(F), and 1833(I) of the Act, payment for facility services furnished in connection with covered ASC procedures furnished by hospitals on an outpatient basis is based on the lesser of the outpatient cost or charges (in the aggregate) net of cost sharing or a blend of hospital cost and ASC rates at 42/58. (See CMS Pub. 15-I, §2830.3.) For cost reporting periods that end on or after October 1, 1997, and before September 30, 1998, it is necessary to subscribe the column to accommodate the change in payment methodology regarding the application of deductibles and coinsurance. For all cost reporting periods that **begin** on or after **October 1, 1997**, continue to use the subscribed column and no longer complete column 1.

Line Descriptions

Line 1--Enter the standard overhead amounts from the PS&R report or from your records. Payments to ASCs for covered procedures are made on the basis of prospectively set rates known as standard overhead amounts (ASC fees). (See CMS Pub. 15-I, §2830.3.)

Line 2--Enter in column 1 the deductibles billed to the program for services prior to October 1, 1997. For column 1.01, do not complete this line.

Line 3--Line 1 minus line 2.

Line 4--Enter 80 percent of line 3 in column 1. For column 1.01 do not complete this line.

Line 5--This amount is the ASC portion of the blended amount. The ASC portion of the blended amount is 58 percent of the amount on line 4 of column 1 and line 1 of column 1.01.

Line 6--Enter the amount of the outpatient ASC cost from Worksheet D, Part V, columns 6 and 6.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges for the same services for outpatient ambulatory surgical procedures only if that amount is lower than the blended ASC amount. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e).

If you bill an all-inclusive rate or bill gross departmental charges and reflect a discount on the bill, you must, when billing Medicare, show gross departmental charges for each service on the bill. Identify the difference between the sum of these gross charges and the net amount you wish to collect. Also maintain a memorandum record when you bill an all-inclusive charge to non-Medicare

patients. Always use the gross departmental charges for cost apportionment purposes. Show the discount amount in the customary charge computations, as appropriate.

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

Line 7--Enter the total charges which relate to reasonable cost on line 6 from Worksheet D, Part V, columns 2 and 2.01 (if applicable), line 104, in columns 1 (if applicable) and 1.01 respectively.

NOTE: If the amounts on Worksheet D, Part V, include charges for professional services, eliminate the amount of the professional component from the charges entered on line 7. Submit a schedule showing these computations with the cost report.

Lines 8 through 11--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fail to make reasonable efforts to collect such charges from those patients. If line 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of the customary charges over the reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 13--Enter the excess of reasonable cost over the customary charges. If line 6 exceeds line 11, enter the difference.

Line 14--Enter the lesser of the reasonable cost on line 6 or the customary charges on line 11.

NOTE: If these services are exempt from LCC, enter the reasonable cost from line 6.

Line 15--Enter in column 1 the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries for outpatient ambulatory surgical procedures. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for the service or procedure, coinsurance entered on this line reflects coinsurance based on 20 percent of full charges, not discounted charges. Make no entry for column 1.01.

NOTE: If these services are exempt from LCC, enter the Part B deductibles from line 2. Exclude Part B coinsurance.

Line 16--Subtract line 15 from line 14 for column 1 and enter the amount on line 14 for column 1.01.

NOTE: If these services are exempt from LCC, subtract the deductibles reported on line 15 from line 14, and multiply the result by 80 percent for column 1 only.

Line 17--Enter 42 percent of line 16.

Line 18--Enter the sum of lines 5 and 17.

Line 19--Enter the lesser of lines 16 or 18 in columns 1 and 1.01.

Line 20--Enter the Part B deductibles and coinsurance in column 1.01 only.

Line 21--In column 1, enter the amount reported on line 19. In column 1.01, subtract line 20 from line 19. If these services are exempt from LCC, subtract the deductibles reported on line 20 from line 19, and multiply the result by 80 percent. Transfer the sum of columns 1 and 1.01 for title XVIII to Worksheet E, Part B, line 20; titles V and XIX to Worksheet E-3, Part III, column 1, line 37.

3630.4 Part D - Outpatient Radiology Services.--Use this worksheet to calculate reimbursement settlement for outpatient radiology services for the hospital and/or subprovider for titles V, XVIII, and XIX, for services rendered prior to August 1, 2000; otherwise do not complete this form.

NOTE: Rural primary care hospitals that have elected the all-inclusive method for payment of outpatient services (see Worksheet S-2, lines 30 through 30.02) and CAHs do not complete this worksheet.

As required by §§1833(a)(2)(E) and 1833(n) of the Act, a payment methodology is imposed for radiology services performed on an outpatient basis by hospitals. Aggregate payment for radiology services performed in a hospital on an outpatient basis is based on the lower of (1) the hospital's reasonable cost or customary charges (in the aggregate) net of cost sharing, or (2) a blend of the hospital's outpatient radiology costs or its charges (whichever are less) net of (a) deductibles and coinsurance and (b) 62 percent of the physicians' fee schedule net of cost sharing as if the services were performed in a physician's office in the same locality. The blend consists of 42 percent hospital-specific cost and 58 percent fee schedule. For cost reporting periods that end on or after October 1, 1997, and on or before September 30, 1998, it is necessary to subscript the column to accommodate the change in payment methodology regarding the application of deductibles and coinsurance. For all cost reporting periods that **begin** on or after **October 1, 1997**, continue to use the subscripted column and no longer complete column 1.

Line Descriptions

Line 1--Enter the fees from the PS&R or your records in columns 1 and 1.01 for services rendered before October 1 and on or after October 1, 1997, respectively.

Line 2--Enter 62 percent of the amount on line 1 and 1.01

Line 3--Enter the deductibles billed to program patients in column 1 only. Obtain this amount from the PS&R or from your records.

Line 4--Enter 80 percent of the result of line 2 minus line 3 in column 1. Make no entry in column 1.01.

Line 5--This amount is the blended charge proportion. Enter 58 percent of line 4 in column 1 and 58 percent of the amount on line 2, column 1.01.

Line 6--Enter the amount of the outpatient radiology cost from Worksheet D, Part V, columns 7 and 7.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

Computation of Lesser of Reasonable Cost or Customary Charges.--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or your customary charges for the same services for outpatient radiology services only if that amount is lower than the blended amount. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e).

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

Line 7--Enter the total charges that relate to reasonable cost on line 6 from Worksheet D, Part V, columns 3 and 3.01 (if applicable), line 104 in columns 1(if applicable) and 1.01 respectively.

NOTE: If the amounts on Worksheet D, Part V, include charges for professional services, eliminate the amount of the professional component from the charges entered on line 7. Submit a schedule showing these computations with the cost report.

Lines 8 through 11--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fail to make reasonable efforts to collect such charges from those patients. If line 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of customary charges over reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 13--Enter the excess of reasonable cost over the customary charges. If line 6 exceeds line 11, enter the difference.

Line 14--Enter the lesser of the reasonable cost on line 6 or the customary charges on line 11.

NOTE: If these services are exempt from LCC, enter the reasonable costs from line 6.

Line 15--Enter the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries in column 1 only. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for the service or procedure, coinsurance entered on this line reflects coinsurance based on 20 percent of full charges, not discounted charges.

NOTE: If these services are exempt from LCC, enter the Part B deductibles from line 3. Exclude Part B coinsurance.

Line 16--Subtract line 15 from line 14 for column 1. Enter the amount from line 14 for column 1.01.

NOTE: If these services are exempt from LCC, subtract the deductibles included on line 15 from line 14, and multiply the result by 80 percent for column 1 only.

Line 17--Enter 42 percent of line 16 in column 1 and 1.01.

Line 18--Enter the sum of lines 5 and 17 for columns 1 and 1.01.

Line 19--Enter the lesser of lines 16 or 18 in column 1 and 1.01.

Line 20--Enter the Part B deductibles and coinsurance in column 1.01 only.

Line 21--In column 1, enter the amount reported on line 19. In column 1.01, subtract line 20 from line 19. If these services are exempt from LCC, subtract the deductibles reported on line 20 from line 19, and multiply the result by 80 percent. Transfer the sum of columns 1 and 1.01 for title XVIII to Worksheet E, Part B, line 20; and for titles V and XIX to Worksheet E-3, Part III, column 1, line 37.

3630.5 Part E - Other Outpatient Diagnostic Procedures.--This worksheet calculates reimbursement settlement for other outpatient diagnostic procedures for both hospital and/or subprovider, for services rendered prior to August 1, 2000; otherwise do not complete this worksheet. As required by §§1833(a)(2)(E) and 1833(n) of the Act, payment for other diagnostic procedures performed in a hospital on an outpatient basis is based on the lower of (1) the hospital's reasonable cost or customary charges (in the aggregate) net of cost sharing, or (2) a blend of the hospital's other outpatient diagnostic procedures costs or its charges, if less (hospital-specific), and 42 percent of the physician fee schedule, net of cost sharing for the same procedures as if the procedures were performed in a physician's office in the same locality. The blend consists of 50 percent hospital-specific cost and 50 percent fee schedule. For cost reporting periods that end on or after October 1, 1997, and on or before September 30, 1998, it is necessary to subscript the column to accommodate the change in payment methodology regarding the application of deductibles and coinsurance. For cost reporting periods that **begin** on or after **October 1, 1997**, continue to use the subscripted column and no longer complete column 1.

NOTE: Rural primary care hospitals that have elected the all-inclusive method for payment of outpatient services and CAHs (see Worksheet S-2, lines 33 through 33.02) do not complete this worksheet.

Line Descriptions

Line 1--Enter the fee schedule amounts from the PS&R or from your records in columns 1 and 1.01 for services rendered before October 1 and on and after October 1, 1997, respectively.

Line 2--Enter 42 percent of the amount on line 1.

Line 3--Enter in column 1 the deductibles billed to program patients. Obtain this amount from the PS&R or from your records.

Line 4--Enter in column 1 80 percent of the result of line 2 minus line 3. No entry is required for column 1.01.

Line 5--This amount is the blended charge proportion. Enter 50 percent of line 4 in column 1 and 50 percent of line 2 in column 1.01.

Line 6--Enter the amount of the outpatient radiology cost from Worksheet D, Part V, columns 8 and 8.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

Computation of Lesser of Reasonable Cost or Customary Charges.--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or your customary charges for the same services for other outpatient diagnostic procedures only if the amount is lower than the blended amount. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b)(2) or customary charges as defined in 42 CFR 413.13(b)(1).

NOTE: If the medical and other health services reported here qualify for exemption from LCC (see §3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

Line 7--Enter the total charges that relate to the reasonable cost on line 6 from Worksheet D, Part V, columns 4 and 4.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

NOTE: If the amounts on Worksheet D, Part V, include charges for professional services, eliminate the amount of the professional component from the charges entered on line 7. Submit a schedule showing these computations with the cost report.

Lines 8 through 11--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fail to make reasonable efforts to collect such charges from those patients. If line 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of customary charges over reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 13--Enter the excess of reasonable cost over the customary charges. If line 6 exceeds line 11, enter the difference.

Line 14--Enter the lesser of the reasonable cost on line 6 or the customary charges on line 11.

NOTE: If these services are exempt from LCC, enter the reasonable costs from line 6.

Line 15--Enter, in column 1, the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries. **DO NOT INCLUDE** deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for the service or procedure, coinsurance entered on line 15 reflects coinsurance based on 20 percent of full charges, not discounted charges.

NOTE: If these services are exempt from LCC, enter the Part B deductibles from line 3. Exclude Part B coinsurance.

Line 16--Subtract line 15 from line 14 for column 1. Enter the amount on line 14 for column 1.01.

NOTE: If these services are exempt from LCC, subtract the deductible on line 15 from line 14, and multiply the result by 80 percent.

Line 17--Enter 50 percent of line 16 for columns 1 and 1.01.

Line 18--Enter the sum of lines 5 and 17.

Line 19--Enter the lesser of lines 16 or 18 in column 1 and 1.01.

Line 20--Enter the Part B deductibles and coinsurance in column 1.01 only.

Line 21--In column 1 enter the amount reported on line 19. In column 1.01 subtract line 20 from line 19. If these services are exempt from LCC, subtract the deductible on line 20 from line 19, and multiply the result by 80 percent. Transfer the sum of columns 1 and 1.01 for title XVIII, to Worksheet E, Part B, line 20; and for titles V and XIX to Worksheet E-3, Part III, column 1, line 37.

3632. WORKSHEET E-2 - CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

This worksheet provides for the reimbursement calculation for swing bed services rendered to program patients under titles V, XVIII, and XIX. It provides for an accumulation of reimbursable costs determined on various worksheets within the cost report package. It also provides (under Part B) for the computation of the lesser of 80 percent of reasonable cost after deductibles or reasonable cost minus coinsurance and deductibles. These worksheets have been designed so that components must prepare a separate worksheet for swing bed-SNF title XVIII, Parts A and B, and separate worksheets for swing bed-NF for title V and title XIX. Use column 1 only on the worksheets for title V and title XIX. Indicate the use of each worksheet by checking the appropriate boxes. When a hospital with a certified SNF component has made an election to use the swing bed optional method for the SNF, the SNF component uses this worksheet to compute the swing bed-SNF reimbursement. (See 42 CFR 413.24(d)(5) and CMS Pub. 15-I, §2230.5.B.)

Line Descriptions

Lines 1 through 9--Enter in the appropriate column on lines 1 through 7 the indicated costs for each component of the health care complex.

Line 1--Enter the cost of swing bed-SNF inpatient routine services transferred from Worksheet D-1, Part II, line 62 (title XVIII only). For RPCH providers, enter this amount from Worksheet C, Part IV, column 2, line 9. Make no entry on line 1 when Worksheet E-2 is used for swing bed-NF unless your state recognizes only SNF level of care. Then do not use lines designated as NF.

Line 2--Enter the cost of swing bed-NF inpatient routine services transferred from Worksheet D-1, Part II, line 65 (titles V and XIX only). For RPCH providers, enter this amount from Worksheet C, Part IV, columns 1 or 3, line 9, for titles V or XIX. Make no entry on line 2 when Worksheet E-2 is used for swing bed-SNF.

Line 3--Enter the amount of ancillary services:

Title V	from	Worksheet D-4, col. 3, line 101
Title XVIII, Part A	from	Worksheet D-4, col. 3, line 101
Title XVIII, Part B	from	The sum of Worksheet D, Part V, cols. 9 and 11, line 104 and Worksheet D, Part VI, line 3
Title XIX	from	Worksheet D-4, col. 3, line 101

Enter title XVIII, Part B amounts only in column 2. Enter all other amounts in column 1.

Line 4--Enter (in column 1 for titles V and XIX and in column 2 for title XVIII) the per diem cost for interns and residents not in an approved teaching program transferred from Worksheet D-2, Part I, column 4, line 2 or line 10, as appropriate.

Line 5--For title XVIII, enter in column 1 the total number of days in which program swing bed-SNF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 10 and 11. For titles V or XIX, enter in column 1 the total number of days in which program swing bed-NF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 12 and 13. For title XVIII, enter in column 2 the total number of days in which Medicare swing bed beneficiaries were inpatients and had Medicare Part B coverage. Determine such days without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days.

3633. WORKSHEET E-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT

The five parts of Worksheet E-3 are used to calculate reimbursement settlement:

- Part I- Calculation of Medicare Reimbursement Settlement Under TEFRA & IRF PPS
- Part II- Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement
- Part III- Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services - Part A Services for Title XVIII PPS SNFs
- Part IV- Direct Graduate Medical Education and ESRD Outpatient Direct Medical Education Costs
- Part V- Calculation of NHCMQ Demonstration Reimbursement Settlement for Medicare Part A Services

3633.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA and IRF PPS.-- Use Worksheet E-3, Part I to calculate Medicare reimbursement settlement under TEFRA for hospitals and subproviders.

Use a separate copy of Worksheet E-3, Part I for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part I to indicate the component for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

For cost reporting periods beginning on or after 1/1/2002, complete lines 1 through 1.06 for inpatient rehabilitation facilities (IRF) only. (see §1886(j) of the Act and PMs A-01-110 and A-01-131)

Line 1--Enter (for TEFRA hospitals, IRFs, and subprovider) the amount from Worksheet D-1, Part II, line 59. For IRFs, if Worksheet S-2, line 58 is Yes, or for cost reporting period beginning on or after 10/1/2002, enter zero on this line.

Line 1.01 through 1.06 pertain to IRF only.

Line 1.01--Enter the result of line 1 times 33 1/3 %.

Line 1.02--Enter the IRF PPS payment for cost reporting periods beginning on or after January 1, 2002. Exclude low income patient (LIP) and outlier payments. Obtain this information from the PS&R and/or your records. Should be 66 2/3% PPS payment if line 1.01 is greater than zero.

Line 1.03--Enter the Medicaid SSI recipient days from your intermediary.

Line 1.04--IRF LIP payment, enter the result of $\{(1 + (\text{line } 1.03/L1) + (L2/L3)) \text{ to the } .4838 \text{ power} - 1\}$ times (line 1.02). L1 = IRF total Medicare Days from Worksheet S-3, Part I, column 4, line 14 or subscripts as applicable. L2 = IRF Medicaid Days from Worksheet S-3, Part I, column 5, line 14 or subscripts as applicable plus Medicaid HMO days (S-3, Part I, column 5, line 2). L3 = IRF total days from Worksheet S-3, Part I, column 6, line 14 or subscripts as applicable plus employee discount days (S-3, Part I, column 6, line 28).

Line 1.05--Enter the IRF outlier payment. Obtain this from the PS&R.

Line 1.06--Enter the sum of lines 1.01, 1.02, 1.04, and 1.05.

Line 2--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-6, Part III, column 1, line 61 when Worksheet E-3, Part I, is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 2 in other situations because the

Medicare program reimburses only CTCs for organ acquisition costs.

Line 3--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter the amount from Worksheet D-9, Part II, column 3, line 16.

Line 4--Enter the sum of lines 1, 2 and 3. IRFs enter the sum of lines 1.06, 2 and 3.

Line 5--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- o Workmens' compensation,
- o No fault coverage,
- o General liability coverage,
- o Working aged provisions,
- o Disability provisions, and
- o Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts Opaid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

Line 9--Enter the Part A coinsurance. Include any primary payer amounts applied to Medicare beneficiaries coinsurance in situations where the primary payer payment does not fully satisfy the obligation of the beneficiary to the provider. Do not include any primary payer payments applied to Medicare beneficiary coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to the provider.

Line 10--Enter the result of subtracting line 9 from line 8.

Line 11--Enter program reimbursable bad debts reduced by recoveries.

Line 11.01--Multiply allowable bad debts from Line 11 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1,

1998; 55 percent for October 1, 1999; and 70 percent for October 1, 2000 and all subsequent periods.

Line 12--Enter the sum of lines 10 and 11.01. If line 11 is negative, recoveries exceed bad debts; add the amount reported on line 11.

Line 13--Enter the amount from Worksheet E-3, Part IV, line 24 for the hospital component only.

Line 14--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 15--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, sequestration, etc, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 16--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.)

Line 17--Enter the sum of lines 12 and 13 plus or minus lines 15 and 16 minus line 14.

Line 18--Enter the sequestration adjustment amount, if applicable.

Line 19--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlements, report on line 19.01 the amount on line 5.99.

Line 20--Enter line 17 minus the sum of lines 18 and 19. Transfer this amount to Worksheet S, Part II, line as appropriate.

Line 21--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations.

3633.2 Part II - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement--Use Worksheet E-3, Part II, to calculate reimbursement settlement for Medicare Part A services furnished by hospitals, including rural primary care hospitals/critical access hospitals, subproviders, and skilled nursing facilities under cost reimbursement (i.e., neither PPS nor TEFRA).

For cost reporting periods beginning on or after July 1, 1998, SNFs will not complete this form. Use a separate copy of Worksheet E-3 for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3 to indicate the component program for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs:

Hospital(CAH) or Subprovider - Worksheet D-1, Part II, line 49

Skilled Nursing Facility - Worksheet D-1, Part III, line 82

RPCH - Worksheet C, Part IV, line 6 (Not applicable for cost reporting periods beginning after October 1, 1997)

Line 2--If you are approved as a CTC, enter the cost of organ acquisition from Worksheet D-6, Part III, column 1, line 61 when this worksheet is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 2 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 3--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter amounts from Worksheet D-9, Part II, column 3, line 16.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- o Workmens' compensation,
- o No fault coverage,
- o General liability coverage,
- o Working aged provisions,
- o Disability provisions, and
- o Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but not in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system. However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--Enter the amount on line 4 minus the amount on line 5.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e). An RPCH/CAH is not subject to this provision for inpatient services.

Line Descriptions

NOTE: An RPCH/CAH does not complete lines 7 through 17.

Lines 7 through 17--These lines provide for the accumulation of charges which relate to the reasonable cost on line 6.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-I, §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §§2570-2577.

Line 7--Enter the program inpatient routine service charges from your records for the applicable

component. Include charges for both routine and special care units. The amounts entered include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 8--Enter the total charges for inpatient ancillary services from Worksheet D-4, column 2, sum of lines 37 through 68.

NOTE: If the amounts on Worksheet D-4 include charges for professional services, eliminate the amount of the professional component from the charges entered on line 11. Submit a schedule showing these computations with the cost report.

Line 9--When Worksheet E-3 is completed for a CTC hospital component, enter the organ acquisition charges from Worksheet D-6, Part III, line 61, column 3.

Line 10--Enter your charges for the services for which the cost is entered on line 3.

Line 11--Enter the sum of lines 7 through 10.

Lines 12 through 15--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or when you fail to make reasonable efforts to collect such charges from those patients. If line 14 is greater than zero, multiply line 11 by line 14, and enter the result on line 15. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 12 through 14. Enter on line 15 the amount from line 11. In no instance may the customary charges on line 15 exceed the actual charges on line 11. (See 42 CFR 413.13(e).)

Line 16--Enter the excess of the customary charges on line 15 over the reasonable cost on line 6.

Line 17--Enter the excess of reasonable cost on line 6 over the customary charges on line 15. Transfer line 17 to line 21.

Computation of Reimbursement Settlement

Line 18--Enter the amount from Worksheet E-3, Part IV, line 24. Complete for the hospital component only.

Line 19--Enter the sum of lines 6 and 18.

Line 20--Enter the Part A deductibles billed to Medicare beneficiaries.

Line 21--Enter the amount, if any, recorded on line 17. If you are a nominal charge provider, enter zero.

Line 22--Enter line 19 less the sum of lines 20 and 21.

Line 23--Enter from PS&R or your records the coinsurance billed to Medicare beneficiaries.

Line 24--Enter line 22 minus line 23.

Line 25--Enter program reimbursable bad debts net of recoveries.

Line 25.01--Multiply allowable bad debts included on Line 25 by 100 percent for cost reporting periods beginning on or after October 1, 1996, 75 percent for October 1, 1997, 60 percent for October 1, 1998 and 55 percent for October 1, 1999; 70 percent for October 1, 2000 and all

subsequent periods. No reduction is required for critical access hospitals. If line 25 is negative, recoveries exceed bad debts; enter that amount with no reduction.

Line 26--Enter the sum of lines 24 and 25 or 25.01(hospitals and subproviders only).

Line 27--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 28--Enter any other adjustments. For example, if you change the recording of vacation pay from cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

For SNFs only, include the title XVIII portion of the amount of the State's bill for determining the validity of nurse aide training and testing under §4211(b)(5) of P.L. 100-203. This adjustment includes the State's cost of deeming individuals to have completed training and testing requirements and the State's cost of determining the competency of individuals trained by or in a facility based program.

Line 29--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.)

Line 30--Enter line 26, plus or minus lines 28 and 29, minus line 27.

Line 31--Enter the sequestration adjustment amount, if applicable.

Line 32--Enter interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlement, report on line 32.01 the amount from line 5.99.

Line 33--Enter line 30 minus the sum of lines 31 and 32. Transfer this amount to Worksheet S, Part II, line as appropriate.

Line 34--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.

3633.3 Part III - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services and Part A Services for Title XVIII PPS SNFs--Worksheet E-3 calculates reimbursement for titles V or XIX services for hospitals, subproviders, other nursing facilities and ICF/MRs. For titles V and XIX, complete column 1. For title XVIII SNFs reimbursed under PPS, complete this part for settlement of Part A services using column 2. For Part B services, all SNFs complete Worksheet E, Part B.

Use a separate copy of this part for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of this part to indicate the component and program for which it is used. When this part is completed for a component, show both the hospital and component numbers. Enter check marks in the appropriate spaces to indicate the applicable reimbursement method for inpatient services (e.g., PPS, TEFRA, OTHER).

If the State program is under PPS for inpatient hospital services, do not complete line 1. Complete lines 24 through 32 for services covered by PPS. Complete lines 2 through 8, 9 through 15, and 16 through 23 only for services not covered by PPS. If the State program follows TEFRA for inpatient hospital services, do not complete lines 24 through 29. If the State program follows cost reimbursement, do not complete lines 15 and 24 through 29.

Computation of Net Costs of Covered ServicesLine Descriptions

Line 1--Enter the appropriate inpatient operating costs.

Cost Reimbursement

Hospital/CAH or Subprovider - Worksheet D-1, Part II, line 49
 Skilled Nursing Facility, Other Nursing Facility, ICF/MR - Worksheet D-1, Part III, line 82. If Worksheet S-2, line 38.03 is answered yes, and multiple Worksheets D-1 are prepared, add the multiple Worksheets D-1 and enter the result. For cost reporting periods beginning on or after July 1, 1998 make no entry.
 RPCH - Worksheet C, Part IV, line 6

TEFRA

Hospital or Subprovider - Worksheet D-1, Part II, line 59

NOTE: If you are a new provider reimbursed under TEFRA, use Worksheet D-1, Part II, line 49.

Line 2--Enter in column 1 the cost of outpatient services for titles V or XIX which is the sum of Worksheet D, Part V, column 9 and **subscripts where applicable** (SNFs only) (**hospitals use column 9 and subscripts where applicable**), line 104 and Worksheet D, Part VI, line 3 **and subscripts where applicable**. For RPCHs, enter the sum of Worksheet C, Part V, lines 107 or 109, and Worksheet D, Part VI, line 3. For title XVIII, enter in column 2 the amount from Worksheet D-4, column 3, line 101. For SNFs participating in the demonstration, enter the amount from Worksheet E-3, Part V, line 5. For cost reporting periods beginning on or after July 1, 1998 make no entry for Title XVIII.

Line 3--Enter in column 1 for titles V or XIX the cost of services rendered by interns and residents as follows from Worksheet D-2

	<u>Title V</u>	<u>Title XIX</u>
Hospital	Part I, col. 8, line 9 plus line 24	Part I, col. 10, line 9 plus line 24
Subprovider	Part I, col. 8, line 10	Part I, col. 10, line 10
Nursing Facility, ICF/MR	Part I, col. 8, line 13	Part I, col. 10, line 13

Line 4--For titles V and XIX, enter in column 1 the amount paid or payable by the State program for organ acquisition.

Line 5--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter in column 1 amounts from Worksheet D-9, Part II, column 3.

<u>Title V</u>	<u>Title XIX</u>
Sum of lines 14 and 15	Sum of lines 18 and 19

Line 6--Enter the sum of lines 1 through 5.

Line 7--Enter the amounts paid or payable by workmens' compensation and other primary payers . where program liability is secondary to that of the primary payer for inpatient services. For title XVIII SNFs reimbursed under PPS, enter in column 2 only the primary payer amounts applicable to Part A routine and ancillary services

Line 8--Enter in column 1 the primary payer amounts applicable to outpatient services for titles V and XIX.

Line 9--Enter line 6 minus the sum of lines 7 and 8.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or your customary charges for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e). RPCH components must follow State instructions regarding the application of LCC to determine the applicability of this provision. This section is not required for SNFs with cost reporting periods beginning on or after July 1, 1998.

Line Descriptions

Lines 10 through 15--These lines provide for the accumulation of charges which relate to the reasonable cost on line 9.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-I, §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §§2570-2577.

Line 10--Enter in column 1 the program inpatient routine service charges from your records for the applicable component for titles V and XIX. This includes charges for both routine and special care units.

The amounts entered on line 10 include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 11--For titles V and XIX, enter in column 1 the sum of the appropriate program ancillary charges from Worksheet D, Part V, column 5 **plus subscripts as applicable**, line 104; Worksheet D, Part VI, line 2; and Worksheet D-4, column 2, line 103.

For title XVIII SNFs reimbursed under PPS (less than 1500 days), for cost reporting periods beginning prior to July 1, 1998, enter in column 2 the amount from Worksheet D-4, column 2, line 103; otherwise make no entry.

Line 12--Enter in column 1 (for titles V or XIX) the total billed charges from your records for services of interns and residents furnished to program beneficiaries.

Line 13--Enter in column 1 (for titles V and XIX) the organ acquisition charges from line 4.

Line 14--Enter in column 1 (for titles V or XIX) your charges for the services for which the cost is entered on line 5.

Line 15--Enter in column 1 (for titles V and XIX) the amount of the incentive resulting from the target amount computation on Worksheet D-1, Part II, line 58, if applicable.

Line 16--Enter the sum of the amounts recorded on lines 10 through 15.

Lines 17 through 20--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fail to make reasonable efforts to collect such charges from those patients. If line 19 is greater than zero, multiply line 16 by line 19, and enter the result on line 20. If you do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 17 through 19. Enter on line 20 the amount from line 16. In no instance may the customary charges on line 20 exceed the actual charges on line 16. For title XVIII SNFs reimbursed under PPS, lines 18 through 20 apply to Part A ancillary services only. For SNFs for cost reporting periods beginning on or after July 1, 1998, no entry is required.

Line 21--Enter the excess of the customary charges over the reasonable cost. If the amount on line 20 is greater than the amount on line 9, enter the excess.

Line 22--Enter the excess of total reasonable cost over the total customary charges. If the amount on line 9 exceeds the amount on line 20, enter the excess. Transfer this amount to line 34.

Line 23--Enter in columns 1 and 2 the amount from line 9.

Prospective Payment Amount

Line 24--Compute in column 1 the sum of the following amounts supplied by the intermediary:

- o The DRG payments made for PPS discharges during the cost reporting period, and
- o The DRG payments made for PPS transfers during the cost reporting period.

For title XVIII SNFs reimbursed under PPS (less than 1500 days), multiply the number of Medicare days by the prospective payment rate, and enter the result in column 2. If the SNF is participating in the demonstration, transfer the amount reported on Worksheet E-3, Part V, line 25. For cost reporting periods beginning on or after July 1, 1998, transfer the amount from Worksheet S-7, column 5, line 46. **SNFs electing 100% federal rate or cost reporting periods beginning on or after 7/1/2001 providers are required to input the total RUG payments.**

Line 25--Enter in column 1 the amount of outlier payments made for PPS discharges during the period. See CMS Pub. 15-I, chapter 28 for a discussion of these outlier payments.

Line 26--Enter in column 1 the payment for inpatient program capital costs from Worksheet L, Part I, line 6; Part II, line 10; or Part III, line 5, as applicable.

Line 27--Enter the amount from Worksheet L, Part IV, line 13, as applicable.

Line 28--Enter the routine service other pass through costs from Worksheet D, Part III, column 8, lines 25 through 30 and 33 for hospital and from line 31 for the subprovider. For cost reporting periods beginning on or after July 1, 1998, for title XVIII SNFs, enter in column 2 the amount from Worksheet D, Part III, column 8, line 34.

Line 29--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101. For cost reporting periods beginning on or after July 1, 1998, for title XVIII SNFs, enter the amount from Worksheet D, Part IV, column 7, line 101.

Line 30--Enter the sum of lines 23 through 29.

Line 31--For titles V and XIX only, enter the customary charges for PPS.

Line 32--For titles V and XIX PPS, enter the lesser of lines 30 or 31. For non PPS, enter the amount from line 30. For title XVIII, enter the amount from line 30.

Line 33--Enter any deductible amounts imposed.

Computation of Reimbursement Settlement

Line 34--Enter the amount, if any, from line 22. For SNFs with cost reporting periods beginning on or after July 1, 1998, do not complete this line.

Line 35--Enter line 32 less the sum of lines 33 and 34.

Line 36--Enter any coinsurance amounts.

Line 37--For titles V and XIX, enter in column 1 the sum of the amounts from line 19 of Worksheet E, Parts C, D, and E. Do not complete this line for title XVIII.

Line 38--Enter program reimbursable bad debts for deductibles and coinsurance net of bad debt recoveries.

Line 38.01--Multiply allowable bad debts reported on line 38 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999; 70 percent for October 1, 2000 and all subsequent periods. If line 38 is negative, (recoveries exceed bad debts), enter that amount with no reduction. (hospitals and subproviders only if title V or XIX follow Medicare principles).

Line 39--Enter the title XVIII reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include the amount on this line in the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, line 81.

Line 40--Enter the sum of lines 35, 37, 38 or 38.01 and 39, minus line 36.

Lines 41 through 48--Do not complete these lines.

Line 49--Enter in column 1, for titles V and XIX, and in column 2, for title XVIII SNFs reimbursed under PPS, the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination of a decrease in program utilization.

NOTE: For titles V or XIX PPS providers for whom capital is included in PPS, the prior periods are only those paid under reasonable cost or the hold harmless methodology under capital PPS.

Line 50--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 51--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. Enter the amount of any

excess depreciation taken as a negative amount.

NOTE: For titles V or XIX PPS providers for whom capital is included in the PPS, the prior periods are only those paid under reasonable cost or the hold harmless methodology under capital PPS.

Line 52--Enter the result of line 40, plus or minus lines 50 and 51, minus line 49.

Line 53--For provider components subject to PPS under titles V and XIX only, enter the amount of the additional payment amounts relating to indirect medical education.

Line 54--Enter the amount from Worksheet E-3, Part IV, line 23 or line 23.01

Line 55--Enter the sum of lines 52, 53, and 54.

Line 56--Enter the sequestration adjustment amount, if applicable.

Line 57--For titles V and XIX, obtain interim payments from your records. For title XVIII, enter the total interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlement, report on line 57.01 the amount from line 5.99.

Line 58--Enter line 55 minus the sum of the amounts on lines 56 and 57. Transfer this amount to Worksheet S, Part II, line as appropriate.

Line 59--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations.

3633.4 Part IV - Direct Graduate Medical Education and ESRD Outpatient Direct Medical Education Costs. --Use this worksheet to calculate each program's payment (i.e., titles XVIII, V, and XIX) for direct graduate medical education (GME) costs as determined under 42 CFR 413.86. This worksheet applies to the direct graduate medical education cost applicable to interns and residents in approved teaching programs in hospitals and hospital-based providers. Complete this worksheet if the response to line 25.01 of Worksheet S-2 is "Y". The direct medical education costs of the nursing school and paramedical education programs continue to be paid on a reasonable cost basis as determined under 42 CFR 413.85. However, the nursing school and paramedical education costs, formerly paid through the ESRD composite rate as an exception, are paid on this worksheet on the basis of reasonable cost under 42 CFR 413.85. Effective for cost reporting periods beginning on or after October 1, 1997 the unweighted direct medical education FTE is limited to the hospital's FTE count for the most recent cost reporting period ending on or before December 31, 1996. This limit applies to allopathic and osteopathic residents but excludes dentistry and podiatry. The GME payment is also based on the inclusion of Medicare HMO patients treated in the hospital beginning for services rendered on or after January 1, 1998. The percent of Medicare HMO patient days that is included is limited to 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent by 2002. For cost reporting periods beginning before October 1, 1997, complete lines 1 through 3. For cost reporting periods beginning on or after October 1, 1997 skip lines 1 through 3 and begin with line 3.01.

NOTE: Do not complete this worksheet for GME if residents were on duty only after the first month of the cost reporting period. These costs are reimbursed as a reasonable cost and as such are not reimbursed through this worksheet. (See 42 CFR 413.86(e)(4).)

Complete this worksheet if this is the first month in which residents were on duty during the first month of the cost reporting period or if residents were on duty during the entire prior cost reporting period. (See 42 CFR 413.86(e)(4).)

This worksheet consists of five sections:

1. Computation of Total Direct GME Amount
2. Computation of Program Patient Load
3. Direct Medical Education Costs for ESRD Composite Rate - Title XVIII only
4. Apportionment of Medicare Reasonable Cost (title XVIII only)
5. Allocation of Medicare Direct GME Costs Between Part A and Part B

Computation of Total Direct GME Amount--This section computes the total approved amount.

Line Descriptions

Lines 1 and 1.01--Enter the total number of FTE residents. Compute this amount in accordance with 42 CFR 413.86(f), (g), and (h).

NOTE: If this is a short period cost report, FTEs are prorated by the ratio of the number of days in the cost reporting period to the number of days in the calendar year.

Lines 2 and 2.01--Enter the updated per resident amount obtained from the intermediary in conformance with the subscribing on line 1.

In accordance with 42 CFR 413.86(e), if this is the first cost reporting period in which residents were on duty during the first month of the cost reporting period, enter the per resident amount based on the lower of:

- o The sum of Worksheet B, Part I, columns 22 and 23, line 103 divided by the number of FTEs reported on line 1; or
- o The weighted mean value of per resident amounts of hospitals located in the same geographic wage area for cost reporting periods beginning in the same fiscal year. Obtain this amount from your fiscal intermediary.

Line 3--Multiply the number of FTE residents on lines 1 and 1.01 by the updated amount on lines 2 and 2.01, and enter the result in the aggregate on line 3. Round to the whole number during each phase of this computation.

FTE residents subject to the cap for cost reporting periods beginning on or after October 1, 1997:

Line 3.01--Enter the unweighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. If this cost report is less than a full 12 months, contact your intermediary. (42 CFR 413.86(g)(4). Also include here the 30 percent increase to the count for qualified rural hospitals (42 CFR 413.86(g)(4)(i), and the increase due to primary care residents that were on approved leaves of absence (42 CFR 413.86(g)(9).(4/01)

Line 3.02--Enter the unweighted resident FTE count for allopathic and osteopathic programs which meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.86(g)(6). For hospitals qualifying for a cap adjustment under 42 CFR 413.86(g)(6)(i), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995. For hospitals qualifying for a cap adjustment under 42 CFR

413.86(g)(6)(ii), the cap for each new program accredited or begun on or after January 1, 1995 and before August 6, 1997, is effective in the fourth program year of each of those new programs (see 66 FR August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 3.01. Also enter the unweighted allopathic or osteopathic FTE count for residents in all years of the rural track program that meet the criteria for an add-on to the cap under 42 CFR 413.86(g)(11). If the rural track program is a new program under 42 CFR 413.86(g)(12) and qualifies for a cap adjustment under 413.86(g)(6)(i) or (g)(6)(iii), do not report FTE residents in the rural track program on this line until the fourth program year of the rural track program. Report these FTEs on line 3.16 or line 3.22 (04/01).

Line 3.03--Enter the adjustment (increase or decrease) for the unweighted resident FTE count for allopathic or osteopathic programs for affiliated programs in accordance with 42 CFR 413.86(b), (g)(4), and (63 FR 26 336 May 12, 1998).

Line 3.04--Enter the sum of lines 3.01 through 3.03, which is the FTE adjusted cap.

Line 3.05--Enter the unweighted resident FTE count for allopathic or osteopathic programs for the current year from your records, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules.(42 CFR 413.86(g)(5) and or (g)(6).

Line 3.06--Enter the lesser of lines 3.04 or 3.05.

Line 3.07--Enter the weighted FTE count for primary care physicians and OB/GYN residents in an allopathic or osteopathic program for the current year other than those in the initial years of the program that meet the criteria for an exception to the averaging rules. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero.(42 CFR 86(g)(5) and/or (g)(6).

Line 3.08--Enter the weighted FTE count for all other physicians in an allopathic or osteopathic program for the current year other than those in the initial years of the program that meet the criteria for an exception to the averaging rules. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero. (42 CFR 86(g)(5) and/or (g)(6) (10/97)).

Line 3.09--Enter the sum of lines 3.07 and 3.08.

Line 3.10--For cost reporting periods beginning prior to October 1, 2001, if line 3.05 is less than or equal to line 3.04, enter the amount from line 3.09, otherwise multiply line 3.09 by (line 3.04/line 3.05). (10/97) For cost reporting periods beginning on or after October 1, 2001, **if line 3.05 is less than or equal to line 3.04, enter the amount from line 3.09, otherwise;** multiply line 3.07 by (line 3.04/line 3.05) and multiply line 3.08 by (line 3.04/line3.05) and add the results. (42 CFR 413.86(g)(4)(iii)).

Line 3.11--Enter the weighted dental and podiatric resident FTE count for the current year. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero (10/97).

Line 3.12--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.10 and 3.11 for column 1 **or column 0, if applicable**. For cost reporting periods beginning on or after October 1, 2001, if the amount from line 3.09 is reported on line 3.10 enter the sum of lines 3.11 and 3.08. Otherwise, enter the sum of line 3.11 and (3.08 times (line 3.04/line 3.05)).

Line 3.13--For cost reporting periods beginning prior to October 1, 2001, enter the total weighted FTE resident count for the prior cost reporting year (if subject to the cap in the prior year, report the sum of lines 3.10 and 3.11 of the prior year), other than those in the initial years of the program that meet the criteria for an exception to the averaging rules. If a zero is entered on this line, enter in

column zero a 1 if the hospital did not report FTEs this period, but did have an approved program. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE count for nonprimary care residents for the prior year (if subject to the cap in the prior year, report the result of line 3.08 times (line 3.04/line 3.05), other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.86 (g)(5)(v)).

Line 3.14--For cost reporting periods beginning on or after October 1, 1998, but prior to October 1, 2001, enter the total weighted FTE resident count for the cost reporting year before last (if subject to the cap in the year before last, report the sum of lines 3.10 and 3.11 of the year before last) other than those in the initial years of the program that meet the exception to the averaging rules. If zero is entered on this line, enter in column zero a 1 if the hospital did not report FTEs but did have an approved program. For cost reporting periods beginning on or after October 1, 2001, enter the total weighted FTE resident count for nonprimary care residents for the cost reporting year before last (if subject to the cap in the year before last, report the result of line 3.08 times (line 3.04/line 3.05) other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.86 (g)(5)(v)).

Line 3.15--For cost reporting periods beginning prior to October 1, 2001, enter the rolling average FTE count by adding lines 3.12 through 3.14 and divide by 3 (See 42 CFR 413.86(g)(5)(v)) unless column zero is completed for any of these lines. For cost reporting periods on or after October 1, 2001, this will be the nonprimary care rolling average count.

Line 3.16--For cost reporting periods beginning prior to October 1, 2001, enter the weighted number of FTE residents in the initial years of a primary care and OB/GYN program that meets the exception. For cost reporting periods beginning on or after October 1, 2001 enter the sum of line 3.15 and the weighted number of nonprimary care FTE residents in the initial years of new allopathic and osteopathic programs (42 CFR 413.86.(g)(5)(v) and/or (g)(6). Also add the temporary weighted adjustments for nonprimary care FTE residents that were displaced by program or hospital closure (42 CFR 413.86(g)(8)).

Line 3.17--For cost reporting periods beginning prior to October 1, 2001, enter the weighted number of FTE residents in the initial years of all other programs that meet the exception criteria in 42 CFR 413.86(g)(6). For cost reporting periods beginning on or after October 1, 2001 enter the nonprimary care per resident amount.

Line 3.18--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.15 through 3.17. For cost reporting periods beginning on or after October 1, 2001, enter the result of multiplying lines 3.16 times line 3.17.

Line 3.19--For cost reporting periods beginning prior to October 1, 2001, enter the primary care and OB/GYN physician per resident amount. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE resident count for primary care and OB/GYN residents for the prior year cost report (if subject to the cap in the prior year, report the result of line 3.07 times (line 3.04/line 3.05)) other than those in the initial years of the program that meet the criteria for an exception to the averaging rules 42 CFR 413.86(g)(5)(v).

Line 3.20--For cost reporting periods beginning prior to October 1, 2001, enter the all other program per resident amount. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE resident count for primary care and OB/GYN residents in the cost reporting year before last (if subject to the cap in the year **before last**, report the product of line 3.07 times (line 3.04/line 3.05) from the year before last), other than those in the initial years of the program that meet the criteria for an exception to the averaging rules. 42 CFR 413.86(g)(5)(v).

For cost reporting periods beginning prior to October 1, 2001, in order to generate a weighted payment amount for lines 3.21 and 3.22, if lines 3.07 and/or 3.08 of column 1 are zero substitute the

count for lines 3.07 and/or 3.08 for the current period with the counts entered in column zero for those lines. (10/01) For cost reporting periods beginning on or after October 1, 2001 this instruction no longer applies (10/01).

Line 3.21--For cost reporting periods beginning prior to October 1, 2001, enter the primary care unadjusted approved amount by multiplying the sum of lines 3.07 and 3.16 by line 3.19. For cost reporting periods beginning on or after October 1, 2001, if the amount from line 3.09 was reported on line 3.10, enter the rolling average primary care and OB/GYN count by adding the sum of (lines 3.07, 3.19 and 3.20)/3) (the denominator corresponds to amounts greater than zero), otherwise, calculate the rolling average for primary care and OB/GYN FTE count as follows (line 3.07 times (line 3.04/line 3.05)), plus line 3.19, and 3.20) and divide the result by 3.

Line 3.22--For cost reporting periods beginning prior to October 1, 2001, enter the other unadjusted approved amount by multiplying line 3.20 by the sum of lines 3.08, 3.11, and 3.17. For cost reporting periods beginning on or after October 1, 2001 enter the sum of line 3.21 and the weighted number of primary care and OB/GYN FTE residents in the initial years of new allopathic and osteopathic programs 42 CFR 413.86(g)(5)(v) and/or (g)(6). Also add any temporary weighted adjustments for primary care and OB/GYN FTE residents that were displaced by program or hospital closure. 42 CFR 413.86(g)(8).

Line 3.23--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.21 and 3.22. For cost reporting periods beginning on or after October 1, 2001 enter the primary care and OB/GYN per resident amount.

Line 3.24--For cost reporting periods beginning prior to October 1, 2001, divide line 3.23 by the sum of lines 3.07, 3.08, 3.11, 3.16, and 3.17. For cost reporting periods beginning on or after October 1, 2001 multiply line 3.23 by 3.22 and enter the result.

Line 3.25--For cost reporting periods beginning prior to October 1, 2001, enter the total approved amount for resident costs, line 3.24 times line 3.18. For cost reporting periods beginning on or after October 1, 2001 enter the sum of lines 3.18 and 3.24.

Computation of Program Patient Load - Non Managed Care--This section computes the ratio of program inpatient days to the total inpatient days. For this calculation, total inpatient days include inpatient days of the hospital along with its subproviders, including distinct part units excluded from the prospective payment system. Record hospital inpatient days of Medicare beneficiaries whose stays are paid by risk basis HMOs and organ acquisition days as non-Medicare days. Do not count inpatient days applicable to nursery, hospital-based SNFs and other nursing facilities, and other non-hospital level of care units for the purpose of determining the Medicare patient load.

Line Descriptions

Line 4--For title XVIII, enter the sum of the days reported on Worksheet S-3, Part I, column 4, lines 1, 6 through 10, and 14. For titles V or XIX, enter the amounts from columns 3 or 5, respectively, sum of lines 1, 6 through 10, and 14.

Line 5--Enter the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 6 through 10, and 14 and subscripts as applicable.

Line 6--Divide line 4 by line 5 and enter the result (expressed as a decimal).

Lines 6.01 through 6.08 are completed for cost reports that end on or after January 1, 1998.

Line 6.01--Enter the total GME payment for non-managed care days. For 12 month cost reporting periods which end between January 1, 1998 and September 29, 1998, multiply line 6 times line 3.

Otherwise multiply line 6 times line 3.25. (Including a short period cost report which begins on or

after October 1, 1997 and ends prior to January 1, 1998.)

Computation of Program Patient Load - Managed Care Days.--Effective January 1, 1998, hospitals will report managed care days to allow for a Medicare plus Choice direct GME payment 42 CFR 413.86(d)(3).

Line 6.02--Enter Medicare managed care days occurring on or after January 1 of this cost reporting period.

Line 6.03--Enter total inpatient days from line 5 above.

Line 6.04--Enter the appropriate percentage for inclusion of the managed care days, beginning

January 1 of each year, i.e. 20 percent for 1998, 40 percent for 1999, 60 percent for 2000, 80 percent for 2001, and 100 percent for 2002 and after.

Line 6.05--Calculate the Graduate Medical Education payment for managed care days on or after January 1 through the end of the cost reporting period, {(line 6.02/line 6.03) times (line 6.04)} times line 3, for cost reporting periods beginning before October 1, 1997, otherwise times line 3.25. For services rendered on or after January 1, 2000, and before January 1, 2001, reduce the amount by the factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. Future updates will be published by CMS for services rendered on and after January 1, 2001.

Line 6.06--Enter the Medicare managed care days occurring before January 1 of this cost reporting period. Make no entry prior to January 1, 1998.

Line 6.07--Enter the percentage using the criteria identified on line 6.04 above. For years prior to January 1, 2003, the percentage is always 20 percent less than the amount reported on line 6.04.

Line 6.08--Calculate the Graduate Medical Education payment for managed care days prior to January 1 of this cost reporting period: {(line 6.06/line 6.03) times line 6.07} times line 3.25. For services rendered on or after January 1, 2000, and prior to January 1, 2001, reduce the amount by the factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. For services on or after January 1, 2001, updates will be published by CMS.

Direct Medical Education Costs for ESRD Composite Rate Title XVIII Only.--This section computes the title XVIII nursing school and paramedical education costs applicable to the ESRD composite rate. These costs are reimbursable based on the reasonable cost principles under 42 CFR 413.85 separate from the ESRD composite rate.

Line Descriptions

Line 7--Enter the amount from Worksheet B, Part I, sum of columns 21 and 24, lines 57 and 64.

Line 8--Enter the amount from Worksheet C, Part I, column 8, sum of lines 57 and 64. This amount represents the total charges for renal and home dialysis.

Line 9--Divide line 7 by line 8, and enter the result. This amount represents the ratio of ESRD direct medical education costs to total ESRD charges.

Line 10--Enter from your records the Medicare outpatient ESRD charges.

Line 11--Enter the result of multiplying line 9 by line 10. This represents the Medicare outpatient ESRD costs. Transfer this amount to Worksheet E, Part B, line 22.

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COSTS

This worksheet provides for the recording of direct HHA costs such as salaries, fringe benefits, transportation, and contracted services as well as other costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. Obtain these direct costs from your records. List the cost centers in a manner which facilitates the sequential listing of accounts and array of expense accounts for transfer of the various cost center data from Worksheets H-1, H-2, and H-3. **For cost reporting periods beginning on or after 10/1/2000 the amounts in columns 1, 2 and 4 are to be input.** All of the cost centers listed do not apply to all agencies.

Column 1--Obtain the expenses listed from Worksheet H-1, column 9. The sum of column 1 must equal Worksheet H-1, column 9, line 24.

Column 2--Obtain the expenses listed from Worksheet H-2, column 9. The sum of column 2 must equal Worksheet H-2, column 9, line 24.

Column 3--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly assigned to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identifiable to a particular cost center, enter them on line 4.

Column 4--Obtain the expenses listed from Worksheet H-3, column 9. The sum of column 4 must equal Worksheet H-3, column 9, line 24.

Column 5--From your books and records, enter on the applicable lines all other identifiable costs which have not been reported in columns 1 through 4.

Column 6--Add the amounts in columns 1 through 5 for each cost center, and enter the totals in column 6.

Column 7--Enter any reclassifications among the cost center expenses listed in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses as negative amounts.

Column 8--Add column 7 to column 6, and extend the net balances to column 8.

Column 9--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §3613.)

Column 10--Adjust the amounts in column 8 by the amounts in column 9, and extend the net balance to column 10.

Transfer the amounts in column 10, lines 1 through 24, to the corresponding lines on Worksheet H-4, Part I, column 0.

Line Descriptions

Lines 1 and 2--These cost centers include depreciation, leases and rentals for the use of facilities

and/or equipment, interest incurred in acquiring land or depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for

patient care.

Line 3--Enter the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of the plant, and protecting employees, visitors, and agency property.

Line 4--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5--Use this cost center to record the expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs.

Line 6--Skilled nursing care is a service that must be provided by or under the supervision of a registered nurse. The complexity of the service, as well as the condition of the patient, are factors to be considered when determining whether skilled nursing services are required. Additionally, the skilled nursing services must be required under the plan of treatment.

Line 7--Enter the direct costs of physical therapy services by or under the direction of a registered physical therapist as prescribed by a physician. The therapist provides evaluation, treatment planning, instruction, and consultation.

Line 8--These services include (1) teaching of compensatory techniques to permit an individual with a physical impairment or limitation to engage in daily activities; (2) evaluation of an individual's level of independent functioning; (3) selection and teaching of task-oriented therapeutic activities to restore sensory-integrative function; and (4) assessment of an individual's vocational potential, except when the assessment is related solely to vocational rehabilitation.

Line 9--These are services for the diagnosis and treatment of speech and language disorders that create difficulties in communication.

Line 10--These services include (1) assessment of the social and emotional factors related to the individual's illness, need for care, response to treatment, and adjustment to care furnished by the facility; (2) casework services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and (3) assessment of the relationship of the individual's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from facility care.

Line 11--Enter the cost of home health aide services. The primary function of a home health aide is the personal care of a patient. The services of a home health aide are given under the supervision of a registered professional nurse and, if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a case must be made in accordance with a written plan of treatment established by a physician which indicates the patient's need for personal care services. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse and not by the home health aide.

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3647. WORKSHEET H-6 - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs to titles V, XVIII, and XIX. Titles V and XIX use the columns identified as Part A for each program.

3647.1 Part I - Computation of Lesser of Aggregate Program Cost, Aggregate of Program Limitation Cost, or Per Beneficiary Cost Limitation--This part provides for the computation of the reasonable cost limitation to designated program patient care visits and is required by 42 CFR 413.30 and 42 CFR 413.53. For cost reporting periods beginning on or after October 1, 1997, §4601 of the Balanced Budget Act requires a home health agency to be paid based on the lesser of aggregate Medicare cost, aggregate Medicare limitation or the agency specific per beneficiary annual cost limit applied to the unduplicated census count.

Cost Per Visit Computation

Column Descriptions

Column 1--Enter the cost for each discipline from Worksheet H-5, Part I, column 29, lines as indicated. Enter the total on line 7.

Column 2--Where the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the hospital's HHA, complete the amounts entered on lines 2 through 4 in accordance with the instructions contained in §3647.2. Enter the total on line 7.

Column 3--Enter the sum of columns 1 and 2.

Column 4--Enter the total agency visits from your records for each type of discipline on lines 1 through 6. Total visits reported in column 4 reflect visits rendered for the entire fiscal year and equal the visits reported on S-3, Part I, regardless of when the episode was completed.

Column 5--Compute the average cost per visit for each type of discipline. Divide the number of visits (column 4) into the cost (column 3) for each discipline.

Columns 6 and 9--To determine title XVIII, Part A, V, and XIX cost of service, multiply the number of covered visits **in completed episodes** made to beneficiaries (column 6) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 9.

NOTE: Statistics in column 7, lines 1 through 16, reflect statistics for services that are part of a home health plan, and thus not subject to deductibles and coinsurance. OBRA 1990 provides for the limited coverage of injectable drugs for osteoporosis. While covered as a home health benefit under Part B, these services are subject to deductibles and coinsurance. Report charges for osteoporosis injections in column 8, line 16, in addition to statistics for services that are not part of a home health plan.

Columns 7 and 10--To determine the Medicare Part B cost of service, not subject to deductibles and coinsurance, multiply the number of visits made **in completed episodes** to Part B beneficiaries (column 7) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 10. Note if the PS&R reports Part B services separately as "subject to and not subject to" deductibles and coinsurance, add the two reports together for each discipline.

For cost reporting periods that overlap October 1, 2000:

Columns 6, 7, 9, 10 and 12--Subscript these columns and report visits and cost for services rendered prior to October 1, 2000 in columns 6, 7, 8, 9, 10, and 12. For services rendered on and after October 1, 2000 enter visits and costs in columns 6.01, 7.01, 9.01, 10.01, and 12.01. No subscripting

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is required for cost reporting periods beginning on or after October 1, 2000.

NOTE: **For cost reporting periods which overlap October 1, 2000, the** sum of visits reported in columns 6 and 7 and subscripts (if applicable) may not equal the corresponding amounts

on Worksheet S-4, column 7, lines 21, 23, 25, 27, 29 and 31, respectively since those visits are reported based upon the completion of the episode during the fiscal year. **However, for cost reporting period beginning on or after October 1, 2000, sum of visits reported in columns 6 and 7 must equal the corresponding amounts on Worksheet S-4, column 7, lines 21, 23, 25, 27, 29 and 31, respectively. These visits are reported for episodes completed during the fiscal year.**

Columns 8 and 11--Do not use these columns.

Column 12 and 12.01--Enter the total program cost for each discipline (sum of columns 9 and 10). Add the amounts on lines 1 through 6, and enter this total on line 7.

Cost Limitation Computation--Enter for each Metropolitan Statistical Area (MSA) the payment limitation for each discipline for lines 8 through 13. This is supplied by your intermediary. Subscript each discipline line to accommodate multiple MSAs serviced by your home health agency. **For cost reporting periods beginning on and after October 1, 2000, the completion of the cost limitation section is no longer required.**

Column Descriptions

Column 5--Enter the program limitation (see §1814(b)(1) of the Act) for each discipline on lines 8 through 13. Your fiscal intermediary furnishes these limits to you.

Columns 6 and 9--To determine the program cost limitation for title XVIII, Part A, V, and XIX cost of services, multiply the number of covered visits made to beneficiaries (column 6, lines 1 through 6) (from your records) by the program cost limit amount in column 5 for each discipline. Enter the product in column 9.

Columns 7 and 10--To determine the Medicare cost limitation for Part B cost of services, not subject to deductibles and coinsurance, multiply the number of visits to Part B beneficiaries (column 7, lines 1 through 6) (from your records) by the Medicare cost limit amount in column 5 for each discipline. Enter the product in column 10.

NOTE: Enter in columns 6, 7, 9, and 10 only, the visits rendered through September 30, 2000.

Columns 8 and 11--Do not use these columns for lines 1 through 14.

Column 12--Enter the total program cost limitation for each discipline and subscripts (sum of columns 9 and 10). Add lines 8 through 13 and subscripts, and enter this total on line 14.

Supplies and Drugs Cost Computation--Certain services covered by the program and furnished by a home health agency are not included in the cost per visit for apportionment purposes. Since an average cost per visit and the cost limit per visit do not apply to these items, develop and apply the ratio of total cost to total charges to program charges to arrive at the program cost for these services.

Column 1--Enter the facility costs in column 1, lines 15 and 16, from Worksheet H-5, Part I, column 29, lines 8 and 9, respectively. For cost reports that overlap October 1, 2000 subscript lines 15 and 16. For cost reporting periods beginning on or after October 1, 2000, no subscripting is required.

Column 2--Enter the shared ancillary costs from Worksheet H-6, Part II, column 3, lines 4 and 5, respectively.

Columns 3 through 5--In column 3, enter the total for each line of columns 1 and 2. Develop a ratio

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This worksheet provides for the analysis of the direct and indirect expenses related to the renal dialysis cost centers, allocation of cost between inpatient and outpatient renal dialysis services where separate cost centers are not maintained, and the allocation of the cost to the various modes of outpatient dialysis treatment. The ancillary renal dialysis cost center is serviced by the general cost centers and includes all reimbursable cost centers within the provider organization which provide services to the renal dialysis department. The cost used in the analysis for the renal dialysis department is obtained, in part, from Worksheets A; B, Part I; and C. Complete a separate Worksheet I series for lines 57 and 64 of Worksheet A. In other words, complete one Worksheet I series for line 57 and one for line 64, if appropriate.

3651. WORKSHEET I-1 - ANALYSIS OF RENAL COSTS

This part provides for recording the direct salaries and other direct expenses applicable to the total inpatient and outpatient renal dialysis cost center or outpatient renal dialysis cost center where you maintain a separate and distinct outpatient renal dialysis cost center. If you have more than one renal dialysis department, and/or more than one home dialysis department, submit one Worksheet I series combining the renal dialysis departments and a separate Worksheet I series combining the home dialysis departments. You must also have on file, as supporting documentation, a Worksheet I series for each renal dialysis department and for each home dialysis department along with the appropriate workpapers. File this documentation with exception requests in accordance with HCFA Pub. 15-I, §2720. Do not combine the cost of the renal dialysis with home program dialysis reported separately on Worksheet A, lines 57 and 64.

This worksheet also provides for recording the indirect expenses applicable to the total renal or outpatient renal dialysis department obtained from Worksheet B, Part I, columns 1 through 24, line 57 as adjusted for post stepdown adjustments, if any. When completing a separate Worksheet I for home program dialysis, transfer the direct expenses from Worksheet B, Part I, columns 1 through 24, line 64. Do not combine the cost of the renal department with home program dialysis. These costs are listed separately on Worksheet A, lines 57 and 64, respectively.

Column Descriptions

Column 1--Enter on lines 1 through 8 the amounts included from Worksheet A, column 7 for salaries only. Enter on lines 10 through 16 and 18 through 28 the amounts from Worksheet B, Part I, all columns for lines 57 and 64. The subtotal on Worksheet I-1, line 29 agrees with the sum of Worksheet B, Part I, column 27, line 57 or line 64 if a home dialysis cost center was established and used on Worksheet A.

Column 2--This column lists the statistical bases for allocating costs on Worksheet I-3.

Column 3--Enter paid hours per type of staff listed on lines 1 through 6.

Column 4--Enter full time equivalents by dividing column 3 by 2080 hours.

Line Descriptions

Lines 1 through 6--Enter on these lines the direct patients care salaries after adjustments and reclassification that you reported in column 7 of Worksheet A. Direct patient care salary includes only the salary of staff providing direct patient care services. Also include fee paid to non-employees providing direct patient care services. Time spent furnishing administrative or management services by direct patient care personnel is reported on line 8, non-patient care salary.

Line 7--Include on this line amounts paid to physicians for their administrative services of managing the renal department. These payments are subject to the limitation contained in §2723.3 of HCFA Pub. 15-I. Also include payments to physicians for their medical services if the box on line 15 of Worksheet S-5 is marked the initial method. A complete description of the initial method is in HCFA Pub. 15-I, §2715. For a renal provider to be paid under the initial method, all renal physicians at the provider must elect the initial method. Under the initial method, renal physicians are paid by the provider for their routine renal medical services and the provider's composite payment rate is increased according to 42 CFR 414.313. No payment to physicians for patient medical services should appear on this line if the monthly capitation payment (MCP) box is marked on Worksheet S-5. Under the MCP, carriers pay physicians directly for their medical services.

Line 8--Enter the amount of salaries paid non-patient care personnel after reclassifications and adjustments that you report in column 7 of Worksheet A.

Lines 10 through 16--Include on the appropriate lines costs directly charged to the renal department after reclassifications and adjustments. Report other direct costs on line 16 that cannot be specifically identified on lines 11 through 15.

NOTE: Line 15 should include the costs of EPO administered to ESRD patients in the renal department.

Lines 18 through 28--Enter the allocated general service costs from Worksheet B, Part I, lines 57 or 64, as listed in the chart below.

<u>Worksheet I-1, Part I, Column 1, Line Number</u>	<u>General Service Cost Centers</u>	<u>Worksheet B, Part I, Lines 57 or 64, Columns</u>
18	Old Capital-Related Costs- Buildings and Fixtures	1
19	Old Capital-Related Costs- Moveable Equipment	2
20	New Capital-Related Costs- Buildings and Fixtures	3
21	New Capital-Related Costs- Moveable Equipment	4
22	Employee Benefits	5
23	Administrative and General	6
24	Maintenance & Repairs, Operation of Plant and Housekeeping	Sum of 7, 8, and 10

25	Medical Education Programs	Sum of 21, 22, 23, 24, and 26 (medical education only)
26	Central Services & Supplies	15
27	Pharmacy	16 and 26 (EPO only)
28	Other Allocated Costs	Sum of 9, 11, 12, 13, 14, 17, 18, 19, and 20

Line 29--Add lines 18 through 28. This total should agree with the total on Worksheet B, column 27, line 57 or line 64 if a home dialysis cost center was established.

Lines 30, 31, and 32--These lines provide for the allocation of costs associated with routine dialysis services furnished to renal patients from other ancillary departments. Multiply charges by the cost to charge ratio from Worksheet C, Part II for the appropriate department. For cost reporting periods beginning on and after August 1, 2000, enter the cost to charge ratio from Worksheet C, Part I, **column 9**. Payment for routine laboratory services, as defined in §E202 of the ESRD Appendix of the Hospital Manual, is paid for under the composite payment rate. No separate payment is made for routine laboratory tests. The costs of these services are allocated to the renal department based on the provider's laboratory cost to charge ratio as computed on Worksheet C, Part II, column 8, line 44. **For cost reporting periods beginning on and after August 1, 2000, enter the cost to charge ratio from Worksheet C, Part I, column 9.** Providers must maintain a log of routine laboratory charges for allocating routine laboratory costs to the renal department. The lab charges reported on Worksheet C do not include the lab charges for ESRD therefore those charges must be grossed up in accordance with PRM-1, § 2314. The cost to charge ratio must be recalculated and applied against the charges reported in column 3 of this worksheet.

Line 33—Enter the sum lines 29 through 32.

3652. WORKSHEET I-2 - ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

The purpose of this schedule is to allocate costs to the different services furnished in the renal department. Line 1 combine the costs reported on Worksheet I-1 for allocating costs to the different services furnished in the renal department.

Line 1--Add the costs from Worksheet I-1, and transfer these amounts to line 1 in the following manner:

<u>Worksheet I-2</u>	<u>Worksheet I-2 Column</u>	<u>Worksheet I-1</u>
Capital & Main Building Costs	1	Sum of lines 11, 18, 20, and 24
Capital, Machine & Repair Costs	2	Sum of lines 12, 13, 19, and 21
Registered Nurses Direct Patient Care Salary	3	Line 1
Other Direct Patient Care Salary	4	Sum of lines 2, 3, 4, 5, and 6
Employee Benefits	5	Sum of lines 10 and 22
Drugs	6	Sum of lines 15 and 27
Medical Supplies	7	Sum of lines 14 and 26
Routine Ancillary Services	8	Sum of lines 30, 31, and 32
Subtotal	9	Not applicable
Overhead	10	Sum of lines 7, 8, 16, 23, and 28

Complete columns 1 through 8 and 10 in conjunction with Worksheet I-3, which contains the statistical bases for allocating costs to the proper lines. For each line item in columns 1 through 8 and 10, multiply the statistic entered in the corresponding line and column of Worksheet I-3 by the unit cost multiplier on line 17.

Lines 2 through 11--These lines identify the type of dialysis treatments that are paid for under the composite payment rate system. The total costs (column 11) for these individual dialysis services are transferred to Worksheet I-4.

Transfer the total on Worksheet I-2, column 11 to Worksheet I-4 per the following instructions.

<u>From Worksheet I-2, Column 11</u>	<u>To Worksheet I-4, Column 2</u>
Line 2	Line 1
Line 3	Line 2
Line 4	Line 3

Line 5	Line 4
Line 6	Line 5
Line 7	Line 6
Line 8	Line 7
Line 9	Line 8
Line 10	Line 9
Line 11	Line 10

If you complete a Worksheet I-2 for the renal department and the home program dialysis department, complete a separate Worksheet I-4.

Lines 12 through 15--These services are not paid for under the composite payment rate system. Therefore, the costs of these services are not transferred to Worksheet I-4. Exclude these costs in the calculation of reimbursement composite payment rate bad debts. (See 42 CFR 413.170(e).)

Line 12--Report inpatient costs. Inpatient dialysis services are paid under the DRG system for Medicare patients.

Line 13--Report the costs of support services furnished to Method II home patients. Payment for Method II home patient dialysis services are subject to the rules in 42 CFR 414.330. Under Method II, a renal provider is only allowed to bill for support services and not dialysis equipment or supplies. Payment for support services is limited to the lower of the provider's reasonable cost or the payment limit as defined in the regulation, which is \$125 per patient per month. This amount includes payment for support services and routine laboratory tests furnished to home patients.

Line 14—Report the direct costs of EPO net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Payment for EPO administered to an end stage renal disease patient is subject to payment limitation of \$10 per 1000 units, rounded to the nearest 100 units.

Line 15--Report the costs of other services furnished and billed in the renal department that are paid for outside the composite payment rate.

Line 16--Add columns and enter totals. Since line 14, column 9 is shaded, no costs for EPO are included in the total for line 16, column 9 **and column 6, line 14 should be excluded from total.**

Line 17--Enter the amount of medical educational program costs from Worksheet I-1, line 25. Payment for medical educational program costs allocated to the renal department is not included in the composite payment rate.

Line 18--Add lines 16 and 17. This total agrees with the sum of Worksheet I-1, column 1, line 33.

Column Description

Columns 1 through 8--For each line, multiply the unit cost multiplier on Worksheet I-3, line 17 by the statistical base, and enter the result on the corresponding line and column on Worksheet I-2.

Column 9--Add columns 1 through 8 for each line, except line 14 (EPO), and enter the total.

Column 10--Multiply the unit cost multiplier on Worksheet I-3, column 10, line 17 by the line amounts in column 9 of Worksheet I-2, and enter the amount in column 10.

Column 11--Add columns 9 and 10 for each line, and enter the result.

3653. WORKSHEET I-3 - DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -STATISTICAL BASIS

To accomplish the allocation of your direct and indirect costs reported on Worksheet I-1 to the different services provided in the department, you must maintain renal department statistics. To facilitate the allocation process, the format of Worksheets I-2 and I-3 is identical.

Line 1--Transfer the amounts on Worksheet I-2, line 1, columns 1 through 10 to Worksheet I-3, line 1, columns 1 through 10.

Lines 2 through 15--Enter on these lines and in the appropriate columns, the statistic for allocating costs to the appropriate line item. The statistical basis used in each column is defined in the column heading and on Worksheet I-1.

NOTE: If you wish to change your allocation basis for a particular general cost center, you must receive written approval from your intermediary before the start of your cost reporting period for which the alternative method is used. (See §3617 for Worksheets B and B-1.)

Line 12--Enter, in the area provided, the number of inpatient dialysis treatments furnished during the cost reporting period.

Line 16--Add the statistical basis for each column, except columns 9 and 10.

Line 17--Calculate the unit cost multiplier by dividing the amount on line 1 by the total statistical basis on line 16 for each column. Multiply the unit cost multiplier by the statistical base, and enter the cost on the appropriate line and column number on Worksheet I-2.

Column Descriptions

Column 1--Use the square footage of the renal department to allocate capital and maintenance building costs.

Column 2--Use percentage of time to allocate capital and maintenance equipment costs.

Columns 3 and 4--Use paid hours to allocate registered nurses and direct patient care salary.

Column 5--Use total direct patient care salaries in columns 4 and 5 of Worksheet I-2 to allocate employee benefits.

Columns 6 and 7--Use cost of requisitions to allocate drug and medical supply costs.

Column 8--Use routine laboratory charges to allocate laboratory costs.

Column 10--Use subtotal costs in column 9, Worksheet I-2 to allocate overhead cost. To compute the unit cost multiplier, transfer the amount from Worksheet I-2, line 16, column 9 to Worksheet I-3, line 16, column 10. Do not allocate overhead costs to line 14 (EPO).

3655. WORKSHEET I-5 - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII, PART B

This worksheet provides for the calculation of reimbursable Part B bad debts relating to outpatient renal dialysis treatments. If you have completed more than one Worksheet I-2 (i.e., one for renal dialysis department and one for home program dialysis), make a consolidated bad debt computation.

Line 1--Enter the amount from Worksheet I-4, column 5, line 11. If you complete more than one Worksheet I-4, enter the sum of the total from each Worksheet I-4, column 5, line 11.

Line 2--Enter the amount from Worksheet I-4, column 7, line 11 (net of deductibles). If you complete more than one Worksheet I-4, enter the sum of the total from each Worksheet I-4, column 7, line 11.

Line 3--Enter the amount shown in your records for deductibles billed to Medicare (Part B) patients for dialysis treatments.

Line 4--Enter the amount shown in your records for coinsurance billed to Medicare (Part B) patients for dialysis treatments.

The amounts on lines 3 and 4 must exclude coinsurance and deductible amounts for services other than dialysis treatments (e.g., epoietin).

Line 5--Enter the uncollectible portion of the amounts entered on lines 3 and 4 reduced by any amount recovered during the cost reporting period.

Line 6--Enter the sum of lines 3 and 4, less line 5.

Line 7--Subtract line 3 from line 2, and enter 80 percent of the difference.

Line 8--Subtract the sum of lines 6 and 7 from the lesser of lines 1 or 2, and enter the difference. If the result is negative, enter zero and do not complete line 9.

Line 9--Enter the lesser of line 5 or line 8. Transfer this amount to Worksheet E, Part B, line 26.

3656. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS

Use this worksheet only if you operate as part of your complex a certified hospital-based community mental health center (CMHC), **comprehensive outpatient rehabilitation facility (CORF), outpatient rehabilitation facility (ORF) which generally furnishes** outpatient physical therapy (OPT), outpatient occupational therapy (OOT), or outpatient speech pathology (OSP). Only those cost centers that represent services for which the facility is certified are used. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility. If all services are paid under established fee schedules **do not complete these worksheets** for cost reporting periods **beginning on or after April 1, 2001 for CORFs and** cost reporting periods **beginning on or after July 1, 2003 for ORFs.**

3656.1 Part I - Allocation of General Service Costs to Outpatient Rehabilitation Provider Cost Centers.--Worksheet J-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 22) from Worksheet A, column 7, lines as appropriate:

<u>Component</u>	<u>From Worksheet A, Column 7</u>
CMHC	line 69 and subscripts
OPT/OOT/OSP	line 69 and subscripts
CORF	line 69 and subscripts

Obtain the cost center allocation (column 0, lines 1 through 21) from your records. The amounts on line 22, columns 0 through 24 and column 26 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 24 and column 26, lines as appropriate:

<u>Component</u>	<u>Worksheet B, Part I, Columns 0 through 24 and 26</u>
CMHC	line 69 and subscripts
OPT/OOT/OSP	line 69 and subscripts
CORF	line 69 and subscripts

Complete the amounts entered on lines 1 through 21, columns 1 through 24 and column 26 in accordance with the instructions contained in §3656.2.

NOTE: Worksheet B, Part I, established the method used to reimburse direct graduate medical education cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 26, excluded the costs of interns and residents, column 26 on this worksheet must also exclude these costs.

Line 23--To calculate the unit cost multiplier for component administrative and general costs divide line 1 by the result of line 22 minus line 1 and round to six decimal places.

3656.2 Part II - Allocation of General Service Costs to Outpatient Rehabilitation Provider Cost Centers - Statistical Basis.--Worksheet J-1, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet J-1, Part I. If there is a difference between the total accumulated costs reported on the Part II statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part II for reporting any adjustments. See §3617 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line must match the reconciliation column number.

To facilitate the allocation process, the general format of Worksheet J-1, Parts I and II, is identical. The statistical basis shown at the top of each column on Worksheet J-1, Part II, is the recommended basis of allocation of the cost center indicated.

3659. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED
OUTPATIENT REHABILITATION PROVIDER FOR SERVICES RENDERED TO
PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your fiscal intermediary.

Line Descriptions

Line 1--Enter the total program interim payments paid to the outpatient rehabilitation provider. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable.

Line 2--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period. It does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Transfer the total interim payments to the title XVIII Worksheet J-3, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due from the provider to the program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet J-3, line 26.

Worksheet L, Parts I through IV, calculate program settlement for PPS inpatient hospital capital-related costs in accordance with the final rule for payment of capital-related costs on a prospective payment system pursuant to 42 CFR 412, Subpart M. (See the August 30, 1991 *Federal Register*.) Only provider components paid under PPS complete this worksheet.

Worksheet L consists of the following four parts:

- Part I - Fully Prospective Method
- Part II - Hold Harmless Method
- Part III Payment Under Reasonable Cost
- Part IV Computation of Exception Payments

COMPLETE ONLY PART I, II, OR III.

At the top of the worksheet, indicate by checking the applicable boxes the health care program, provider component, and the PPS capital payment method for which the worksheet is prepared.

3660.1 Part I - Fully Prospective Method--This part computes settlement under the fully prospective method only, as defined in 42 CFR 412.340. Use the fully prospective method for PPS capital settlement when the hospital's base year hospital-specific rate is below the adjusted Federal rate.

Line Descriptions

Line 1--Enter the amount of the hospital-specific rate portion of capital payments for discharges during the period. Do not complete this line for cost reporting periods beginning on and after October 1, 2001 for hospitals paid 100 percent of the Federal rate.

Line 2--Enter the amount of the Federal rate portion of the capital DRG payments for other than outlier during the period.

Line 3--Enter the amount of the Federal rate portion of the capital outlier payments made for PPS discharges during the period. (See 42 CFR 412.312(c).) Subscript this line to report outlier payments received for services rendered before October 1, 1997, and on or after October 1, 1997.

Enter the amount of the Federal rate portion of the additional capital payment amounts relating to the indirect medical education adjustment. (See 42 CFR 412.322.)

Line 4-- Enter the result of dividing **the sum of** total patient days (Worksheet S-3, Part I, column 6, **lines 12 and 28**) by the number of days in the cost reporting period (365 or 366 in case of leap year). Do not include statistics associated with an excluded unit (subprovider).

NOTE: Reduce total patient days by nursery days (Worksheet S-3, Part I, column 6, line 11), and swing bed days (Worksheet S-3, Part I, column 6, lines 3 and 4).

Line 4.01--Enter the number of interns and residents from Worksheet S-3, Part I, column 9, line 12. For cost reporting periods beginning on or after October 1, 1997 obtain the intern and resident amount from Worksheet E, Part A, line 3.17.

Line 4.02--Enter the result of the following calculation: $\{e^{.2822 \times \text{line 4.01}/\text{line 4}}\}-1$ where $e = 2.71828$. (See 42 CFR 412.322(a)(3) for limitation of the percentage of I&Rs to average daily census. Line 4.01 divided by line 4 can not exceed 1.5.

Line 4.03--Multiply line 4.02 by the sum of lines 2 and 3. Do not include line 3.01. Enter the

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extraordinary circumstance percentage adjustment in decimal format, e.g., 85 percent is displayed as .85 or 0.85.

Line 7--Enter the product of line 2 multiplied by line 6.

Line 8--Enter the sum of lines 5 and 7.

Line 9--Enter the amount from Part I, line 6 or Part II, line 10, as applicable.

Line 10--Enter line 8 less line 9.

Lines 11 through 14--A hospital is entitled to an additional payment if its capital payments for the cost reporting period is less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive. This additional payment amount is reduced for any amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels.

A positive amount on line 10 represents the amount of capital payments under the minimum payment level in the current year. This amount must be offset for the amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels in prior years, as reported on line 11. If the net amount on line 12 remains a positive amount, this amount represents the current year's additional payment for capital payments under the minimum payment level. Report this amount on line 13. If the net amount on line 12 is a negative amount, this amount represents the reduced amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. In this case, no additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the following cost reporting period.

A negative amount on line 10 represents the amount of capital payments over the minimum payment level in the current year. Add any carry forward of prior years' amounts of the hospital's cumulative payments in excess of cumulative minimum payment levels, as reported on line 11, to the current year excess on line 12. The net amount on line 12 represents the total amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. No additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the following cost reporting period.

Line 11--If applicable, enter the amount from the prior year's Worksheet L, Part IV, line 14.

Line 12--Enter the sum of lines 10 and 11.

Line 13--If the amount on line 12 is positive, enter the amount on this line.

Line 14--If the amount on line 12 is negative, enter the amount on this line.

For cost reporting periods beginning on and after October 1, 2001.

Line 15--Enter the current years allowable operating and capital payments calculated from Worksheet E, Part A, line 6, plus the capital payments reported on line 9 above, minus 75 percent of the current year's operating disproportionate share payment amount reported on Worksheet E, Part A, line 4.04.

Line 16--Current years operating and capital costs from worksheet D-1, line 49 minus the sum of D, Part III, lines 25 through 30, column 8 (PPS subproviders use line 31, column 8), and D, Part IV, column 7, line 101.

Line 17--Current year's exception offset amount. Line 12 plus line 15 minus line 16. Transfer this amount to Worksheet E, Part A, line 10.

3661. WORKSHEET L-1 - ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

This worksheet provides for the determination of direct and indirect capital-related costs associated with capital expenditures for extraordinary circumstances, allocated to inpatient operating costs. Only complete this worksheet for providers that qualify for an additional payment for extraordinary circumstances under 42 CFR 412.348(e).

3661.1 Part I - Allocation of Allowable Capital Costs for Extraordinary Circumstances.--Use this part in conjunction with Worksheet B-1. The format and allocation process employed is similar to that used on Worksheets B, Part I and B-1. Any cost center subscripted lines and/or columns added to Worksheet B, Part I, are also added to this worksheet in the same sequence.

Column O--Assign capital expenditures relating to extraordinary costs to specific cost centers on this worksheet, column 0. Enter on the appropriate lines those capital-related expenditure amounts relating to extraordinary costs which were directly assigned on Worksheet B, Part III. Enter on lines 3 and 4, as applicable, the remaining capital expenditure amounts relating to extraordinary costs which have not been directly assigned.

NOTE: Recognize capital expenditures relating to extraordinary costs as new capital-related costs.

Columns 1 through 24--Transfer amounts on the top lines of columns 3 and 4 from column 0, line as applicable. For example, transfer line 3, column 0 to line 3, column 3. For all other columns, the top line represents the cross total amount.

For each column, enter on line 104 of this worksheet, Part I, the total statistics of the cost center being allocated. Obtain this amount from Worksheet B-1 from the same column and line number used to allocate cost on this worksheet. (For example, obtain the amount of new capital-related costs - buildings and fixtures from Worksheet B-1, column 3, line 3.)

Divide the amount entered on line 104 by the total capital expenses entered in the same column on the first line. Enter the resulting unit cost multiplier on line 105. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services rendered. Report applicable cost center statistics on Worksheet B-1. Enter the result of each computation on this worksheet in the corresponding column and line. (See §3600.1 for rounding standards.)

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 103) of all the cost centers receiving the allocation on this worksheet must equal the amount entered on the first line. Perform the preceding procedures for each general service cost center. Complete the column for one cost center before proceeding to the column for the next cost center.

After the capital-related costs of all the general service cost centers have been allocated, enter in column 25 the sum of columns 4A through 24 for lines 25 through 102. (See §3617 for exception regarding negative cost centers.)

When an adjustment is required to capital costs for extraordinary circumstances after cost allocation, show the amount applicable to each cost center in column 26. Submit a supporting schedule showing the computation of the adjustment.

3664. WORKSHEET M-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet applies to title XVIII only and provides for the reimbursement calculation. Use this worksheet to determine the interim all inclusive rate of payment and the total program payment due you for the reporting period for each RHC or FQHC being reported.

Determination of Rate For RHC/FQHC Services.--Worksheet M-3 calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line descriptions

Line 1--Enter the total allowable cost from Worksheet M-2, line 20.

Line 2--Do not complete this line. For services rendered on and after August 1, 2000 report vaccine costs on this line from Worksheet M-4.

Line 3--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4--Enter the greater of the minimum or actual visits by the health care staff from Worksheet M-2, column 5, line 8.

Line 5--Enter the visits made by physicians under agreement from Worksheet M-2, column 5, line 9.

Line 6--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

Lines 8 and 9--The limits are updated every January 1. Complete columns 1 and 2 of lines 8 and 9 to identify costs and visits affected by different payment limits for a cost reporting period that overlaps January 1. If only one payment limit is applicable during the cost reporting period (calendar year reporting period), complete column 2 only.

Line 8--Enter the per visit payment limit. Obtain this amount from CMS Pub. 27, §505 or from your intermediary. If Worksheet S-8, line 17 was answered yes, subscript to accommodate the exclusion of the limit.

Line 9--Enter the lesser of the amount on line 7 or line 8.

NOTE: If you are based in a small rural hospital with less than 50 beds, Worksheet S-3, Part I, column 1, line 12 minus the sum of (line 11 plus the sum of (column 6, line 26/(**))) in accordance with 42 CFR §412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2. (* Substitute for the asterisk in the denominator for the number of days in the cost reporting period.)

Calculation of Settlement.--Complete lines 10 through 26 to determine the total program payment due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period. Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

Line descriptions

Line 10--Enter the number of program covered visits excluding visits subject to the outpatient mental health services limitation from your intermediary records.

Line 11--Enter the subtotal of program cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered program beneficiary visits for RHC/FQHC services during the reporting period).

Line 12--Enter the number of program covered visits subject to the outpatient mental health services limitation from your intermediary records.

Line 13--Enter the program covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14--Enter the limit adjustment. This is computed by multiplying the amount on line 13 by the outpatient mental health service limit of 62 ½ percent. This limit applies only to therapeutic services not initial diagnostic services.

Line 15--Enter the amount of GME pass through costs determined by dividing the (program intern and resident visits reported on Worksheet S-8, line 16 by the total visits reported on Worksheet M-2, column 5,) sum of lines 8 and 9. Multiply that result by the allowable GME costs equal to the sum of Worksheet M-1, column 7, line 20 and Worksheet M-2, line 17.

Line 16--Enter the total program cost. This is equal to the sum of the amounts in columns 1 and 2, lines 11, 14, and 15.

Line 16.01--Enter the primary payer amounts from your records (1/98).

Line 17--Enter the amount credited to the RHC's program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the intermediary from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the intermediaries. FQHCs enter zero on this line as deductibles do not apply.

Line 18--Enter the net program cost, excluding vaccines. This is equal to the result of subtracting the amounts on lines 16.01 and 17 from the amount on line 16.

Line 19--For title XVIII, enter 80 percent of the amount on line 18.

Line 20--Do not use this line. For services rendered on and after August 1, 2000 enter the amount from Worksheet M-4, line 16.

Line 21--Enter the total reimbursable Medicare cost, sum of the amounts on lines 19 and 20.

Line 22--Enter your total reimbursable bad debts, net of recoveries, from your records.

Line 23--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see CMS Pub. 15-I §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 24--This is the sum of lines 21 and 22 plus or minus line 23.

Line 25--Enter the total interim payments from Worksheet M-5 made to you for covered services furnished to program beneficiaries during the reporting period (from intermediary records). For final settlement, report on line 25.01 the amount on line 5.99 of Worksheet M-5.

Line 26--Enter the total amount due to/from the program (lines 24 minus line 25). Transfer this amount to Worksheet S, Part II, column 3, line 9.

Line 27--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying reasonable methodology which closely

approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) A schedule showing the supporting details and computations must be attached.

3665. WORKSHEET M-4 – COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of these vaccines for services rendered on and after August 1, 2000. Prior to that date all vaccines were reimbursed through the provider based hospital and could not be claimed by the RHC and FQHC.

Line 1--Enter the health care staff cost from Worksheet M-1, column 7, line 10.

Line 2--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4--Enter the cost of the pneumococcal and influenza vaccine medical supplies from your records.

Line 5--Enter the sum of lines 3 and 4.

Line 6--Enter the amount from Worksheet M-1, column 7, line 22. This is your total direct cost of the facility.

Line 7--Enter the amount from Worksheet M-2, line 16.

Line 8--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9--Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10--Enter the sum of the amounts on lines 5 and 9.

Line 11--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12--Enter the cost per pneumococcal and influenza vaccine injections by dividing the amount on line 10 by the number on line 11.

Line 13--Enter the number of program pneumococcal and influenza vaccine injections from your records or the PS&R.

Line 14--Enter the program cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15--Enter the total cost of pneumococcal and influenza vaccine and its(their) administration by entering the sum of the amount in column 1, line 10 and the amount in column 2, line 10.

Transfer this amount to Worksheet M-3, line 2.

Line 16--Enter the Medicare cost of pneumococcal and influenza vaccine and its(their) administration. This is equal to the sum of the amount in column 1, line 14 plus column 2, line 14.

Transfer the result to Worksheet M-3, line 20.

3666. **WORKSHEET M-5 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES**

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based RHC/FQHC, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your fiscal intermediary.

Line Descriptions

Line 1--Enter the total program interim payments paid to the outpatient rehabilitation provider. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable.

Line 2--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period. It does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Transfer the total interim payments to the title XVIII Worksheet M-3, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET M-5. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due from the provider to the program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet M-3, line 24.

To download the forms associated with this revision, click [here](#).