

# 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 16

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<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
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### NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates Chapter 36, Hospital and Hospital Health Care Complex Cost Report, (Form CMS 2552-96) to reflect further clarification to existing instructions and incorporates select provisions of the Deficit Reduction of Act (DRA) of 2005. The effective date for instructional changes will vary due to various implementation dates.

#### DRA2005 Revisions:

- Section 5004 of DRA 2005 to reduce allowable bad debt by 30% for beneficiaries treated in Skilled Nursing Facilities (SNF) who are not “full benefit dual eligible” as defined in 42 CFR Sec. 423.772 effective for cost reporting periods beginning on or after October 1, 2005.
- Section 5105 of DRA 2005 pays hold harmless transitional outpatient payment (TOPs) to small rural hospitals with 100 or fewer beds for services rendered from January 1, 2006 through December 31, 2008. (See Change Request 4367, transmittal 877, dated February 26, 2006)

#### Existing Payment System Revisions:

- For Inpatient Rehabilitation Facilities (IRF) the low income patient (LIP) payment is revised effective for discharges occurring on or after October 1, 2005. Also, the IRF teaching adjustment is implemented for discharges occurring on or after October 1, 2005. (See Federal Register , Vol. 70, FR 156, dated August 15, 2005) and Change Request 4037 (CMS Pub. 100-04, transmittal 680)

#### Other Significant Revisions:

- Worksheet S - Incorporated Healthcare Cost Report Information System (HCRIS) data collection elements indicating the cost report status. Impacts HCRIS not the Electronic Cost Report (ECR).
- Worksheet S - Added simplified question to initiate TOPS calculation.
- Worksheet S - Added home office identifying information when the provider is part of a chain.
- Worksheet S - Reflects the election of ambulance data collection for services on or after January 1, 2006.
- Worksheet S - Added IRF question to initiate IRF teaching adjustment.
- Worksheet S-3, Part I - Clarifies instructions regarding the coverage of SNF & NF swing beds.
- Worksheet S-4 - Revised instructions to reflect transition to core based statistical areas (CBSA).
- Worksheet D, Part III & IV - Clarified instructions regarding payment for certified registered nurse anesthetists (CRNA).
- Worksheet D, Part V - Revised instructions to reflect the elimination of ambulance fee payments for services rendered on or after January 1, 2006.
- Worksheet D-1, Part II - Revised instructions to reflect long-term care hospital (LTCH) update budget neutrality factor.
- Worksheet E, Part A - Revised instructions to reflect clarification to the three year rolling average.
- Worksheet E, Part B - Revised instructions to reflect the implementation of TOPs for small rural non-sole community hospitals (SCH). This worksheet also clarifies 101% calculation for critical access hospitals (CAH).
- Worksheet E-3, Part I - Revised instructions to reflect the implementation of the IRF teaching adjustment and the update of the LIP payment.
- Worksheet E-3, Part III - Revised instructions to implement the bad debt reduction for SNF patients.
- Worksheet E-3, Part IV - Clarified instructions regarding the three year rolling average for graduate medical education (GME).
- Worksheet E-3, Part VI - Clarified instructions regarding the redistribution of interns & residents (I&R).
- Worksheet L, Part I - Revised instruction to comport with worksheet E-3, Part VI.

**REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE:** Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after October 1, 2005.

**DISCLAIMER:** *The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

4. Round to 5 decimal places:
  - a. Sequestration (e.g., 2.092 percent is expressed as .02092)
  - b. Payment reduction (e.g., capital reduction, outpatient cost reduction)
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
CBSA	-	Core Based Statistical Areas
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
<i>DRA</i>	-	<i>Deficit Reduction Act of 2005</i>
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
HSR	-	Hospital Specific Rate
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
IPF	-	Inpatient Psychiatric Facility
IRF	-	Inpatient Rehabilitation Facility
LIP	-	Low Income Patient

LOS	-	Length of Stay
LCC	-	Lesser of Reasonable Cost or Customary Charges
LTCH	-	Long Term Care Hospital
MCP	-	Monthly Capitation Payment
MDH	-	Medicare Dependent Hospital (10/97)
MED-ED	-	Medical Education
MMA	-	Medicare Prescription Drug Improvement and Modernization Act of 2003
MSA	-	Metropolitan Statistical Area (10/97)
MSP	-	Medicare Secondary Payer
NF	-	Nursing Facility
NHCMQ	-	Nursing Home Case Mix and Quality Demonstration
<i>NPI</i>	-	<i>National Provider Identifier</i>
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
SCHIP	-	State Children Health Insurance Program
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>Form CMS</u>	<u>Worksheet</u>	<u>Part</u>	<u>Health Care Program (Title)</u>	<u>Component</u>
2552-96	E-3	III	XIX	SNF
2552-96	E-3	III	XIX	NF, ICF/MR
2552-96	E-3	IV	V, XVIII, & XIX	Hospital
2552-96	E-3	V	V, XVIII, & XIX	Hospital
2552-96	G			
2552-96	G-1			
2552-96	G-2			
2552-96	G-3			
2552-96	I-2 - I-4			Renal Dialysis
2552-96	I-2 - I-4			Home Program
				Dialysis
2552-96	J-1 - J-2			CORF, CMHC, and OPT
2552-96	J-3		V	CORF, CMHC, and OPT
2552-96	J-3		XVIII	CORF, CMHC, and OPT
2552-96	J-3		XIX	CORF, CMHC, and OPT
2552-96	J-4		XVIII	CORF, CMHC, and OPT
2552-96	K			Hospital-based Hospice
2552-96	K-1			Hospital-based Hospice
2552-96	K-2			Hospital-based Hospice
2552-96	K-3			Hospital-based Hospice
2552-96	K-4	I & II		Hospital-based Hospice
2552-96	K-5	I, II & III		Hospital-based Hospice
2552-96	K-6		XVIII, XIX	Hospital-based Hospice
2552-96	L		V, XVIII, & XIX	Hospital
2552-96	L		V, XVIII, & XIX	Subprovider
2552-96	L-1	I		Hospital
2552-96	L-1	II	V, XVIII, & XIX	Hospital
2552-96	L-1	III	V, XVIII, & XIX	Hospital
2552-96	L-1	III	V, XVIII, & XIX	Subprovider
2552-96	M-1		V, XVIII, & XIX	Hospital-based RHC/FQHC
2552-96	M-2		V, XVIII, & XIX	Hospital-based RHC/FQHC
2552-96	M-3		V, XVIII, & XIX	Hospital-based RHC/FQHC
2552-96	M-4		V, XVIII, & XIX	Hospital-based RHC/FQHC
2552-96	M-5		V, XVIII, & XIX	Hospital-based RHC/FQHC

**3603. WORKSHEET S - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**

The intermediary should indicate in the appropriate box whether this is the initial cost report (first cost report for *the provider number, for this fiscal intermediary*), final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened. The intermediary should also indicated in HCRIS on line 1, column 3 of worksheet S the following codes that correspond to the filing status of the cost report: 1=As submitted; 2=Settled; 3=Settled with Audit; 4=Reopened; and 5=Amended.

*The intermediary indicates general information about this cost report. This data is submitted as alpha-numeric data in the HCRIS file as follows:*

*Line 1, Column 1--Enter the cost report status code of 1 for as submitted, 2 for settled, 3 for settled with audit, 4 for reopened, 5 for amended. (Refer to section 10.3 of Chapter 8 of Office of Financial Management Manual Pub 100-06.)*

*Line 1, Column 2--Enter the date (mm/dd/yyyy) an accepted cost report was received from the provider.*

*Line 1, Column 3-- Enter I for initial, enter F for final, or enter N for neither. An initial report is the very first cost report the FI submits for a particular provider number. It may not be the first cost report ever for this provider number which may have been handled by a previous FI, but it would be the initial cost report for the new FI.*

*A final report is the terminating cost report for a particular provider number. If, for example, the provider terminated in 2004, but the 1998 cost report was reopened and submitted after the submission of the 2004 report, the 2004 report is still considered the final report for the provider.*

*If a provider does have a cost report that is both an initial and final report for a particular year then this field should contain an I if the cost report is an as submitted report, and a F if the cost report is a settled report.*

*Line 1, Column 4--If this is a reopened cost report, enter the number of times the cost report has been reopened. This field should only be completed if the cost report status code in line 1, column 1 is 4.*

*Line 2, Column 2--Enter the 5 position Fiscal Intermediary Number.*

*Line 2, Column 4--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2, 3 or 4.*

**3603.1 Part I - Certification by Officer or Administrator of Provider(s).**--This certification is read, prepared, and signed after the cost report has been completed in its entirety.

Check the appropriate box to indicate whether you are filing electronically or manually. For electronic filing, indicate on the appropriate line the date and time corresponding to the creation of the electronic file. This date and time remains as an identifier for the file by the intermediary and is archived accordingly. This file is your original submission and is not to be modified.

**3603.2 Part II - Settlement Summary.**--Enter the balance due to or due from the applicable program for each applicable component of the complex. Transfer settlement amounts as follows:

<u>Hospital/ Hospital Component</u>	<u>Title V</u>	<u>FROM</u>		<u>Title XIX</u>
		<u>Title XVIII Part A</u>	<u>Title XVIII Part B</u>	
Hospital	Wkst. E-3, Part III, line 58	Wkst. E, Part A, line 29 or Wkst. E-3, Part I, line 20 or Wkst. E-3, Part line 33	Wkst. E, Part B, line 35	Wkst. E-3, Part III, line 58
Subprovider	Wkst E-3, Part III, line 58	Wkst E, Part A, <i>line 29</i> <i>or</i> Wkst E-3 Part I line 20 or Wkst E-3 Part II line 33	Wkst E Part B, <i>line 35</i>	Wkst E-3, E-3, Part III line 58
Swing Bed - SNF	Wkst. E-2,col.1, line 21	Wkst. E-2, col. 1,line 21	Wkst. E-2, col. 2,line 21	Wkst E-2, col. 1,line 21
Swing Bed - NF	Wkst. E-2, col.1, line 21	N/A	N/A	Wkst. E-2, col. 1, line 21

<u>Hospital/ Hospital Component</u>	<u>Title V</u>	<u>FROM</u>		<u>Title XIX</u>
		<u>Title XVIII Part A</u>	<u>Title XVIII Part B</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

<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>
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



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3604. WORKSHEET S-2 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX 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. *Column 2.01 is reserved for future use.* 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) or §1861(mm)(1) 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.) *Effective for cost reporting periods beginning on or after July 1, 2002, Medicare swing-bed services will be paid under the SNF PPS system (indicate payment system as "P").* CAHs are reimbursed on a cost basis for swing-bed services and should indicate "O" as the payment system.

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.) RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-4, chapter 9, §30.8. Do not subscript this line if you elect to file under the consolidated cost reporting method. See section 3608.2 for further instructions.

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.

- |   |                       |
|---|-----------------------|
| 1 = General Short Term                            | 2 = General Long Term |
| 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 in column 1 if your hospital is either urban or rural at the end of the cost reporting period. Enter 1 for urban or 2 for rural. Indicate in column 2 if your facility is geographically classified or located in a rural area and contains 100 or fewer beds (see Worksheet E, Part A, line 3). Enter yes or "N" for no. (Effective after 8/1/2000s and before 2/29/04 FYE)

Line 21.01--Does your facility qualify and is currently receiving payments for disproportionate share hospital adjustment, 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 after the first day of the cost reporting period from rural to urban or vice versa? Enter "Y" for yes and "N" for no. If yes report in column 2 the effective date. If the effective date is other than the beginning date of the provider's fiscal year, subscript Worksheet E, Part A. (4/30/03s) (on or before 2/29/04 FYE)

Line 21.03--Indicate in column 1 your hospital's actual geographic location by entering either 1 for Urban or 2 for Rural. If you answer Urban in column 1, indicate a "Y" for yes and "N" for no in column 2 if you have received either a Wage or Standard Geographic reclassification to a Rural location. If column 2 is "Y" enter in column 3 the effective date. Does this facility contain 100 (see Worksheet E, Part A, line 3) or fewer beds in accordance with 42 CFR 412.105? Enter in column 4 "Y" for yes or "N" for no. (2/29/04)

Line 21.04--For the Standard Geographic classification (not wage), what is your status at the beginning of the cost reporting period. Enter 1 for Urban or 2 for Rural. (2/29/04)

Line 21.05--For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter 1 for Urban or 2 for Rural. (2/29/04)

*Line 21.06--Effective for services rendered after December 31, 2005, does the hospital qualify for the three year transition of hold harmless payments for small rural hospitals under the prospective payment system for hospital outpatient department services, under DRA 5105? Enter "Y" for yes or "N" for no. Also see CR 4367, transmittal 877, dated February 24, 2006. This response impacts the TOPs calculation on worksheet E, Part B, line 1.06. (1/1/2006s)*

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 and receiving payment for I&R? 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 *Worksheets D, Parts III and IV and D-2, Part II*, if applicable.

**NOTE:** CAHs complete question 30.04 in lieu of questions 25, 25.01, and 25.02

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, "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 25.05--Has your facility's direct GME FTE cap (column 1), or IME FTE cap (column 2), been reduced under 42 CFR 413.79(c)(3) or 42 CFR 412.105(f)(1)(iv)(B)? Enter "Y" for yes and "N" for no in the applicable column. (Impacts Worksheet E, Part A; E-3, Part IV; and E-3 Part VI.)

Line 25.06--Has your facility received additional direct GME (column 1) resident cap slots or IME (column 2) resident cap slots under 42 CFR 413.79(c)(4) or 42 CFR 412.105(f)(1)(iv)(C)? Enter "Y" for yes and "N" for no in the applicable column. (Impacts Worksheet E, Part A; E-3, Part IV; and E-3, Part VI.)

Line 26--If this is a sole community hospital (SCH), enter the number of periods (0, 1 or 2) within this cost reporting period that SCH status was in effect. Enter the beginning and ending dates of SCH status on line 26.01. Use line 26.02 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/yyyy).

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 immune-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 if you have not transitioned to 100 percent SNF PPS payment. Enter in column 2 the classification of the SNF at the end of the cost reporting period, either (1) for urban or (2) for rural. Enter in column 3 the SNF's MSA code. Where the cost reporting period overlaps October 1, 2005, enter in column 3 the SNF's MSA code for services rendered prior to October 1, 2005, and enter in column 4 the SNF's CBSA code for services rendered on or after October 1, 2005. For cost reporting periods which begin on or after October 1, 2005, enter in column 4 the SNF's CBSA code. If you are located in a rural area enter your State code as your MSA or CBSA code, as applicable.

Lines 28.03 through 28.20--A notice published in the August 4, 2003, **Federal Register**, Vol. 68, No. 149 provided for an increase in RUG payments to Hospital based Skilled Nursing Facilities (SNF) for payments on or after October 1, 2003, however, this data is required for cost reporting periods beginning on or after October 1, 2003. Congress expected this increase to be used for direct patient care and related expenses. Subscript line 28 into the following lines: 28.03 - Staffing, 28.04 - Recruitment, 28.05 - Retention of Employees, 28.06 - Training, and 28.07-28.20 - Other. Enter in column 1 the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. For each line, indicate in column 2 whether the increased RUG payments received for cost reporting periods beginning on or after October 1, 2003 reflects increases associated with direct patient care and related expenses by responding "Y" for yes. Indicate "N" for no if there was no increase in spending in any of these areas. If the increased spending is in an area not previously identified in areas one through four, identify on the "Other (Specify)" line(s), the cost center(s) description and the corresponding information as indicated above.

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. For CAHs the response is always “N” as the optional reimbursement method is not available to CAHs.

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 *on or* after October 1, 1997, the classification of rural primary care hospital is replaced by critical access hospitals (10/1/97b).

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 *on or* after October 1, 1997 RPCHs are eliminated and critical access hospitals are established and paid on the basis of reasonable costs. This question does not apply to CAHs (10/1/97b).

Line 30.02--If this facility qualifies as an RPCH/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 (10/1/97b).

**NOTE:** If the facility elected the all-inclusive method for outpatient services, professional component amounts should be excluded from deductible and coinsurance amounts and should not be included on E-1.

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 30.04--If this facility qualifies as a CAH is it eligible for cost reimbursement for I&R training programs? Enter a “Y” for yes or an “N” for no. If yes, the GME elimination is not made on Worksheet B, Part I, column 26 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II.

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. If yes, for cost reporting periods beginning on or after October 1, 2002, do you elect to be reimbursed at 100 percent Federal capital payment? Enter "Y" for yes or "N" for no in column 2.

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.) (This also includes providers that were previously hold harmless, but are now considered

100 percent fully prospective for purposes of completing Worksheet L, Part I in lieu of Worksheet L, Part II.) Enter "Y" for yes or "N" for no in the applicable columns. (For cost reporting periods beginning on or after October 1, 2001, the response is always "Y", except for new providers with fiscal years beginning before October 1, 2002 under 42 CFR 412.300(b) which the response is "N" for the provider's first 2 years.) Questions 36 and 37 are mutually exclusive.

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, except for new providers certified prior to October 1, 2001.

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. (Not applicable for cost reporting periods beginning on or after October 1, 2001, except for new providers certified prior to October 1, 2001. If a new provider's response is "Y", complete Worksheet A, line 90 and Worksheet B, Parts II and III.)

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. (Not applicable for cost reporting periods beginning on or after October 1, 2001, except for new providers certified prior to October 1, 2001.)

**NOTE:** Providers deemed to be new in accordance with 42 CFR 412.300(b) for cost reporting periods beginning prior to October 1, 2001, the response to questions 37 and 37.01 is "N" for the provider's first two cost reporting periods. For the third thru tenth cost reporting period the response is "Y".)

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). *If this facility is part of a chain enter the name, street address, post office box (if applicable), the city, state, zip code of the home office on lines 40.01 through 40.03.*

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 52.01--If you are a fully prospective or hold harmless provider, are you eligible for the special exception payment pursuant to 42 CFR 412.348(g)? Enter "Y" for yes or "N" for. If yes, complete Worksheet L, Part IV. (10/1/2001)

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, *however you are still subject to the fee/cost blend*. 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 (column 2) chronologically, in accordance with your fiscal year. Applicable chronological dates (column 0) 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 percent fee schedule amount is transitioned on 1/1/2006. *For cost reporting periods that straddle 1/1/2006, only report ambulance fee schedule amounts for services rendered before 1/1/2006.*

CAHs exempt from the ambulance 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. A CAH exempt *from the ambulance PPS (Worksheet S-2, line 30.03, column 1 equals "Y")* is cost reimbursed and not subject to the fee/cost blend *or the ambulance per trip limits*.

*Do not complete line 56 for cost reporting periods beginning on or after January 1, 2006.*

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--Are you an Inpatient Rehabilitation Facility (IRF) or do you contain an IRF subprovider? Enter in column 1 "Y" for yes and "N" for no. If you are an IRF or if the hospital complex contains an IRF subprovider, have you made the election for 100 percent Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. Complete only column 2 for cost reporting period beginning on or after January 1, 2002 and before October 1, 2002. The response in column 2 determines the IRF payment system, i.e., a response of "N" indicates the payment system as "T" for TEFRA or TEFRA BLEND and follows the TEFRA calculation while a response of "Y" indicates the payment system as "P" for PPS and follows the PPS calculation. All IRFs will be reimbursed at 100 percent Federal PPS for cost reporting periods beginning on or after 10/1/2002.

*Line 58.01--If this facility is an IRF or contains an IRF subprovider (response to line 58, column 1 is "Y" for yes), did the facility train residents in teaching programs in the most recent cost reporting period ending on or before November 15, 2004? Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in new teaching programs in accordance with FR, Vol. 70, No. 156, page 47929 dated August 15, 2005? Enter in column 2 "Y" for yes or "N" for no. (Note: questions 1 and 2 must have opposite answers, i.e., if column 1 is "Y", then column 2 must be "N" and vice versa; columns 1 and 2 cannot be "Y" simultaneously, columns 1 and 2 can be "N" simultaneously.) If yes, enter a "1", "2", or "3", respectively, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that begins during the current cost reporting period. If the current cost reporting period covers the beginning of the fourth academic year of the first new teaching program's existence, enter the number "4" in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program's existence, enter the number "5" in column 3.*

Line 59--Are you a Long Term Care Hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. If you are a LTCH, have you made the election for 100 percent Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. The election must be made in writing 30 days prior to the start of your cost reporting period. Only complete column 2 for cost reporting period beginning on or after 10/1/2002 and before 10/1/2006. The response in column 2 determines the LTCH payment system, i.e., a response of "N" indicates the payment system as "T" for TEFRA or TEFRA BLEND and follows the TEFRA calculation while a response of "Y" indicates the payment system as "P" for PPS and follows the PPS calculation. All LTCHs will be reimbursed at 100 percent Federal PPS for cost reporting periods beginning on or after 10/1/2006. LTCHs can only exist as independent /freestanding facilities.

Line 60--Are you an Inpatient Psychiatric Facility (IPF) or do you contain an IPF subprovider? Enter in column 1 "Y" for yes and "N" for no. If you are a IPF or if the hospital complex contains an IPF subprovider, is this a new facility in accordance with CR 3752 (dated 3/4/2005)? Enter in column 2 "Y" for yes and "N" for no. Only complete column 2 for cost reporting period beginning on or after 1/1/2005 and before 1/1/2008. The response in column 2 determines the IPF payment blend during the transition, i.e., a response of "Y" indicates a new provider that will be paid at 100% of the PPS amount. A response of "N" indicates the payment system as "T" for TEFRA or TEFRA BLEND and follows the TEFRA calculation while a response of "Y" indicates the payment system as "P" for PPS and follows the PPS calculation. All IPFs will be reimbursed at 100 percent Federal PPS for cost reporting periods beginning on or after 1/1/2008.

Line 60.01--If this facility is an IPF or contains an IPF subprovider (response to line 60, column 1 is "Y" for yes), did the facility train residents in ***teaching programs in the most recent cost reporting period filed on or before November 15, 2004?*** Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in new teaching programs in accordance with §412.424(d)(1)(iii)(2)? Enter in column 2 "Y" for yes or "N" for no. (Note: questions 1 and 2 must have opposite answers, i.e., if column 1 is "Y", then column 2 must be "N" and vice versa; columns 1 and 2 cannot be "Y" simultaneously, columns 1 and 2 can be "N" simultaneously.) If yes, enter a "1", "2", or "3", respectively, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that begins during the current cost reporting period. If the current cost reporting period covers the beginning of the fourth academic year of the first new teaching program's existence, enter the number "4" in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program's existence, enter the number "5" in column 3.

**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--Effective for discharges occurring on or after October 1, 2004, refer to 42 CFR 412.105(b) and Vol. 69 of the Federal Register 154, dated August 11, 2004, page 49093 to determine the facility bed count. 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 all CAH patients spend in each category on lines 1 and 6 through 10, effective for (August 31, 2002) and later cost reports. This data is for informational purposes only.

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. For LTCH, enter in column 4 the number of covered Medicare days (from the PS&R) and in column 4.01 the number of noncovered days (from provider's books and records) for Medicare patients and continue to capture this data even after the LTCH has transitioned to 100 percent PPS.

Report the program days for PPS providers (acute care hospital, LTCH, and IRF) in the cost reporting period in which the discharge is reported. This also applies to providers under the TEFRA/PPS blend. 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(f) for the indirect medical education adjustment. *The FTE residents reported by an IPF PPS facility or an IRF PPS facility (whether freestanding or a unit reported on line 14 or 14.01 of an IPPS hospital's cost report) shall be determined in accordance with 42 CFR 412.424(d)(1)(iii) for IPFs and in accordance with the Federal Register, Vol. 70, number 156, dated August 15, 2005, pages 47929-30 for IRFs.*

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)(iv)). 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. *Do not complete effective for cost reporting periods beginning on or after August 1997.*

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, 5, and 6, enter the number of adult and pediatric hospital days excluding the SNF and NF swing bed, observation, *hospice* and HMO days. **Do not include in column 4 Medicare Secondary Payer/Lesser of Reasonable Cost (MSP/LCC) days.** Include these days only in column 6.

Line 2--Enter title XVIII and XIX HMO days and other Medicaid eligible days not included on line one. (10/97) Subscript this line for IRF subproviders to capture Medicaid HMO days in column 5. (1/1/02b)

Line 3--Enter the Medicare covered swing bed days (*which are considered synonymous with SNF swing bed days*) for all *Title XVIII* programs where applicable. *See 42CFR 413.53(a)(2).*

Line 4--Enter the non-Medicare covered swing bed days (*which are considered synonymous with NF swing bed days*) for all programs where applicable. *See 42CFR 413.53(a)(2).*

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 - 11 for columns 1 - 6, and for columns 12 - 15, enter the amount from line 1. For columns 7 - 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 as inpatients but only the hours up to the time of admission as well as the hours for observation of patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge from the facility. 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.

Effective for cost reporting periods beginning on or after October 1, 2004, for line 26 add (unshade) column 5 (total Medicaid observation bed days), subscript column 5 by adding column 5.01 (Medicaid observation bed days for patients who are subsequently admitted as inpatients but only the hours up to the time of admission), and column 5.02 (Medicaid observation bed days for patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge). Additionally, subscript column 6 by adding column 6.01 (Total observation bed days for patients who are subsequently admitted as inpatients but only the hours up to the time of admission) and column 6.02 (Total observation bed days for patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge). The amount in column 5 must equal the



sum of columns 5.01 and 5.02 and the amount in column 6 must equal the sum of columns 6.01 and 6.02. (10/1/2004b)

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 subscribing (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 (*DSH*), *Worksheet L, line 4 (capital IME)*, and Worksheet E-3, Part I, line 1.04 (*LIP*). Subscript this line for IRF subproviders to capture Employee discount days in column 6. (1/1/02b)

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 IPPS hospitals (see §1886(d)), any hospital with an IPPS subprovider, or any hospital that would be subject to IPPS 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 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. *Do not include salary costs for* 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 reported for Hospital-based RHC and FQHC 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 related organization 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 and subscript this line to report these costs on line 9.01 and 9.02 respectively (10/97). For cost reporting periods beginning on or after October 1, 2000, DO NOT use lines 9.01 and 9.02, but include on line 9 contract pharmacy and laboratory wage 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 Form CMS-339, *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 9.03--Enter the amount paid for **management and administrative services** furnished under contract, rather than by employees. Report only those personnel costs associated with the contract. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. DO NOT include the chief executive officer, chief operating officer, and nurse administrator; these services are included on line 9. DO NOT include the administrative and general services included on line 22.01. (10/1/2003b).

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 and/or related organization, who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office/related organization salaries included on line 7 and the associated wage-related costs. This figure must be based on recognized methods of allocating an individual's home office/related

organization salary to the hospital. If no home office/related organization exists or if you cannot accurately determine the hours associated with the home office/related organization 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 6 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 6, 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 6 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 hospitals should use GAAP in developing related costs, the amount reported for wage index purposes must meet the reasonable costs provisions of Medicare. For example, the cost reported for self insurance must not exceed the cost of available comparable commercial insurance (see PRM, Part I, §2162).

**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 6 of 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 6 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.)

Health Insurance and Health-Related Wage Related Costs:

For cost reporting periods beginning on or after October 1, 1998, hospitals and fiscal intermediaries are *not* 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 *does not apply* 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 *for employees whose services are paid under IPPS* 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 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 **2, 3, 4.01, 5, 5.01, 6, 6.01**, and 7 equals or exceeds a threshold of 15 percent. 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.

Lines 22.01, 26.01, and 27.01--Enter the amount paid for services **under contract**, rather than by employees, for administrative and general, housekeeping, and dietary services, respectively. DO NOT include costs for equipment, supplies, travel expenses, and other miscellaneous or overhead items. Report only personnel costs associated with these contracts. Continue to report on the standard lines (line 22, 26, and 27), the amounts paid for services rendered by employees not under contract. (10/1/2003b)

**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; 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, 5.01, 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).

Line 13--Enter from Part II above, the sum of lines 21 through 35. If the hospital's ratio for excluded area salaries to net salaries is greater than 5 percent, the hospital must complete all columns for this line. (See instructions in Part II, lines 21 through 35 for calculating the percentage.)

### 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--***For HHA services rendered on or after January 1, 2006, geographic areas are identified as CBSAs.* Enter in *column 1* the number of *MSAs* and in *column 1.01* the number of *CBSAs* you serviced during this cost reporting period (*1/1/2006s*).

**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). *For HHA services rendered on or after January 1, 2006, enter the 5 digit CBSA code and Non-CBSA (rural). Rural CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the state of Maryland the rural CBSA code is 99921 and rural MSA codes are assembled by placing the digits "99" in front of the two digit State code, e.g., for the state of Maryland the rural MSA code is 9921.*

**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 60<sup>th</sup> 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 60<sup>th</sup> 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 (standard/non-outlier) 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 outlier 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).

**NOTE:** Lines 36 and 37 are mutually exclusive.

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.

**3607. WORKSHEET S-5 - HOSPITAL RENAL DIALYSIS DEPARTMENT 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 the Medicare program. The statistics reported on this worksheet pertain to the renal dialysis department. The data maintained, depending on the services provided by the hospital, includes patient data, the number of treatments, number of stations, and home program data.

If you have more than one renal dialysis department, submit one Worksheet S-5 combining all of the renal dialysis departments' data. You must also have on file (as supporting documentation), a Worksheet S-5 for each renal dialysis department and the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-I, §2720. Enter on the combined Worksheet S-5 each renal dialysis provider's satellite number if you are separately certified as a satellite facility.

Line Descriptions

Line 1--Enter the number of patients receiving dialysis at the end of the cost reporting period.

Line 2--Enter the average number of times patients receive dialysis per week. For CAPD and CCPD patients, enter the number of exchanges per day.

Line 3--Enter the average time for furnishing a dialysis treatment.

Line 4--Enter the average number of exchanges for CAPD.

Line 5--Enter the number of days dialysis is furnished during the cost reporting period.

Line 6--Enter the number of stations used to furnish dialysis treatments at the end of the cost reporting period.

Line 7--Enter the number of treatments furnished per day per station. This number represents the number of treatments that the facility can furnish not the number of treatments actually furnished.

Line 8--Enter your utilization. Compute this number by dividing the number of treatments furnished by the product of lines 5, 6, and 7. This percentage can not exceed 100 percent.

Line 9--Enter the number of times your facility reuses dialyzers. This number is the average number of times patients reuse a dialyzer. If none, enter zero.

Line 10--Enter the percentage of patients that reuse dialyzers.

Line 11--Enter the number of patients who are awaiting a transplant at the end of the cost reporting period.

Line 12--Enter the number of patients who received a transplant during the fiscal year.

Line 13--Enter the direct product cost net of discount and rebates for Epoetin (EPO). Include all EPO cost for patients receiving outpatient, home (method I or II), 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 disease dialysis patient. Report on this line the amount included in line 57 of Worksheet A (10/97).

Line 13.01--*Based on the instructions contained on line 13*, enter the amount of epoetin included on line 64 (home dialysis program) from Worksheet A (10/97).



Line 14--Enter the number of EPO units furnished *relating to the renal dialysis department*.

Line 14.01--Enter the number of EPO units furnished *relating to the home dialysis program*.

Line 15--Identify how physicians are paid for medical services provided to Medicare beneficiaries. Under the monthly capitation payment (MCP) methodology, carriers pay physicians for their Part B medical services. Under the initial method, the renal facility pays for physicians' Part B medical services. The facility's payment rate is increased in accordance with 42 CFR 414.313. There are a limited number of facilities electing this method.

#### Column Descriptions

Columns 1 and 2--Include in these columns information regarding outpatient hemodialysis patients. **Do not include information regarding intermittent peritoneal dialysis.** In column 2, report information if you are using high flux dialyzers.

Columns 3 through 6--Report information concerning the provider's training and home programs. **Do not include intermittent peritoneal dialysis information in columns 3 and 5.**

center. Make a similar reclassification to the appropriate line for other ancillaries when the HHA costs are readily identifiable.

**NOTE:** This cost report provides separate HHA cost centers for all therapy services. If services are provided to HHA patients from a shared hospital ancillary cost center, make the cost allocation on Worksheet H-4, Part II.

Lines 72 through 81--Do not use these lines.

Lines 82 through 93--Use these lines for special purpose cost centers. Special purpose cost centers include kidney, heart, liver, and lung acquisition costs, costs of other organ acquisitions which are nonreimbursable but which CMS requires for data purposes, cost centers which must be reclassified but which require initial identification, and ASC and hospice costs which are needed for rate setting purposes.

**NOTE:** Prorate shared acquisition costs (e.g., coordinator salaries, donor awareness programs) among the type of organ acquisitions. Generally, this is done based on the number of organs procured. Further, if multiple organs have been procured from a community hospital or an independent organ procurement organization, prorate the cost among the type of acquisitions involved.

Line 82--Record any costs in connection with lung acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 83--This cost center includes the cost of services purchased under arrangement or billed directly to the hospital in connection with kidney acquisition. Such direct costs include but are not limited to:

- o Fees for physician services (preadmission for transplant donor and recipient tissue-typing and all tissue-typing services performed on cadaveric donors);
- o Cost for kidneys acquired from other providers or kidney procurement organizations;
- o Transportation costs of kidneys;
- o Kidney recipient registration fees;
- o Surgeons' fees for excising cadaveric donor kidneys; and
- o Tissue-typing services furnished by independent laboratories.

**NOTE:** No amounts or fees paid to a donor, their estate, heirs, or assigns in exchange for a kidney or for the right to remove or transplant a kidney are included in kidney acquisition costs. Also, such amounts or fees are not included in any other revenue producing or general service cost center.

Only hospitals which are certified transplant centers are reimbursed directly by the Medicare program for organ acquisition costs. All such costs are accumulated on Worksheet D-6.

Hospitals which are not certified transplant centers are not reimbursed by the Medicare program for organ acquisition costs. Such hospitals sell any organs excised to a certified transplant center or an

organ procurement organization. The costs are accumulated in this cost center and flow through cost finding to properly allocate overhead costs to this cost center. However, only a certified transplant center completes Worksheet D-6.

Line 84--Record any costs in connection with liver acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 85--Record any costs in connection with heart acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 85.01--Record any costs in connection with pancreas acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs (8/99).

Line 86--Record any costs related to organ acquisitions which are not already recorded on lines 82, 83, 84, 85 and 85.01. This cost center flows through cost finding and accumulates any appropriate overhead costs (8/99).

Line 87--Do not use this line.

Line 88--Enter all interest paid by the facility. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

**NOTE:** If capital-related and working capital interest are commingled on this line, reclassify working capital interest to A & G expense. Reclassify capital-related interest to lines 1 through 4, as appropriate, in accordance with the instructions for those lines.

Line 89--Include only utilization review costs of the hospital-based SNF. All costs are either reclassified or adjusted in total depending on the scope of the review. If the scope of the review covers all patients, all allowable costs are reclassified in column 4 to A & G expenses (line 6). If the scope of the review covers only Medicare patients or Medicare, title V, and title XIX patients, then (1) in column 4, reclassify to A & G expenses all allowable costs other than physicians' compensation and (2) deduct in column 6 the compensation paid to the physicians for their personal services on the utilization review committee. The adjusted amount is then reinstated on Worksheet D-1, line 81 for each program. The sum of the amounts reported on each Worksheet D-1 and/or the amount reported on Worksheet E-2, column 1, line 7 must equal the amount adjusted on Worksheet A-8 (9/96).

Line 90--In accordance with 42 CFR 412.302(b)(4), enter all other capital-related costs, including but not limited to taxes, insurance, and license and royalty fees on depreciable assets. This line also includes any directly allocated home office other capital cost. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

A **PPS hospital** or **a complex with a PPS excluded unit** which is paid for PPS inpatient capital using the hold harmless method is required to allocate the costs in this cost center between old and new capital and between buildings and fixtures and movable equipment on the basis of the ratio of the hospital's gross old asset value to total asset value in each cost reporting period on Worksheet A-7, Part III.

For cost reporting periods beginning on or after October 1, 2001, PPS providers paid 100 percent Federal do not complete line 90, columns 1 and 2 and Worksheet A-7, Parts III and IV. Complete Worksheet A-7, Parts I (if applicable) and II for cost reporting periods ending on or after February 29, 2004. However, for cost reporting periods ending on or after April 30, 2005, PPS providers paid 100 percent Federal will again complete line 90, column 2 and Worksheet A-7, Parts I (if applicable), II, III and IV.

Column 7--Enter on each line the total patient days, excluding swing bed days, for that cost center. For line 25, enter the total days reported on Worksheet S-3, Part I, column 6, the sum of lines 1 and 26. For lines 26 through 33, enter the days from Worksheet S-3, Part I, column 6, lines 6 through 10, 14, and 11 respectively. For subprovider, line 31, add to line 14 of worksheet S-3, the observation bed days, if applicable, reported on the subscripts of line 26.

Column 8--Enter the program inpatient days for the applicable cost centers. For line 25, enter the days reported on Worksheet S-3, Part I, columns 3, 4, or 5, as appropriate, line 1. For lines 26 through 33, enter the days from Worksheet S-3, Part I, columns 3, 4, or 5, as appropriate, lines 6 through 10, 14, and 11, respectively.

**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.) Add any program days for general care patients of the component who temporarily occupied beds in an intensive care or other special care unit to line 25, and decrease the appropriate intensive care or other special care unit by those days.

Column 9--Divide the old capital costs of each cost center in column 3 by the total patient days in column 7 for each line to determine the old capital per diem cost. Enter the resultant per diem cost in column 9.

Column 10--Multiply the per diem in column 9 by the inpatient program days in column 8 to determine the program's share of old capital costs applicable to inpatient routine services, as applicable.

Column 11--Divide the new capital costs of each cost center in column 6 by the total patient days in column 7 for each line to determine the new capital per diem cost. Enter the resultant per diem cost in column 11.

Column 12--Multiply the per diem in column 11 by the inpatient program days in column 8 to determine the program's share of new capital costs applicable to inpatient routine services, as applicable.

3621.2 Part II - Apportionment of Inpatient Ancillary Service Capital Costs--This worksheet is provided to compute the amount of capital costs applicable to hospital inpatient 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 the old capital-related costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 27. For the hospital component or subprovider, if applicable, enter on line 62 the amount from Worksheet D-1, Part IV, column 5, line 86.

Column 2--Enter on each line the new capital-related costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part III, column 27. For the hospital and subprovider components only, enter on line 62 the amount from Worksheet D-1, Part IV, column 5, line 87.

Column 3--Enter on each line the total charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

**Column 4**--Enter on each line the appropriate title V, XVIII, Part A, or XIX inpatient charges from Worksheet D-4, column 2. Enter on line 62 the title XVIII observation bed charges applicable to title XVIII patients subsequently admitted after being treated in the observation area. Enter on line 66 the Medicare charges for medical equipment rented by an inpatient. The charges are reimbursed under the DRG. However, you are entitled to the capital-related cost pass through applicable to this medical equipment.

**NOTE:** Program charges for PPS providers are reported in the cost reporting period in which the discharge is reported. TEFRA providers report charges in the cost reporting period in which they occur.

Do not include in Medicare charges any charges identified as MSP/LCC.

**Column 5**--Divide the old capital cost of each cost center in column 1 by the charges in column 3 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**--Multiply the old capital ratio in column 5 by the program charges in column 4 to determine the program's share of old capital costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

**Column 7**--Divide the new capital cost of each cost center in column 2 by the charges in column 3 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 7.

**Column 8**--Multiply the new capital ratio in column 7 by the program charges in column 4 to determine the program's share of new capital costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

**3621.3 Part III - Apportionment of Inpatient Routine Service Other Pass Through Costs**--This part computes the amount of pass through costs other than capital applicable to hospital inpatient routine service costs. Determine capital-related inpatient routine service costs on Worksheet D, Part I. Complete only one Worksheet D, Part III for each title. Report hospital, subprovider, SNF and NF/ICFMR (if applicable) information on the same worksheet, lines as appropriate. For cost reporting periods beginning on or after July 1, 1998, SNFs are required to report medical education costs as a pass through cost.

**Column 1**--For PPS hospitals and components which qualify for the exception to the implementation of the CRNA fee schedule, enter on each line the nonphysician anesthetist cost for each cost center, as appropriate. (See §3610, line 20 description for more information.) Obtain this amount from Worksheet B, Part I, column 20 after taking into consideration any post step down adjustments that may have been made after cost finding. *(The following language is eliminated in T16, but will remain in the manual for historical(backward compatibility) purposes:* For cost reporting periods that straddle April 1, 2003, prorate this amount by the ratio of days prior to 4/1/2003 to total days in the cost reporting period. For cost reporting periods beginning on or after 4/1/2003 do not complete this column (enter zero).)

**Column 2**--Enter on each line (after taking into consideration any post step down adjustments applicable to direct medical education costs made after cost finding) the direct medical education cost 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 (reported on Worksheet B-2) applicable to direct medical education costs for nursing school and paramedical education. For SNF/NFs 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.

**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. *(The following language is eliminated in T16, but will remain in the manual for historical purposes: For cost reporting periods that straddle April 1, 2003, prorate this amount by the ratio of days prior to April 1, 2003 to total days in the cost reporting period. For cost reporting periods beginning on or after April 1, 2003 do not complete this column (enter zero).)*

*Column 1.01--For cost reporting periods ending on or after 4/1/2003, column 1 will be subscripted. Column 1.01 will represent outpatient CRNA costs for hospitals and components qualifying for the exception to the CRNA fee schedule. For cost reporting periods that straddle April 1, 2003, prorate the amount in column 1 by the ratio of days prior to 4/1/2003 to total days in the cost reporting period. For cost reporting periods beginning on or after 4/1/2003 do not complete this column (enter zero).*

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, line 46.30 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. (8/31/02) (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 3.01--For cost reporting periods ending on or after 4/1/2003, column 3 will be subscripted. Column 3.01 will represent outpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 1.01 and 2, including subscripts of column 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 5.01--For cost reporting periods ending on or after 4/1/2003, column 5 will be subscripted. Divide the cost of each cost center in column 3.01 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 5.01.*



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, 5.03, and 5.04, if applicable. Do not include in Medicare charges any charges identified as MSP/LCC (8/00).

**NOTE:** Columns 8 and 9 will be subscripted to reflect to separate columns for worksheet D, Part V, columns 5.03 and 5.04, if applicable. (8/2000)

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).

*Column 9 (and subscripts)--For cost reporting periods ending prior to 4/1/2003, multiply the ratio in Column 5 by the charges in Column 8 (and subscripts). For cost reporting periods ending on and after 4/1/2003, multiply the ratio in Column 5.01 by the charges in Column 8 (and subscripts).*

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 RPDH 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. Subscripting 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 subscripting 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 OPSS 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 subscripting 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. *Do not subscript line 65 for cost reporting periods beginning on or after 1/1/2006, as the ambulance PPS payment blend will transition to 100 percent fee based payments.*

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 fee 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 column 5 by the appropriate ratio in column 1 and multiply the charges reported in columns 5.01 by the appropriate ratio in column 1.01 and add the results. Compare that to the limit amount calculated as indicated above and enter the lesser of the two in column 9.02.

Ambulance services on or after 4/1/2002 through 12/31/2005 are reimbursed on a blend of the lesser of the cost (the lesser of the cost to charge ratio times charges or limit (applicable limit from Worksheet S-2, line 56 and subscripts, column 2 times the corresponding trips from Worksheet S-3, line 27 and subscripts, column 4)) 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 (cost percentage/fee percentage) are: Calendar year 2003 is 60/40, 2004 is 40/60, 2005 is 20/80, and 2006 and after is 100 percent fee schedule amounts. *Once ambulance payment has transitioned to 100 percent of the fee amount (services rendered on or after 1/1/2006), line 56 will no longer include fee schedule payments.*

*Generally*, CAHs follow the instructions for ambulance services subject to the limit (10/1/97b) and/or the blend (4/1/02s). *However, CAHs eligible for cost reimbursement for ambulance* (Worksheet S-2, line 30.03, column 1 = "Yes") multiply 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--*Generally*, for title XVIII, *Medicare outpatient covered clinical laboratory services are paid on a fee basis, and should not be included on this line. Outpatient CAH clinical laboratory services rendered on or after November 29, 1999 will be paid on a reasonable cost basis not subject to deductibles and coinsurance. In addition, hospital outpatient laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area will also be paid on a reasonable cost basis not subject to deductibles and coinsurance, for cost reporting periods beginning on or after July 1, 2004, but before July 1, 2006.* For title 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. Include charges for drugs paid at 80 percent of cost subject to deductibles and coinsurance, such as osteoporosis drugs and drugs paid under OPSS such as hepatitis vaccines. Do not include vaccine charges for vaccines reimbursed at 100 percent of cost such as pneumococcal and influenza vaccines not subject to deductibles and coinsurance. 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 before August 1, 2000. 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>	<u>Title XVIII, Part B Swing Bed</u>	<u>To</u>	<u>Titles V or XIX or Title XVIII, Part B</u>
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, 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. Pneumococcal and Influenza vaccines rendered on or after January 1, 2003 have transitioned back to cost reimbursed.

For services rendered prior to 4/1/2001 vaccines are reimbursed under cost. For services rendered from 4/1/2001 through 12/31/2002 vaccines are reimbursed under OPPS and will be included in the OPPS PS&R. Therefore vaccine cost will be included in worksheet D, Part V, columns 5.01 or 5.03 amounts for 4/1/2001 through 12/31/2002 (reimbursed at 80% of cost subject to coinsurance and deductibles) and flow to the proper lines on Worksheet E, Part B. For vaccines reimbursed at 100% of cost not subject to coinsurance and deductibles (pneumococcal and influenza vaccines rendered on or after January 1, 2003) Worksheet D, Part VI, line 3, will be transferred to Worksheet E, Part B, line 1.

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 April 1, 2001, no subscripting is required except for cost reporting periods which overlap January 1, 2003.

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 the charges for hepatitis B vaccines on worksheet D, Part V as 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, except for cost reporting periods which overlap January 1, 2003. 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 and on or after January 1, 2003. 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 and before January 1, 2003. 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. Transfer the amount on line 3 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. *See 413.53(a)(2)*

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.

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 (includes IRFs and LTCHs during the TEFRA/PPS blend), 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 (includes IRFs and LTCHs under 100 percent PPS), 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. *If this is a CAH and there is a private room differential, process as a non PPS provider.*

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 including IRF, **IPF** and LTCH, reimbursed at 100 percent Federal rate 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.

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--For cost reporting periods beginning on or after October 1, 1997, 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.

For long-term care hospitals and psychiatric hospitals or psychiatric subproviders the 1 percent limitation is increased to 1.5 percent for cost reporting periods beginning on and after October 1, 2000 and before October 1, 2001 and to 2 percent for cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002. For cost reporting periods beginning on or after 10/1/2002, the instructions in the above paragraph are again applicable.

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 (42 CFR §413.40(j)), except cancer and children's hospitals, for services rendered on and after October 1, 1997 and on or before September 30, 2002, 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-1, which are obtained from 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 (10/1/97s). To recalculate line 52, for cost reporting periods that overlap the September 30, 2002 expiration date, multiply the capital pass through costs included on lines 50 and 51 of Worksheet D-1, which are obtained from Worksheet D, Parts I and II, by the ratio of days on and before September 30, 2002, to total days for the period applied to the capital pass through amount. Multiply that result by 85 percent and add to that 100 percent of the ratio of days after September 30, 2002, to total days for the period. For cost reporting periods beginning on or after October 1, 2002, multiply the capital amount reported on lines 50 and 51 by 100 percent. Add the result of the 100 percent of capital to the non capital pass through costs included on lines 50 and 51 as the capital reduction is no longer applicable (9/30/02s).

Lines 59.01 through 59.08--Lines 59.01 through 59.08 will be completed for long-term care providers with cost reporting periods beginning on or after October 1, 2002 and before October 1, 2006, that have not elected to be reimbursed at 100 percent of the Federal rate.

Line 59.01--Enter the allowable inpatient cost per discharge, computed as line 59 divided by line 54.

Line 59.02--Enter the number of program discharges occurring from the beginning of the cost reporting period through **June 30**. For full year cost reporting periods ending June 30, this amount will agree with the discharges entered on line 54.

Line 59.03--Enter the number of program discharges occurring from July 1 through the end of the cost reporting period.

**NOTE:** Subscripted line 59.04 and 59.07 will be required for cost reporting periods greater than 12 months that overlap two July 1 dates.

Line 59.05 through 59.07--Compute the reduced inpatient cost per discharge for each period by applying the appropriate budget neutrality factor to the allowable inpatient cost per discharge reported on line 59.01. Budget neutrality factors have been identified in the Federal Register dated August 30, 2002, page 56034, June 6, 2003, page 34153, and May 7, 2004, page 25703 and are reflected as follows:

- 93.40 percent for discharges occurring from 10/1/2002 through 6/30/2003
- 94.00 percent for discharges occurring from 7/1/2003 through 6/30/2004
- 99.50 percent for discharges occurring from 7/1/2004 through 6/30/2005
- *1.000 (a 0.0 percent reduction) for discharges occurring from 7/1/2005 through 6/30/2006 (70 FR 24202)*
- *1.000 (a 0.0 percent reduction) for discharges occurring from 7/1/2006 through 6/30/2007 (70 FR 24202)*

Line 59.08--Enter the sum lines 59.02 times 59.05, 59.03 times 59.06, and 59.04 times 59.07 (if applicable). Transfer this amount to Worksheet E-3, Part I, line 1 for long-term care hospital providers with cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, that have not elected to be reimbursed at 100 percent of the Federal rate.

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 for cost reporting periods beginning prior to July 1, 2002. However, CAHs continue to transfer this amount to worksheet E-2.

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.



Column 3--Enter on lines 26 and 35 the amounts in column 1 minus the amount in column 2. Enter on line 27 the amount from column 2. Enter on lines 29 through 33 and 37 the amounts from column 1.

Column 4--Enter the total inpatient days applicable to the various patient care areas of the complex. (See instructions for Part I, column 3. For line 27, this is from Worksheet D-1, sum of lines 5 and 6.)

Column 5--Divide the allocated expense in column 3 by the inpatient days in column 4 to arrive at the average per diem cost for each cost center.

Column 6--Enter on lines 26, 27, 29 through 33, and 35 through 37, as applicable, the total number of days in which inpatients were covered under Medicare Part B but did not have Part A benefits available.

Column 7--Multiply the average per diem cost in column 5 by the number of inpatient days in column 6 to arrive at the expense applicable to title XVIII for each cost center. Transfer the amount on line 27, or lines 35.01 or 35.02 if you are a subprovider with a swing bed, to Worksheet E-2, column 2, line 6.

For columns 1, 3, and 7, enter on line 34 the sum of the amounts on line 26 plus the sum of the amounts on lines 29 through 33.

Transfer the expenses on lines 34, 35, and 37 to the appropriate lines on Part III, column 4, whenever you complete both Parts I and II.

However, when only Part II is completed, transfer the amount entered in column 7, lines 34, 35, and 37 to Worksheet E, Part B, line 2, as appropriate.

3623.3 Part III - Summary for Title XVIII (To be completed only if both Parts I and II are used)--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 is applicable to Medicare only and is provided to summarize the amounts apportioned to the program in Parts I and II. This part is completed only if both Parts I and II are used.

Transfer title XVIII expenses.

<u>Description</u>	<u>From Column 6</u>		
Hospital	Line 41	TO	Worksheet E, Part B, line 2
Subprovider	Line 42	TO	Worksheet E, Part B, line 2
SNF	Line 44	TO	Worksheet E, Part B, line 2

## 3624. WORKSHEET D-4 - INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

All providers must complete this worksheet (including CAHs) with the exception of RPDH components. (See Worksheet S-2, line 30.) At the top of the worksheet, indicate by checking the appropriate lines the health care program, provider component, and the payment system for which the worksheet is prepared. When reporting Medicare charges on the appropriate lines and columns, do not include Medicare charges identified as MSP/LCC.

Line Descriptions

Lines 25 through 30--Enter the program charges from the PS&R or your records (hospital only).

Line 31--Enter in column 2 the inpatient program charges for subproviders. For the subprovider component do not complete lines 25-30. For the Hospital *component* do not complete line 31.

Lines 37 through 68--These cost centers have the same line numbers as the respective cost centers on Worksheets A, B, B-1, and C. This design facilitates referencing throughout the cost report.

**NOTE:** The worksheet line numbers start with line 37 because of this referencing feature.

Line 101--Enter the total of the amounts in columns 2 and 3, lines 37 through 64 and 66 through 68.

In accordance with 42 CFR 413.53, this worksheet provides for the apportionment of cost applicable to hospital inpatient services reimbursable under titles V, XVIII, Part A, and XIX. Complete a separate copy of this worksheet for each subprovider, hospital-based SNF, swing bed-SNF, swing bed-NF, and hospital-based NF for titles V, XVIII, Part A, and XIX, as applicable. Enter the provider number of the component in addition to the hospital provider number when the worksheet is completed for a component.

**NOTE:** If you are a rural hospital with an attached SNF electing the optional swing bed reimbursement method, use the SNF component number. However, in this case, if you also have certified swing beds, use the swing bed-SNF component number instead of the SNF provider number on all applicable worksheets.

Column 1--Enter the ratio of cost to charges developed for each cost center from Worksheet C, Part I. The ratios in columns 10 and 11 of Worksheet C, Part I are used only for hospital or subprovider components for titles V, XVIII, Part A, and XIX inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) or PPS (see 42 CFR 412.1(a) through 412.125), respectively. Use the ratios in column 9 in all other cases.

**NOTE:** Make no entries in columns 1 and 3 for any cost center with a negative balance on Worksheet B, Part I, column 27. However, complete column 2 for such cost centers.

Column 2--Enter from the PS&R or your records the indicated program inpatient charges for the appropriate cost centers. The hospital program inpatient charges exclude inpatient charges for swing bed services. If gross combined charges for professional and provider components were used on Worksheet C, Part I to determine the ratios entered in column 1 of this worksheet, then enter gross combined charges applicable to each health care program in column 2. If charges for provider component only were used, then use only the health care program charges for provider component in column 2.

**NOTE:** Certified transplant centers (CTCs) have final settlement made based on the hospital's cost report. 42 CFR 413.40(c)(iii) states that organ acquisition costs incurred by hospitals approved as CTCs are reimbursed

Complete line 1.08 for cost reports with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004.

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 services beginning in the government's fiscal year 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 or April 1, 2004 through September 30, 2004.

Line 1.08--Enter the total managed care "simulated payments" from the PS&R on or after April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004.

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.

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 for cost reporting periods beginning before October 1, 2004 or Worksheet S-3, Part I, column 6.02, line 26 for cost reporting periods beginning on or after October 1, 2004).

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 3.04 to 3.24.

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  $(1.89 \times \{(1 + \text{line 3.01}/\text{line 3}) \text{ to the } .405 \text{ power} - 1\})$ .

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)(1)(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) Effective for discharges occurring on or after October 1, 2001, temporarily reduce the FTE count of a hospital that closed a program(s), if the regulations at 42 CFR 412.105(f)(1)(ix) are applicable.

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 413.79(e). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1), 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 413.79(e)(2), 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 413.79(i) and qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (3), 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). Also include here any temporary adjustment to the cap due to a hospital closing for cost reporting periods beginning before October 1, 2001.

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 413.75(b), 413.79(c)(2)(iv) and Vol. 64 **Federal Register**, page 26336, May 12, 1998.

Line 3.07--Enter the sum of lines 3.04 through 3.06 *for all cost reporting periods ending prior to July 1, 2005 and for cost reporting periods ending on or after July 1, 2005, only if worksheet S-2, line 25.05 column 2 is "N"*. If the IME FTE cap was reduced under 42 CFR 412.105(f)(1)(iv)(B) due to unused residency slots, (Worksheet S-2, line 25.05, column 2 is "Y"), for cost reporting periods ending on or after July 1, 2005, enter the sum of the amounts from line 3.06 plus the amount on Worksheet E-3, Part VI, line 15.

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. Residents in new programs who were included in the cap (line 3.04) should be included on lines 3.08, 3.09, 3.11, 3.12, and prior years' counts on lines 3.15 and 3.16. These residents are not included after the rolling average. Do not include residents in the initial years of the new 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. Do not include residents in the initial years of the program. **For cost reporting periods beginning on or after October 1, 1997, do not complete these lines.**

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 413.79(d).

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 413.79(d).

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. *However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 43 CFR 412.105(f)(i)(v)) expired, enter on this line the allowable FTE count from line 3.14 plus the count of FTE residents in that specific program included in line 3.17 of the prior year's cost report.* If you had no approved teaching program make no entry (10/97). See comment for line 3.08. 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 (*applicable for cost reporting periods ending before 6/30/2006*).

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 had no approved teaching program make no entry. Do not include residents in the initial years of the program (42 CFR 413.79(d)(5)). *However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 43 CFR 412.105(f)(i)(v)) expired, enter on this line the allowable FTE count from line 3.14 plus the count of FTE residents in that specific program included in line 3.17 of the penultimate year's cost report.* (10/97) See comment for line 3.08. 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 (*applicable for cost reporting periods ending before 6/30/2006*).

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 413.79(d).) Add to that result the number of FTE residents in the initial years of the program that meet the rolling average exception in 42 CFR 413.79(d)(5) and (e)(6). Effective for discharges occurring on or after October 1, 2001, 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)).

*For cost reporting periods ending on or after June 30, 2006, enter in column zero the number of FTE residents in the initial years of a new program that meet the rolling average exception in 42CFR 412.105(f)(1)(v) and temporary adjustments for FTE residents that were displaced by program or hospital closure 42CFR 412.105(f)(1)(ix)). Enter in column 1 the sum of lines 3.14 and 3.16 divided by three and add to this count the FTEs reported in column zero.*

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

Line 3.19--In general, for cost reporting periods beginning on or after October 31, 1997, enter from the prior year cost report the intern and resident to bed ratio by dividing line 3.14 by line 3. 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 (see 42CFR413.79(e)) from line 3.17 of that year. Also, add to the numerator (i.e., prior years FTEs) the number of additional FTE residents in the current year due to an affiliation agreement (see FR Vol. 66, No. 148 dated August 1, 2001, page 39880). Effective for cost reporting periods beginning on or after October 1, 2002, 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 were displaced by hospital or program closure (42 CFR 412.105(a)(1)(iii)). *Also, in the cost reporting period following the last year the receiving hospital's FTE cap is temporarily adjusted for the displaced residents, adjust the numerator of the prior year ratio by subtracting the displaced FTE residents reported on line 3.17 of the prior year's cost report.(42 CFR 412.105 (a)(1)(iv).* 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.

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 1<sup>st</sup> 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 through September 30, 2003 – 1.35; On or after October 1, 2003 through March 31, 2004 – 1.35; On or after April 1, 2004 through September 30, 2004 – 1.47; On or after October 1, 2004 through September 30, 2005 – 1.42; On or after October 1, 2005 through September 30, 2006 – 1.37; On or after October 1, 2006 through September 30, 2007 – 1.32; On or after October 1, 2007 – 1.35.

For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, an additional computation will be required for discharges occurring during these periods. See line 3.24 below and the revised payment chart on page 36-136.1 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  $\{\text{line } 1.01 + (\text{line } 1.04 \text{ times the appropriate percentage identified in the paragraph prior to line } 1.03)\}$ .

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  $\{\text{line } 1.02 + (\text{line } 1.05 \text{ times the appropriate percentage identified in the paragraph prior to line } 1.03)\}$ .

\* For cost reporting periods beginning on or after October 1, 1997, replace  $\{(\text{line } 3.14 \text{ divided by line } 3) \text{ (adjust line } 3.14 \text{ by the interns and residents in the initial years of the program)}\}$  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 with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, 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  $\{\text{the sum of line } 1.07 + (\text{line } 1.08 \text{ times the appropriate percentage identified in the paragraph prior to line } 1.03)\}$ . For cost reporting periods ending on or after July 1, 2005, add to this result the amount from Worksheet E-3, Part VI, line 23.

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, or as a result of the application of the MMA provisions effective for discharges on and after April 1, 2004, (i.e., geographic reclassification) subscript column 1 (add column 1.01) for lines 1, 1.01, 1.02, 1.07, 4.03 and 4.04 and 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 SCHMDH and 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.

For cost reporting periods beginning on or after October 1, 2004, enter the percentage resulting from the calculation of the total Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, plus column 5.01, line 26, minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12, plus column 6.01, line 26, 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.

For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, enter in column 0 the percentage to be applied against PPS payment for the period April 1 through September 30.

**NOTE:** For cost reporting periods ending on or after October 1, 2004 and before October 1, 2006, 42 CFR 412.102 provides for a transition to a rural DSH payment amount from a urban payment amount over two years, for hospitals that were considered urban under the MSA definition, but are considered rural under the CBSA definition. Impacted hospitals whose DSH payment adjustment exceeds 12% will receive 2/3 of the difference between the urban and rural operating DSH for FY 2005 and 1/3 of the difference between the urban and rural operating DSH for FY 2006.

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, and 1.02. For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, add to this amount the product of the payment percentage identified on line 4.03, column 0, applied to the payments identified on line 1.07. 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. Effective for cost reporting periods beginning on or after 10/1/2004, include only discharges for ESRD beneficiaries who receive dialysis services during the inpatient stay of the current cost reporting period in determining the hospital's eligibility for the additional payment. (see Vol. 69, FR 154,



dated August 11, 2004, page 49087).

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 beginning in the government's fiscal year 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 (HSR) 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 services rendered on or after October 1, 2003, use the hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, or 1996.

Line 7.01--In addition to the comparison of 1982 and 1987, hospitals can compare the hospital specific rate for cost reporting periods beginning in FY 1996. For SCHs with cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003, enter on this line the hospital-specific payment amount based on the cost reporting period beginning in FY 1996 as supplied by your fiscal intermediary. For services rendered on or after October 1, 2003, do not use this line, but rather use line 7.

Line 8--For SCHs, enter the greater of line 6 or 7. For MDHs (for discharges occurring on or after October 1, 1997, and before October 1, 2006), if line 6 is greater than line 7, enter the amount on line 6. Where line 7 is greater than line 6, enter the amount on line 6, plus 50 percent of the amount that line 7 exceeds line 6. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 6.

For hospitals subscribing column 1 of line 6 due to a change in geographic location, this computation will be computed separately for each column, and the sum of the calculations will be entered in column 1 of this line.

For SCHs with cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003 - The transition into the FY 1996 rate is actually a blend based on discharges for FY 2001 (October 1, 2000 - September 30, 2001) of 75 percent of the higher of the 1982, 1987, or Federal amount and 25 percent of 1996. For FY2002 (October 1, 2001 - September 30, 2002), the blend is 50/50, and for FY 2003 (October 1, 2002 - September 30, 2003) the blend is 25/75.

If line 7.01 is greater than lines 6 and 7, enter the higher of lines 7 or 6 multiplied by the appropriate blend percentage. Add to this amount, the amount on line 7.01 multiplied by the appropriate FY 1996 HSR blend percentage. (42 CFR 412.92) If line 7.01 is not greater than lines 6 or 7, enter the greater of lines 6 or 7. If line 6 is greater than lines 7 and 7.01, enter that amount on this line.

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 for cost reporting periods beginning before October 1, 2001. For cost reporting periods beginning on and after October 1, 2001, if the provider continues to qualify for the additional payment for extraordinary circumstances pursuant to 42 CFR 412.348(e) enter the exception payment for inpatient program capital from Worksheet L, Part IV, line 13. If the provider qualifies for the special exceptions payment pursuant to 42 CFR 412.348(g) enter the result of Worksheet L, Part IV, line 13 less Worksheet L, Part IV, line 17. If this amount is negative, enter zero on this line.

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

Obtain the payment amounts for lines 11.01 and 11.02 from your fiscal intermediary.

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

Line 11.02--Enter the special add-on payment for new technologies (see change request 2301).

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. If recoveries exceed the current year's bad debts, line 21 and 21.01 will be negative.

Line 21.01--Enter line 21 (including negative amounts) 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.

Line 21.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 21. (4/1/2004b)

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.

Lines 31 through 49 were intentionally skipped to accommodate future revisions to this worksheet.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART A. LINES 50 THROUGH 53 ARE FOR INTERMEDIARY USE ONLY.**

Line 50--Enter the original outlier amount from line 2.01 sum of all columns of this worksheet.

Line 51--Enter the outlier reconciliation amount in accordance with CMS Pub. 100-4, Chapter 3, §20.1.2.5-§20.1.2.7.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-4, Chapter 3, §20.1.2.5-§20.1.2.7.)

Line 53--Enter the time value of money.

**NOTE:** If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

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 subscribed 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 subscribed columns. Order the subscribed 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 (and/or 3.01 as applicable) for services rendered through March 31, 2001 and on or after January 1, 2003. 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 August 1, 2000, 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. Subtract from this amount outpatient pass through costs reported on Worksheet D, Part IV, line 101, columns 9 and subscripts as applicable.

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. If a new provider does not file a full cost report for a cost reporting period that ends prior to January 1, 2001, the provider is not eligible for transitional corridor payments and should enter zero (0) on this line. (See PM A-01-51)

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 purposes of determining the bed count for small rural hospitals see 42 CFR §412.105(b).

*For cost services rendered from January 1, 2006 through December 31, 2008, calculate this line when the response to Worksheet S-2, line 21.06 is "Y".*

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 E, Part A, line 3 is  $\leq 100$ , 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  $\geq 90$  percent but  $< 100$  percent, enter 80 percent of (line 1.04 minus line 1.02).
- d. If line 1.05 is  $\geq 80$  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  $\geq 70$  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 E, Part A, line 3 is  $\leq 100$ , 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  $\geq 90$  percent but  $< 100$  percent, enter 70 percent of the result of line 1.04 minus line 1.02.
- d. If line 1.05 is  $\geq 80$  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 E, Part A, line 3 is  $\leq 100$  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  $\geq 90$  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.

For services rendered on or after January 1, 2004 for cancer or children's hospitals only:

- a. 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 services rendered January 1, 2004, through December 31, 2005, for small rural hospitals and small rural SCHs:

- 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 E, Part A, line 3 is  $\leq 100$  enter the result of line 1.04 minus line 1.02.
- b. 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 E, Part A, line 3 is  $\leq 100$ , and Worksheet S-2, line 26 is  $\geq 1$  (sole community hospitals (SCH)) enter the result of line 1.04 minus line 1.02.

For cost reporting periods beginning on or after January 1, 2004, through services rendered on or before December 31, 2005, for rural SCHs:

- a. If line 1.02 is  $<$  line 1.04 or Worksheet S-2, line 26 response is  $\geq 1$  (number of periods SCH status in effect) enter the result of line 1.04 minus line 1.02.

**NOTE:** For purposes of TOPs, a hospital is considered rural if it is geographically rural, classified to rural for wage index purposes, or classified to rural for the standardized amount purposes. For example, a hospital that is geographically rural is always considered rural for TOPs, even if it is reclassified to urban for the wage index and/or standardized amount. A hospital that is geographically urban, but reclassified to rural for the wage index and/or standardized amount, is considered rural for purposes of TOPs.

*In accordance with DRA 2005, section 5105, for services rendered January 1, 2006, through December 31, 2008, rural hospitals with 100 or fewer beds that are not SCHs are entitled to hold harmless TOPs:*

- a. *For services rendered January 1, 2006, through December 31, 2006, if Worksheet S-2, line 21.06, is "Y", enter 95 percent of (line 1.04 minus line 1.02).*
- b. *For services rendered January 1, 2007, through December 31, 2007, if Worksheet S-2, line 21.06, is "Y", enter 90 percent of (line 1.04 minus line 1.02).*
- c. *For services rendered January 1, 2008, through December 31, 2008, if Worksheet S-2, line 21.06, is "Y", enter 85 percent of (line 1.04 minus line 1.02).*

Line 1.07--Enter the pass through amount from worksheet D, Part IV, columns 9, 9.01 and 9.02, 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. CAHs enter on this line the reasonable costs from line 5. For CAHs with cost reporting periods beginning on or after January 1, 2004, enter on this line 101 percent of the reasonable costs from line 5. (1/1/20004b)

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 percent 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 percent 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 percent times the result of line 17 minus (sum of line 18 plus *101%* of Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus *101%* of Worksheet D, Part VI, line 3). Add back *101%* of Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus *101%* of 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 percent times the result of (line 17 minus line 18 minus *101%* of lab cost (Worksheet D, Part V, column 9, lines 44, 45, and subscripts) minus *101%* of 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 from your records reimbursable bad debts for deductibles and coinsurance net of recoveries for other services, excluding professional services. Do not include ESRD bad debts. These are reported on line 26. Bad debts associated with ambulance services rendered on or after April 1, 2002 (implementation of the cost/fee blend) are not allowable. If recoveries exceed the current year's bad debts, line 27 and 27.01 will be negative.

Line 27.01--Multiply the amount (including negative amounts) 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.

Line 27.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 27. (4/1/2004b)

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. *For cost reporting periods ending on or after June 30, 2006, enter on line 30.99 the MSP-LCC reconciliation amount. Obtain this amount from the PS&R.*

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 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 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.

**3631. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**

Complete this worksheet for each component of the health care complex which has a separate provider or subprovider number as shown on Worksheet S-2. If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. When the worksheet is completed for a component, show both the hospital provider number and the component number. Complete this worksheet for only Medicare interim payments by the intermediary. Do not complete it for purposes of reporting interim payments for titles V or XIX or for reporting payments made under the composite rate for ESRD services. Providers paid on an interim basis on periodic interim payment (PIP) adjust the interim payments for MSP/LCC claims.

The following components use the indicated worksheet instead of Worksheet E-1:

- o Hospital-based HHAs use Worksheet H-8.
- o Hospital-based outpatient rehabilitation facilities use Worksheet J-4.

The column headings designate two categories of payments:

Columns 1 and 2 - Inpatient Part A  
Columns 3 and 4 - Part B

Complete lines 1 through 4. The remainder of the worksheet is completed by your intermediary. All amounts reported on this worksheet must be for services, the costs of which are included in this cost report.

**NOTE:** When completing the heading, enter the provider number and the component number which corresponds to the provider, subprovider, SNF, or swing bed-SNF which you indicated.

DO NOT reduce any interim payments by recoveries as result of medical review adjustments where the recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not also adjusted.

*DO NOT include fee-schedule payments for ambulance services rendered on or after January 1, 2006.*

### Line Descriptions

Line 1--Enter the total Medicare interim payments paid to you (excluding payments made under the composite rate for ESRD services), including amounts paid under PPS. The amount entered must reflect 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 must also include amounts withheld from your interim payments due to an offset against overpayments applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2--Enter the total Medicare interim payments (excluding payments made under the ESRD composite rate) 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.



Also, include in column 4 the total Medicare payments payable for servicing home program renal dialysis equipment when the provider elected 100 percent cost reimbursement.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer as follows:

<u>Reimbursement Method</u>	<u>From Column</u>	<u>Transfer To</u>
Part B Payments	4	Wkst. E, Part B, line 34
<u>Part A Payments</u>		
PPS	2	Wkst. E, Part A, line 28
TEFRA	2	Wkst. E-3, Part I, line 19
Cost	2	Wkst. E-3, Part II, line 32

**NOTE:** For a swing bed-SNF, transfer the column 2, line 4, and column 4, line 4, amounts to Worksheet E-2, columns 1 and 2, line 20, respectively.

For SNFs reimbursed under PPS, transfer the amount in column 2, line 4, to Worksheet E-3, Part III, column 2, line 57.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.**

Line 5--List separately each settlement payment after the cost report is received together with the date of payment. If the cost report is reopened after the NPR has been issued, continue to report all settlement payments after the cost report is received separately on this line.

Line 6--Enter the net settlement amount (balance due the provider or balance due the program). Obtain the amounts as follows:

<u>Worksheet E-1, Column as Indicated</u>	<u>From Settlement Worksheet</u>
2	Wkst. E, Part A, line 29
4	Wkst. E, Part B, line 35
2	Wkst. E-3, Part I, line 20
2	Wkst. E-3, Part II, line 33

For swing bed-SNF services, column 2 must equal Worksheet E-2, column 1, line 21. Column 4 must equal Worksheet E-2, column 2, line 21.

For SNFs paid under PPS, column 2 must equal Worksheet E-3, Part III, column 2, line 58.

**NOTE:** On lines 3, 5, and 6, when a provider to program amount is due, 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 in columns 2 and 4 the sum of lines 4 through 6. Enter amounts due the program as a negative number. This amount must agree with amount due provider reported on Worksheet E, Part A, line 26, Worksheet E, Part B, line 32, Worksheet E-2, line 18, Worksheet E-3, Part I, line 17, Worksheet E-3, Part II, line 30, and Worksheet E-3, Part III, line 55.

## 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, LTCH PPS, and IPF 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, IRF PPS, LTCH PPS, and IPF 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

Lines 1.01, 1.02, 1.05, and 1.06 pertain only to inpatient rehabilitation facilities (IRF) for cost reporting periods beginning on or after January 1, 2002 and long term care hospitals (LTCH) for cost reporting periods beginning on or after October 1, 2002. Line 1.03 and 1.04 pertain only to IRFs with cost reporting periods beginning on or after January 1, 2002. (See §1886(j) of the Act and PMS A-01-110 and A-01-131). Inpatient psychiatric facilities (IPF) complete lines 1, 1.01 and 1.08 through 1.23 for cost reporting periods beginning on or after January 1, 2005. Lines 1.08 through 1.23 are used exclusively for IPF services. (See Vol. 69, FR 219 dated November 15, 2004, page 66922 and CRs 3541 (December 1, 2004), 3678 (January 21, 2005), 3752 (March 4, 2005), and 3809 (April 29, 2005))

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, column 2 is yes, or for cost reporting period beginning on or after October 1, 2002, enter zero on this line. Enter for LTCHs with cost reporting periods beginning on or after October 1, 2002 and before October 1, 2006 the amount from Worksheet D-1, Part II, line 59.08. For LTCHs, if Worksheet S-2, line 59, column 2 is yes, or for cost reporting period beginning on or after October 1, 2006, enter zero on this line. Enter for IPFs with cost reporting periods beginning on or after January 1, 2005 and before January 1, 2008 the amount from Worksheet D-1, Part II, line 59. For IPFs, if Worksheet S-2, line 60, column 2 is yes, or for cost reporting period beginning on or after January 1, 2008, enter zero on this line.

Line 1.01--For IRFs enter hospital specific amount by multiplying line 1 times 33 1/3 percent. For LTCH enter the hospital specific amount by multiplying line 1 times the blended TEFRA rate percentage (see Vol. 67 FR 169 dated August 30, 2002 page 55976 for rates) for the appropriate cost reporting period. For IPF enter the hospital specific amount by multiplying line 1 times the blended TEFRA rate percentage (See Vol. 69 FR 219 dated November 15, 2004, page 66922 for rates) for the appropriate cost reporting period.

Line 1.02--Enter the Net Federal IRF PPS for cost reporting periods beginning on or after January 1, 2002. The Federal payment includes short stay outlier amounts. Exclude low income patient (LIP) and outlier payments. Obtain this information from the PS&R and/or your records. If line 1.01 is greater than zero, the PS&R will reflect 66 2/3 percent of the Federal IRF PPS payment amount (excluding LIP and outlier payments).

*In accordance with The Federal Register, Vol. 70 FR 156 page 47933, dated August 15, 2005 and CR 4037 dated September 16, 2005, effective for IRF discharges rendered on or after October 1, 2005, it is necessary to subscript column 1 to identify the Net Federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2005 (column 1) and the Net Federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2005 (column 1.01) to appropriately prorate the LIP adjustment on line 1.04. Only subscript column 1 when the cost reporting period overlaps October 1, 2005. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2005.*

Enter the Net Federal LTCH PPS payment for cost reporting periods beginning on or after October 1, 2002, including short stay outlier payments. Obtain this information from the PS&R and/or your records. If line 1.01 is greater than zero, the PS&R will reflect the applicable reduced percent of the Federal IRF PPS payment amount (excluding short stay outlier payments). (See Vol. 67 FR 169 dated August 30, 2002, page 55976 for rates.)

Line 1.03--Enter the Medicare SSI ratio from your intermediary as applicable for a freestanding IRF (IRF hospital or facility) or a hospital based IRF (subprovider or subunit). Not applicable for LTCH. (4/30/2003)

Line 1.04--IRF LIP payment, enter the result of  $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .4838 \text{ power} - 1\}$  times (line 1.02). L1 = IRF total Medicare Days from Worksheet S-3, Part I, column 4, lines 1 or 14 and subscripts as applicable (L1 is not applicable for T10 & subsequent transmittals). L2 = IRF Medicaid Days from Worksheet S-3, Part I, column 5, lines 1 or 14 and subscripts as applicable plus Medicaid HMO days (S-3, Part I, column 5, line 2 (subscript line 2 for IRF subproviders)). L3 = IRF total days from Worksheet S-3, Part I, column 6, lines 1 or 14 and subscripts as applicable plus employee discount days (S-3, Part I, column 6, line 28 (subscript line 28 for IRF subproviders)). Not applicable for LTCH.

*In accordance with Vol. 70 FR 156 page 47933 dated August 15, 2005 and CR 4037 dated September 16, 2005, effective for discharges on or after October 1, 2005, the IRF LIP payment formula has been updated. For cost reporting periods that overlap October 1, 2005, column 1 must be subscripted. To calculate the IRF LIP payment for discharges prior to October 1, 2005, enter in column 1 the result of  $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .4838 \text{ power} - 1\}$  times (line 1.02, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2005, enter in column 1.01 the result of  $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .6229 \text{ power} - 1\}$  times (line 1.02, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2005. To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2005, enter in column 1 the result of  $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .6229 \text{ power} - 1\}$  times line 1.02. Not applicable for LTCH.*

Line 1.05--Enter the IRF outlier payment. For LTCH enter the high cost outlier payments. Obtain this from the PS&R and/or your records.

Line 1.06--Enter the sum of lines 1.01; 1.02, *columns 1 and 1.01 as applicable*; 1.04, *columns 1 and 1.01 as applicable*, 1.05, and 1.42.

Line 1.07--Enter the amount of Nursing and Allied Health Managed Care payments if applicable. Only complete this line if your facility is a freestanding/independent non-PPS provider that does not complete Worksheet E, Part A.

*Inpatient psychiatric facilities (IPF) complete lines 1, 1.01 and 1.08 through 1.23 for cost reporting periods beginning on or after January 1, 2005.*

Inpatient Psychiatric Facility (IPF)-Lines 1.08 through 1.23

In accordance with the Federal Register (see Vol. 69, FR 219 dated November 15, 2004, page 66922) and Change Request 3541 (CMS Pub. 100-04, transmittal 384 dated December 1, 2004) *and Change Request 3678 (CMS Pub. 100-04, transmittal 444 dated, January 21, 2005)* complete these lines for IPFs effective for cost reporting periods beginning on or after January 1, 2005.

Line 1.08--Enter the net (blended) Federal IPF PPS payment for cost reporting periods beginning on or after January 1, 2005. This amount excludes payments for outliers, stop-loss, electroconvulsive therapy (ECT), and the teaching adjustment. Obtain this information from the PS&R and/or your records.

Line 1.09--Enter the net (blended) IPF outlier payment. Obtain this from the PS&R and/or your records.

Line 1.10--Enter the net (blended) IPF payments for ECT. Obtain this from the PS&R and/or your accounting books and records.

**NOTE:** Complete only line 1.11 or line 1.12, but not both.

Line 1.11--For providers that trained residents in the most recent cost reporting period *filed* on or before November 15, 2004 (response *on Worksheet S-2*, line 60.01, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period *filed* on or before November 15, 2004. See the above referenced Federal Register for a detailed explanation.

Line 1.12--For providers that did not train residents in the most recent cost report *filed* on or before November 15, 2004, but qualify to receive a cap adjustment under §412.424(d)(1)(iii)(2) for training residents in a newly accredited program(s) after that cost reporting period, enter the unweighted cap adjustment (response to *Worksheet S-2*, line 60.01, column 2 is "Y" for yes and column 3 contains a "4" or "5"). Do not complete this line until the fourth program year of the first new program. If your fiscal year end does not correspond to the program year end, and this current cost reporting period includes the beginning of the fourth program year of the first new program, then prorate the cap adjustment accordingly.

Line 1.13--Enter the current year unweighted FTE resident count for **other than the FTEs** in the first 3 program years of the first new program's existence. If your fiscal year end does not correspond to the program year end and the current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program, then prorate the count accordingly.

Line 1.14--Enter the current year unweighted FTE count for residents in new programs. Complete this line only during the first 3 program years of the first new program's existence. If your fiscal year end does not correspond with the program year end, and the current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program, then prorate the count accordingly.

Line 1.15--For providers that completed line 1.11, enter the lower of the FTE count on line 1.13 or the cap amount on line 1.11.

For providers that qualify to receive a cap adjustment under §412.424(d)(1)(iii)(2) during the first 3 program years of the first new program's existence, enter the FTE count from line 1.14.

Beginning with the 4<sup>th</sup> program year of the first new program's existence, enter the lower of the FTE count on line 1.13 or the FTE count on line 1.12. Add to this count the FTEs on line 1.14 if your fiscal year end does not correspond with the teaching program year end, and this current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program.

Line 1.16--Enter the total IPF patient days divided by number of days in the cost reporting period (*Worksheet S-3*, column 6, line 1 (independent/freestanding) or 14 *and applicable subscripts* (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 1.17--Enter the medical education adjustment factor by adding 1 to the ratio of line 1.15 to line 1.16. Raise that result to the power of .5150. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as  $\{(1 + (\text{line 1.15} / \text{line 1.16})) \text{ to the } .5150 \text{ power} - 1\}$ .

Line 1.18--Enter the medical education adjustment by multiplying line 1.08 by line 1.17.

Line 1.19--Enter the adjusted net IPF PPS payments by entering the sum of lines 1.08, 1.09, 1.10, and 1.18.

Line 1.20--Enter the stop loss floor by entering the result of line 1 multiplied by 70 percent. For new IPFs (100 percent PPS) and for cost reporting periods beginning on or after January 1, 2008, enter zero (0) on this line.

Line 1.21--Enter the adjusted net payment floor by multiplying line 1.20 by the appropriate Federal blend payment percentage: (25 percent for cost reporting periods beginning on or after January 1, 2005 but prior to January 1, 2006, 50 percent for cost reporting periods beginning on or after January 1, 2006 but prior to January 1, 2007, or 75 percent for cost reporting periods beginning on or after January 1, 2007 but prior to January 1, 2008). Enter 100 percent if this is a new IPF (*worksheet S-2, line 60, column 2 equals "Y"*) or for cost reporting periods beginning on or after January 1, 2008.

Line 1.22--If line 1.21 is greater than line 1.19 enter the amount on line 1.21 minus the amount on line 1.19; otherwise enter zero (0). This is the amount of the stop loss adjustment.

Line 1.23--Enter the IPF PPS payments by adding the amounts from lines 1.01, 1.19 and 1.22.

*Inpatient Rehabilitation Facility (IRF)-Lines 1.35 through 1.42*

*In accordance with the Federal Register (see Vol. 70, No. 156, pages 47928-47932, dated August 15, 2005) and Change Request 4037 (CMS Pub. 100-04, transmittal 680 dated September 16, 2005), complete these lines for IRFs effective for discharges on or after October 1, 2005.*

***NOTE:** Complete only line 1.35 or line 1.36, but not both.*

*Line 1.35--For providers that trained residents in the most recent **cost reporting period ending on or before November 15, 2004** (response to line 58.01, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period ending on or before November 15, 2004. See the above referenced Federal Register for a detailed explanation.*

*Line 1.36--For providers that did not train residents in the most recent cost report ending on or before November 15, 2004, that qualify to receive a cap adjustment (see Vol. 70, FR 156, page 47929, dated August 15, 2005) for training residents in a newly accredited program(s) after that cost reporting period, enter the unweighted cap adjustment (response to line 58.01, column 2 is "Y" for yes and column 3 contains a "4" or "5"). Do not complete this line until the fourth program year of the first new program. If your fiscal year end does not correspond to the program year end, and this current cost reporting period includes the beginning of the fourth program year of the first new program, then prorate the cap adjustment accordingly.*

*Line 1.37--Enter the current year unweighted FTE resident count for **other than the FTEs** in the first 3 program years of the first new program's existence. If your fiscal year end does not correspond to the program year end and the current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program, then prorate the count accordingly.*

*Line 1.38--Enter the current year unweighted FTE count for residents in new programs. Complete this line only during the first 3 program years of the first new program's existence. If your fiscal year end does not correspond with the program year end, and the current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program, then prorate the count accordingly.*

*Line 1.39--For providers that completed line 1.35, enter the lower of the FTE count on line 1.37 or the cap amount on line 1.35.*

*For providers that qualify to receive a cap adjustment (see Vol. 70, FR 156, page 47929, dated August 15, 2005), during the first 3 program years of the first new program's existence enter the*



*FTE count from line 1.38.*

*Beginning with the 4<sup>th</sup> program year of the first new program's existence, enter the lower of the FTE count on line 1.37 or the FTE count on line 1.36. Add to this count the FTEs on line 1.38 if your fiscal year end does not correspond with the teaching program year end, and this current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program.*

*Line 1.40--Enter the total IPF patient days divided by number of days in the cost reporting period (Worksheet S-3, column 6, line 1 (independent/freestanding) or 14 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.*

*Line 1.41--Enter the medical education adjustment factor by adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .9012. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as  $\{(1 + (\text{line 1.39}/\text{line 1.40})) \text{ to the } .9012 \text{ power} - 1\}$ .*

*Line 1.42--Enter the medical education adjustment by multiplying line 1.02 by line 1.41. Add this amount to line 1.06.*

**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, 1.07, 2 and 3. IRFs/LTCH enter the sum of lines 1.06, 1.07, 2 and 3. IPFs enter the sum of lines 1.23, 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 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 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. If recoveries exceed the current year's bad debts, lines 11 and 11.01 will be negative.

Line 11.01--Multiply the amount (including negative amounts) 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 11.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 11. (4/1/2004b)

Line 12--Enter the sum of lines 10 and 11.01.

Line 13--Enter the amount from Worksheet E-3, Part IV, line 24 for the hospital component only.

Line 13.01--For IRF cost reporting periods beginning on or after January 1, 2002, LTCH cost reporting periods beginning on or after October 1, 2002, and IPF cost reporting periods beginning on or after January 1, 2005, enter the routine service other pass through costs from Worksheet D, Part III, column 8, line 25 for a freestanding facility or line 31 for the subproviders. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101. For IRFs, LTCHs, or IPFs reimbursed on a blended TEFRA rate percentage (worksheet S-2, line 58, 59, or 60, respectively, column 2 equals "N") reduce the pass through amounts by the TEFRA blend percentage used on line 1.01 for IRFs, IPFs, and LTCHs, respectively. After the respective transition periods have elapsed do not reduce this line as these facilities are entitled to 100 percent of other pass through costs.

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, 13, and 13.01 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 1.01--Enter the amount of Nursing and Allied Health Managed Care payments if applicable. Only complete this line if your facility is a freestanding/ independent non-PPS provider or CAH that does not complete Worksheet E, Part A.

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. For CAHs with cost reporting periods beginning on or after January 1, 2004, enter on this line 101 percent of the line 4 minus line 5. (1/1/20004b)

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 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 percent Federal rate for cost reporting periods beginning on or after July 1, 2001, providers are required to input the total RUG payments. Obtain this from your books and records or the PS&R.

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 for cost reporting periods beginning before October 1, 2001. For cost reporting periods beginning on and after October 1, 2001, enter the result of Worksheet L, Part IV, line 13 less Worksheet L, Part IV, line 17. If this amount is negative, enter zero on this line.

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 from your records program reimbursable bad debts for deductibles and coinsurance net of bad debt recoveries. If recoveries exceed the current year's bad debts, lines 38 (*title XVIII SNFPPS, V or XIX*) and 38.01 (*title V or XIX*) will be negative. *Reimbursable bad debts for hospital-based PPS SNFs under title XVIII are paid at 100 percent for cost reporting periods beginning prior to October 1, 2005.*

Line 38.01, column 1--*Applies to hospitals and subproviders only if title V or XIX follow Medicare principles*--Multiply the amount (including negative amounts) 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.

Line 38.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 38. (4/1/2004b)

Line 38.03--*DRA 2005 SNF Bad Debt--For cost reporting periods beginning on or after October 1, 2005 calculate this line as follows:  $[(\text{line 38} - \text{line 38.02}) * .7] + \text{line 38.02}$ . This is the adjusted SNF allowable bad debt in accordance with DRA 2005, section 5004. (10/1/2005b)*

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--*For cost reporting periods beginning prior to October 1, 2005*, enter the sum of lines 35, 37, 38 (*title XVIII, column 2*) or 38.01 (*title V or XIX, column 1*) and 39, minus line 36. *For cost reporting periods beginning on or after October 1, 2005*, enter the sum of lines 35, 37, 38.01 (*title V or XIX, column 1*) or 38.03 (*title XVIII, column 2*) 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 413.83. 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) Effective for cost reporting periods beginning on or after October 1, 2001, temporarily reduce the FTE count of a hospital that closed a program(s), if the regulations at 42 CFR 413.86(g)(9)(iii)(B) are applicable.

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 413.79(j). If the rural track program is a new program under 42 CFR 413.79(l) and qualifies for a cap adjustment under 413.79(e)(1) or (e)(3), 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). Also include here any temporary adjustment to the cap due to a hospital closing effective for cost reporting periods beginning before October 1, 2001.

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 413.75(b), 413.79(c)(2)(iv), 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. *For cost reporting periods ending on or after July 1, 2005, if worksheet S-2, line 25.05, column 1 is "N", enter the sum of lines 3.01 through 3.03.* If this hospital's FTE cap is reduced under 42 CFR §413.79(c)(3) due to unused resident slots, (Worksheet S-2, line 25.05, column 1 is "Y"), effective for cost reporting periods ending on or after July 1, 2005, enter the sum of line 3.03 and line 4 from Worksheet E-3, Part VI.

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 rolling average rules. (42 CFR 413.79(d) and/or (e)).

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 rolling average 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 413.79(d) and/or (e)).

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 rolling average 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 413.79(d) and/or (e) (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 (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/line 3.05) and add the results. (42 CFR 413.79(c)(2)(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 rolling average 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) plus line 3.11, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). *However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific nonprimary program included in line 3.16 of the prior year's cost report.*

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) plus line 3.11 other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules (42 CFR 413.79(d)(5)). *However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific nonprimary program from line 3.16 of the penultimate year's cost report.*

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 413.79(d)(5)) unless column zero is completed for any of these lines. For cost reporting periods *beginning* 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 to the rolling average rules. 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 413.79(d)(5) and/or 413.79(e). Effective for cost reporting periods beginning on or after October 1, 2001, also add the temporary weighted adjustments for nonprimary care FTE residents that were displaced by program or hospital closure. (42 CFR 413.79(h)).

*For cost reporting periods ending on or after June 30, 2006, enter in column zero the weighted number of nonprimary care FTE residents in the initial years of new allopathic and osteopathic programs (42 CFR 413.79(d)(5) and/or 413.79(e)) and add the temporary weighted adjustments for nonprimary care FTE residents that were displaced by program or hospital closure. Enter in column 1 the sum of lines 3.15 and the number reported in column zero of this line.*

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 rolling average exception criteria in 42 CFR 413.79(d). 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 413.79(d)(5). *However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific primary program included in line 3.22 of the prior year's cost report.*

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 the rolling average exception. 42 CFR 413.79(d)(5). *However, if the period of years during which the FTE residents in any year of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific primary program included in line 3.22 of the penultimate year's cost report.*

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, 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 413.79(d)(5) and/or 413.79(e). Effective for cost reporting periods beginning on or after October 1, 2001, also add any temporary weighted adjustments for primary care and OB/GYN FTE residents that were displaced by program or hospital closure. 42 CFR 413.79(h).

*For cost reporting periods ending on or after June 30, 2006, enter in column zero the weighted number of primary care OB/GYN FTE residents in the initial years of new allopathic and osteopathic programs (42 CFR 413.79(d)(5) and/or 413.79(e)) and add the temporary weighted adjustments for primary care and OB/GYN FTE residents that were displaced by program or hospital closure. Enter in column 1 the sum of lines 3.21 and the number reported in column zero of this line.*

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.) For cost reporting periods that end *on or* after July 1, 2005, multiply line 6 times line 3.25 and to this amount, add the hospital's section 422 direct GME payment for non-managed care, from line 11 from Worksheet E-3, Part VI.

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 413.76(c).

Line 6.02--Enter Medicare managed care days occurring on or after January 1 of this cost reporting period. These days are included in the days reported on Worksheet S-3, Part I, column 4, line 2. The balance of the days prior to January 1 are entered on line 6.06. (4/30/03) *Effective for cost reporting periods ending on after June 30, 2006, enter all Medicare managed care days on line 6.02.*

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. This line equals Worksheet S-3, Part I, column 4, line 2 minus line 6.02 above. *Do not complete this line for cost reporting periods ending on or after December 31, 2005.*

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. After reducing this amount by the Nursing and Allied Health Medicare Advantage (formerly Medicare + Choice) factor, *for fiscal years ending on or after July 1, 2005, add to this amount the hospital's section 422 direct GME payment for managed care, if applicable, from line 12 of W/S E-3, Part VI. For cost reporting periods ending on or after June 30, 2006, this line will only reflect the hospital's section 422 direct GME payment for managed care, if applicable, from line 12 of W/S E-3, Part VI.*

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.

Apportionment of Medicare Reasonable Cost of GME--This section determines the ratio of Medicare reasonable costs applicable to Part A and Part B. The allowable costs of GME on which the per resident amounts are established include GME costs attributable to the entire hospital complex (including non-hospital portions of a health care complex). Therefore, the reasonable costs used in the apportionment between Part A and Part B include the hospital, hospital-based providers, and distinct part units. Do not complete this section for titles V and XIX.

### Line Descriptions

Line 12--Include the Part A reasonable cost for the entire hospital complex computed by adding the following amounts:

- o Hospital and Subprovider(s) - Sum of each Worksheet D-1, line 49;
- o Hospital-Based HHAs - Worksheet H-7, Part I, column 1, line 1;
- o Swing Bed-SNF - Worksheet D-1, line 62 (for cost reporting periods beginning prior to July 1, 2002) swing Bed-SNF - Worksheet E-2, line 1, column 1 (for cost reporting periods beginning on or after July 1, 2002);
- o Hospital-Based Non-PPS SNF - Worksheet D-1, line 82; and
- o Hospital-Based PPS SNF - Sum of Worksheet D-1, line 70 and Worksheet E-3, Part III, column 2, line 6.

Line 13--Enter the organ acquisition costs from Worksheet(s) D-6, Part III, column 1, line 61.

Line 14--Enter the cost of teaching physicians from Worksheet(s) D-9, Part II, column 3, line 16.

Line 15--Enter the total Medicare Part A primary payer amounts for the hospital complex from the applicable worksheets.

- o PPS hospital and/or subproviders - Worksheet E, Part A, line 17;
- o TEFRA hospital and/or subproviders - Worksheet E-3, Part I, line 5;
- o Cost reimbursed hospital and/or subproviders and Non-PPS SNFs - Worksheet E-3, Part II, line 5;
- o Hospital-based HHAs - Each Worksheet H-7, Part I, column 1, line 9;
- o Swing Bed SNF and/or NF - Worksheet E-2, column 1, line 9; and
- o Hospital-based PPS SNF - Worksheet E-3, Part III, column 2, line 7.

Line 16--Enter the sum of lines 12 through 14 minus line 15.

Line 17--Enter the Part B Medicare reasonable cost. Enter the sum of the amounts on each title XVIII Worksheet E, Part B, columns 1 and 1.01, sum of lines 1, 1.01, 1.07, 2 through 4; Worksheet E, Parts C, D, and E, columns 1 and 1.01 line 6; Worksheet E-2, column 2, line 8; Worksheet H-7, Part I, sum of columns 2 and 3, line 1; Worksheet J-3, columns 1 and 1.01 if applicable, lines 1 and 1.01, and Worksheet M-3, line 16.

Line 18--Enter the Part B primary payer amounts. Enter the sum of the amounts on each Worksheet E, Part B, line 24; Worksheet E-2, column 2, line 9; Worksheet H-7, Part I, sum of columns 2 and 3, line 9; and Worksheet J-3, line 2, columns 1 and 1.01 if applicable.

Line 19--Enter line 17 minus line 18

Line 20--Enter the sum of lines 16 and 19.

Line 21--Divide line 16 by line 20, and enter the result.

Line 22--Divide line 19 by line 20, and enter the result.

Allocation of Medicare Direct GME Costs Between Part A and Part B--Use this section to compute the GME payments for title XVIII, Part A and Part B, and to compute the total GME payments applicable to titles V and XIX.

#### Line Descriptions

Line 23--For cost reporting periods ending prior to January 1, 1998, multiply line 3 by line 6, and enter the result. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, line 54. Do not compute lines 24 and 25.

Line 23.01--For cost reporting periods that end on or after January 1, 1998, enter the sum of lines 6.01, 6.05, and 6.08. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, line 54. Do not compute lines 24 and 25.

Line 24--Complete for title XVIII only. Multiply line 23 or 23.01 by line 21, and enter the result. If you are a hospital subject to PPS, transfer this amount to Worksheet E, Part A, line 11. Although this amount includes the Part A GME payments for subproviders, for ease of computation, transfer this amount to the *primary* hospital component worksheet only. If you are *freestanding facility* subject to TEFRA, *an LTCH PPS, IPF PPS, or IRF PPS*, transfer this amount to Worksheet E-3, Part I, line 13. If you are subject to cost reimbursement, *i.e., CAH*, transfer this amount to Worksheet E-3, Part II, line 18.

Line 25--Complete for title XVIII only. Multiply line 23 or 23.01 by line 22, and enter the result. Transfer this amount to Worksheet E, Part B, line 21. Although this amount includes the Part B GME payments for subproviders, for ease of computation, transfer this amount to the hospital component only.

3633.5 Part V - Calculation of NHCMQ Demonstration Reimbursement Settlement for Medicare Part A Services--Use this part to calculate reimbursement if you are a part of the NHCMQ demonstration project for cost reporting periods beginning before July 1, 1998.

Part A - Inpatient Services: Provider Computation of Reimbursement--Use this part to calculate payment for title XVIII services furnished by NHCMQ Demonstration participants. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ Demonstration.

#### Line Descriptions

Line 1--Enter the number of total title XVIII inpatient days. Obtain this figure from Worksheet S-3, Part I, column 4, line 15.



Line 2--Enter the number of demonstration program days. Obtain this figure from Worksheet S-7, line 46, columns 3.01 and 4.01.

Lines 3 through 5--Calculate the net non-NHCMQ Demonstration Part A inpatient ancillary services. These include radiology, laboratory, intravenous therapy, oxygen, electrocardiology, medical supplies charged to patients, and drugs charged to patients and others.

Line 3--Enter the total Part A ancillary program costs. Obtain this figure from Worksheet D-4, column 3, line 101.

Line 4--Enter the physical, occupational, and speech therapy ancillary program costs. To obtain this figure, add lines 50, 51, and 52 on Worksheet D-4, column 3.

Line 5--Subtract line 4 from line 3, and enter the difference. This amount represents the net ancillary services not applicable to the NHCMQ Demonstration. Enter this amount on Worksheet E-3, Part III, column 2, line 2.

Line 6--Enter the NHCMQ Demonstration inpatient routine/ancillary PPS amount paid. Obtain this figure from Worksheet S-7, column 5, line 46.

Lines 8 through 9--Calculate the program inpatient capital costs. The capital costs are not part of the PPS calculation. Instead the capital costs flow through the cost finding stepdown process on Worksheet B.

Line 7--Do not use this line.

Line 8--Enter the per diem capital-related cost from Worksheet D-1, line 72.

Line 9--Enter the program capital-related cost. Obtain this amount by multiplying line 8 by line 1.

Lines 10 through 24--Calculate the indirect cost component of the demonstration ancillary services. The indirect cost component of the demonstration ancillary services is not part of the PPS calculation. Instead the indirect costs are passed through from cost finding on the cost report. For participants in the demonstration, ancillary services are calculated as part of the PPS payment beginning in phase 3. Lines 10 through 24 are completed only for phase 3.

Line 10--Enter the total general service cost allocation for physical therapy. Obtain this amount from Worksheet B, Part I, column 27, line 50.

Line 11--Enter the total general service cost allocation for occupational therapy. Obtain this amount from Worksheet B, Part I, column 27, line 51.

Line 12--Enter the total general service cost allocation for speech therapy. Obtain this amount from Worksheet B, Part I, column 27, line 52.

Line 13--Enter the direct cost for physical therapy. Obtain this amount from Worksheet B, Part I, column 0, line 50.

Line 14--Enter the direct cost for occupational therapy. Obtain this amount from Worksheet B, Part I, column 0, line 51.

Line 15--Enter the direct cost for speech therapy. Obtain this amount from Worksheet B, Part I, column 0, line 52.

Line 16--Enter line 10 less line 13. This is the physical therapy indirect cost for the entire reporting unit.

Line 17--Enter line 11 less line 14. This is the occupational therapy indirect cost for the entire reporting unit.

Line 18--Enter line 12 less line 15. This is the speech therapy indirect cost for the entire reporting unit.

Line 19--Enter the charge to charge ratio for physical therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 50 by the amount on Worksheet C, Part I, column 8, line 50.

Line 20--Enter the charge to charge ratio for occupational therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 51 by the amount on Worksheet C, Part I, column 8, line 51.

Line 21--Enter the charge to charge ratio for speech therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 52 by the amount on Worksheet C, Part I, column 8, line 52.

Line 22--Calculate the physical therapy demonstration indirect cost by multiplying line 16 by line 19.

Line 23--Calculate the occupational therapy demonstration indirect cost by multiplying line 17 by line 20.

Line 24--Calculate the speech therapy demonstration indirect cost by multiplying line 18 by line 21.

Line 25--Enter the sum of lines 6, 9, 22, 23, and 24. Transfer this amount to Worksheet E-3, Part III, line 24.

3633.6 Part VI – Direct GME and IME Payments related to MMA section 422 (Public Law 108-173) “Redistribution of Unused Residency Slots”--Use this worksheet in conjunction with Worksheet E-3, Part IV and Worksheet E, Part A to calculate payment for direct GME as determined under 42 CFR 413.75 through 413.83 and IME as determined under 42 CFR 412.105 for hospitals that received an adjustment (reduction or increase) to their FTE resident caps for direct GME and/or IME under Section 422 of Public Law 108-173. Do not use this worksheet if the cost reporting period ends prior to July 1, 2005 or if the cost reporting period ends after July 1, 2005 but the hospital did not receive an adjustment to either the GME or IME cap under Section 422 of Public Law 108-173.

Line 1--Enter the ratio of the number of days from July 1, 2005 to the end of the cost reporting period divided by the total number of days in the cost reporting period. For example, for a cost reporting period of October 1, 2004 to September 30, 2005, enter .252055 (i.e., 92 days from July 1, 2005 to September 30, 2005 divided by 365 days in the cost reporting period). *For cost reporting periods which do not overlap July 1, 2005, enter 1 on this line.*

Lines 2-4--Computation of reduced direct GME cap under 42 CFR §413.79(c)(3). Complete lines 2 through 4, only where Worksheet S-2, line 25.05, column 1, is “Y”.

Line 2--Reduced Direct GME FTE Cap. Effective for cost reporting periods ending on or after July 1, 2005, enter the reduced direct GME cap as specified under 42 CFR §413.79(c)(3).

Line 3--Unadjusted Direct GME FTE Cap. Enter the unadjusted direct GME FTE Cap from Worksheet E-3, Part IV, sum of lines 3.01 and 3.02.



Line 4 --For cost reporting periods that overlap July 1, 2005, enter the ratio on line 1 multiplied by the count on line 2. Add to this count the count on line 3 multiplied by the result of “1” minus line 1. This is the prorated cap for that fiscal year. For cost reporting periods beginning on or after July 1, 2005, enter the count on line 2. This is the hospital’s reduced direct GME FTE cap.

Lines 5-12--Computation of additional direct GME payments for unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 CFR §413.79(c)(4). Complete lines 5 through 12, only where Worksheet S-2, line 25.06, column 1, is “Y”.

Line 5--Section 422 Direct GME FTE Cap. Enter the number of unweighted allopathic and osteopathic direct GME FTE resident cap slots the hospital received under 42 CFR §413.79(c)(4).

*Line 5.01-Prorated Direct GME FTE Cap. For cost reporting periods that overlap July 1, 2005, enter the result of multiplying the ratio on line 1 by the number on line 5 in order to establish the cap for the portion of the cost reporting period occurring after July 1, 2005. Use this line only when the cost reporting period overlaps July 1, 2005.*

Line 6--Direct GME FTE Resident Weighted Count Over the Cap: Subtract line 3.10 on Worksheet E-3, Part IV from line 3.09 on Worksheet E-3, Part IV and enter the result here. If the result is zero or negative, the hospital does not need to use the direct GME 422 cap and lines 7 through 12 will not be completed.

Line 7--Section 422 Allowable Direct GME FTE Resident Count: If the count on line 6 is *greater than zero but less than or equal to* the count on line 5, then enter the count from line 6. If the count on line 6 is higher than the count on line 5, enter an “imputed” weighted FTE count which is computed by dividing Worksheet *E-3, Part IV*, line 3.09 by line 3.05 and multiplying the resulting ratio by line 5 of this worksheet. For cost reporting periods that overlap the July 1, 2005 effective date, *substitute line 5.01 for line 5, in the calculation of line 7.*

Line 8--Enter the locality adjusted national average per resident amount as specified at 42 CFR section 413.77(g), inflated to the hospital’s cost reporting period.

Line 9--Enter the product of Line 7 and Line 8. This is the allowable section 422 GME cost.

Line 10--Enter the Medicare program patient load from Line 6 of Worksheet E-3, Part IV.

Line 11--Enter the product of line 9 and line 10. This is the section 422 direct GME payment for non-managed care days.

Line 12--Determine the direct GME payment for managed care days by multiplying line 9 by the managed care patient load computed from worksheet E-3, Part IV: [(line 6.02 + line 6.06)/line 5].

Lines 13-15--Computation of reduced IME cap under 42 CFR §412.105(f)(1)(iv)(B). Complete lines 13 through 15, only where Worksheet S-2, line 25.05, column 2, is “Y”.

Line 13--Reduced IME FTE Cap. Effective for cost reporting periods ending on or after July 1, 2005, enter the reduced IME FTE resident cap for allopathic and osteopathic residents as specified under 42 CFR §412.105(f)(1)(iv)(B).

Line 14--Unadjusted IME FTE Cap. Enter the unadjusted IME FTE Cap from Worksheet E, Part A, sum of lines 3.04 and 3.05.

Line 15 --For cost reporting periods that overlap July 1, 2005, enter the ratio on line 1 multiplied by the count on line 13. Add to this count the count on line 14 multiplied by the result of “1” minus line 1. This is the reduced cap for that fiscal year. For cost reporting periods beginning on or after July 1, 2005, enter the count on line 13. This is the hospital’s reduced IME FTE cap.

Lines 16 - 23--Computation of IME payments for additional allopathic and osteopathic resident cap slots received under 42 CFR §412.105(f)(1)(iv)(C). Complete lines 16 through 23 only where Worksheet S-2, line 25.06, column 2, is "Y".

Line 16--Section 422 IME FTE Cap--Enter the number of allopathic and osteopathic IME FTE residents cap slots the hospital received under 42 CFR §412.105(f)(1)(iv)(C).

Line 17--IME FTE Resident Count Over the Cap--Subtract Line 3.07 on Worksheet E, Part A from Line 3.08 on Worksheet E, Part A and enter the result here. If the result is zero or negative, the hospital does not need to use the 422 IME cap. Therefore, do not complete lines 18 through 23.

*Line 18--Section 422 Allowable IME FTE Resident Count--If the count on line 17 is greater than zero, enter the lower of Line 16 or Line 17.*

Line 19--Resident to Bed Ratio for Section 422--Divide Line 18 by Line 3 of Worksheet E, Part A.

Line 20--IME Adjustment Factor for Section 422 IME Residents--Enter the result of the following:  $.66 * [(1 + \text{Line 19}) \text{ to the } .405 \text{ power}] - 1$ .

Line 21--For cost reporting periods that overlap July 1, 2005, enter the amounts reported on Worksheet E, Part A, lines 1, 1.01 and 1.02, relating to discharges occurring on or after July 1, 2005. For cost reporting periods beginning on or after July 1, 2005, enter the sum of Worksheet E, Part A, lines 1 through 1.02.

Line 22--For cost reporting periods that overlap July 1, 2005, enter the amounts reported on Worksheet E, Part A, lines 1.03, 1.04 and 1.05, relating to discharges occurring on or after July 1, 2005. For cost reporting periods beginning on or after July 1, 2005, enter the sum of Worksheet E, Part A, lines 1.03 through 1.05.

Line 23--Enter the sum of lines 21 and 22, multiplied by the factor on line 20 and transfer to Worksheet E, Part A, line 3.24.

**3634. WORKSHEET K - ANALYSIS OF PROVIDER-BASED HOSPICE COSTS**

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Effective for cost reporting periods ending on or after September 30, 2000, the K series Worksheets must be completed by all hospital-based hospices. This worksheet provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner, which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets K, K-4, Parts I & II, the line numbers are consistent, and the total line is set at 34). Not all of the cost centers listed apply to all providers using these forms.

Column 1--Obtain salaries to be reported from Worksheet K-1, column 9, line 3-33.

Column 2--Obtain employee benefits to be reported from Worksheet K-2 column 9, lines 3-33.

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 identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center enter them on line 22.

Column 4--Obtain the contracted services to be reported from Worksheet K-3, col. 9, lines 3-33.

Column 5--Enter in the applicable lines all costs which have not been reported in columns 1 through 4.

Column 6--Enter the sum of columns 1 through 5 for each cost center.

Column 7--Enter any reclassifications among cost center expenses 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--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8, line 34 must equal the total of column 6, line 34.

Column 9--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §3613.)

Column 10--Adjust the amounts in column 8 by the amounts in column 9, (increases or decreases) and extend the net balances to column 10.

Transfer the amount in column 10, line 1 through 33 to the corresponding lines on Worksheet K-4, Part I, column 0, lines 1 through 33.

**LINE DESCRIPTIONS**

Lines 1 and 2 - Capital Related Cost - Buildings and Fixtures and Capital Related Cost -Movable Equipment.--These cost centers should include depreciation, leases and rentals for the use of the facilities and/or equipment, interest incurred in acquiring land and 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.

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 of total cost (column 3) to total charges (column 4) (from your records), and enter this ratio in column 5.

Columns 6 through 8--Enter in the appropriate column the program charges for drugs and medical supplies charged to patients and not subject to reimbursement on the basis of a fee schedule.

#### Line Descriptions for Columns 6 through 8

Line 15--Enter the program covered charges for services rendered prior to October 1, 2000, for medical supplies charged to patients for items not reimbursed on the basis of a fee schedule.

Line 15.01-- Enter the program covered charges for services rendered on or after October 1, 2000, for medical supplies charged to patients for items not reimbursed on the basis of a fee schedule. *For cost reporting periods beginning on or after October 1, 2000, continue to capture medical supply charges in columns 5, 6, and 7 for statistical purposes (has no reimbursement impact) as all medical supplies are covered under the PPS benefit for this period. Report charges only for the services rendered in that fiscal year end regardless of when the episode is concluded. For reporting periods that begin on or after April 1, 2001, eliminate line 15.01 and record all charge and resulting cost data on line 15.*

Line 16--Enter the program covered charges for services rendered prior to April 1, 2001, for drugs charged to patients for items not reimbursed on the basis of a fee schedule. Enter in column 7 the charges for pneumococcal vaccine and its administration and influenza vaccine and its administration. Do not enter the charges for hepatitis B vaccine and its administration for services rendered on or after April 1, 2001. For cost reporting periods which overlap April 1, 2001, enter in column 8 the total charges for covered osteoporosis drugs for services rendered prior to April 1, 2001.

For services rendered on or after April 1, 2001 through December 31, 2002, do not enter any amounts in column 7 as pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration are reimbursed on a fee basis, but continue to enter in column 8 the charges for covered osteoporosis drugs as they remain cost reimbursed. (See §1833(m)(5) of the Act.)

For services rendered on and after January 1, 2003, do not enter in column 7 program charges for hepatitis vaccines and its administration as it is fee reimbursed. Enter in column 7 program charges for pneumococcal vaccines and its administration and influenza vaccine and its administration (cost reimbursed) for services rendered on or after January 1, 2003 (*for cost reporting periods ending on or after April 30, 2005 (T14) complete only column 7, not column 7.01 (eliminated)*). Enter in column 8 the program charges for injectable osteoporosis drugs (cost reimbursed).

Line 16.01-- For reporting periods that overlap April 1, 2001, enter the covered program charges for services rendered on or after April 1, 2001 for drugs charged to patients for items not reimbursed on the basis of a fee schedule in the applicable column. Report program charges for injectable drugs for osteoporosis only in column 8 for services rendered on or after April 1, 2001 through the fiscal year end. For reporting periods that begin on or after April 1, 2001, eliminate line 16.01 and record all charge and resulting cost data on line 16.

**NOTE:** For lines 15.01 and 16.01 use the same cost to charge ratio reported for lines 15 and 16 respectively.

Columns 6 and 9--To determine the program cost, multiply the program charges (column 6) by the

ratio (column 5) for each line. Enter the product in column 9.

Columns 7 (and subscripts) and 10 (and subscripts)--To determine the Medicare Part B cost, multiply the Medicare charges (column 7) by the ratio (column 5) for each line. Follow the same procedure for the corresponding subscripts. Enter the product in column 10 (and 10.01 as applicable).

Columns 8 and 11--To determine the Medicare Part B cost, multiply the Medicare charges (column 8) by the ratio (column 5) for each line. Enter the result in column 11.

#### Per Beneficiary Cost Limitation

Line 17--Enter the Medicare unduplicated census count for services prior to October 1, 2000 only, from Worksheet S-4, column 2, line 2, for Medicare for cost reporting periods that overlap October 1, 2000. Subscript the line for multiple MSAs as they were reported on S-4 line 20. For cost reporting periods beginning on or after October 1, 2000, completion of the per beneficiary cost limitation data (*lines 17 through 19*) is no longer required.

Line 18--Enter the agency specific per beneficiary annual limitation supplied by your intermediary for each MSA.

Line 19--Multiply line 17 and subscripts by line 18 and subscripts. If there are multiple MSAs and lines 17 and 18 are subscripted, add them together and enter the result.

3647.2 Part II - Apportionment of Cost of HHA Services Furnished by Shared Hospital Departments--Use this part only 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. Subscript lines 1-5, as applicable, if subscripted on Worksheet C, Part I.

Column 1--Where applicable, enter in column 1 the cost to charge ratio from Worksheet C, Part I, column 9, lines as indicated.

Column 2--Where hospital departments provide services to the HHA, enter on the appropriate lines the charges applicable to the hospital-based home health agency.

Column 3--Multiply the amounts in column 2 by the ratios in column 1, and enter the result in column 3. Transfer the amounts in column 3 to Worksheet H-6, Part I as indicated. If lines 1-5 are subscripted, transfer the aggregate of each line.

3647.3 Part III - Outpatient Therapy Reduction Computation--Services are subject to deductible and coinsurance net of operating and capital reductions. This section computes the payment and reduction (for services rendered on or after January 1, 1998) for Part B visit costs subject to deductibles and coinsurance for various home health services provided. For cost reporting periods that overlap the January 1, 1998 effective date, subscripting of columns 2 and 3 is required. For cost reporting periods beginning on or after January 1, 1998, no subscripting is required. For services rendered on and after January 1, 1999, these services are paid under a fee schedule. Report the visits incurred for purposes of balancing total visits with the cost report.

Column 2--Enter in column 2 the average cost per visit amount from Part I, column 5, lines 2 through 4 above.

Column 2.01--Enter in this column the number of visits rendered for each service prior to January 1, 1998.

Column 3--Enter the number of visits applicable to each service on and after January 1, 1998.

Column 3.01--Enter the result of multiplying column 2 by column 2.01.

Column 4--Multiply column 2 by column 3. Enter 90 percent of the result.

Column 5--Enter the number of visits on or after January 1, 1999.

Line 4--Enter the sum of lines 1 through 3.

### 3648. WORKSHEET H-7 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

This worksheet applies to title XVIII only and provides for the reimbursement calculation of Part A and Part B. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

Worksheet H-7 consists of the following two parts:

- Part I - Computation of the Lesser of Reasonable Cost or Customary Charges
- Part II - Computation of HHA Reimbursement Settlement

3648.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges--Services not paid based on a fee schedule are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the providers for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in the 42 CFR 413.13(e).

**NOTE:** Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider only completes lines 1, 2, and 9 of Part I. Transfer the resulting cost to line 10 of Part II.

#### Line Descriptions

Line 1--This line provides for the computation of reasonable cost of program services. Enter the cost of services from Worksheet H-6, Part I as follows:

For cost reporting periods beginning prior to October 1, 1997:

If Worksheet H-6, Part I, column 12, line 7 is less than column 12, line 14, transfer (aggregate program cost):

<u>To Worksheet H-7, Line 1</u>	<u>From Worksheet H-6,</u>
Col. 1, Part A	Part I, col. 9, sum of lines 7, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 7, 15, and 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, sum of lines 7, 15, and 16

If column 12, line 14 is less than column 12, line 7, transfer (aggregate program limitation):

<u>To Worksheet H-7, Line 1</u>	<u>From Worksheet H-6</u>
Col. 1, Part A	Part I, col. 9, sum of lines 14, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 14, 15, and 16
Col. 3, Part B - Subject to deductible and coinsurance	Part I, col. 11, sum of lines 14, 15, and 16

For cost reporting periods beginning on or after October 1, 1997:

If Worksheet H-6, Part I, column 12, line 7 plus the sum of columns 9, 10, and 11, line 15 is less than column 12, line 14 plus the sum of columns 9, 10, and 11, line 15 or column 2, line 19, transfer (aggregate program cost): Do not include in the calculations below the subscripted columns reported on Worksheet H-6 for services rendered on and after October 1, 2000 except for line 16 or 16.01, column 11, osteoporosis drug costs.

For the following vaccines administered on or after January 1, 2003, enter on line 1, only the cost of pneumococcal and influenza vaccines and their administration reported on Worksheet H-6, line 16, column 10.01 (for cost reporting periods ending on or after April 30, 2005 (T14) transfer column 10, not column 10.01 (eliminated)) and osteoporosis drug costs reported on Worksheet H-6, line 16, column 11. Enter no other costs on this line as drugs for hepatitis are fee reimbursed, and all other services are PPS reimbursed.

To Worksheet H-7, Line 1

From Worksheet H-6,

Col. 1, Part A

Part I, col. 9, sum of lines 7, 15, and 16

Col. 2, Part B - Not subject to deductibles and coinsurance

Part I, col. 10 & 10.01, sum of lines 7, 15, and 16

Col. 3, Part B - Subject to deductibles and coinsurance

Part I, col. 11, lines 15 and 16 added to Part III, sum of columns 3.01 and 4, line 4 for services rendered prior to January 1, 1999

If column 12, line 14 plus the sum of columns 9, 10, and 11 line 15 is less than column 12, line 7 plus the sum of columns 9, 10, and 11 line 15 or column 2, line 19, transfer (aggregate program limitation):

To Worksheet H-7, Line 1

From Worksheet H-6,

Col. 1, Part A

Part I, col. 9, sum of lines 14, 15, and 16

Col. 2, Part B - Not subject to deductibles and coinsurance

Part I, col. 10, sum of lines 14, 15, and 16

Col. 3, Part B - Subject to deductibles and coinsurance

Part I, col. 11, lines 15 and 16 *added to* Part III, sum of columns 3.01 and 4, line 4 for services rendered prior to January 1, 1999

If Column 2, line 19 is less than column 12, line 7 or line 14 plus the sum of columns 9, 10, and 11 line 15 apportion the amount to Part A and Part B in proportion to the Part A and Part B costs reported in columns 9 and 10, line 7 of Worksheet H-6, Part I. Add the amount reported in columns 9 and 10, line 16 to Parts A and B (Not subject to deductible and coinsurance). Enter in column 3 (subject to deductible and coinsurance) the sum of Worksheet H-6, Part I, column 11, lines 15 and 16 and Part III, columns 3.01 and 4, line 4.

Lines 2 through 6--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1. Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-I, chapter 21) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs. For cost reports that overlap October 1, 2000, enter only the charges for services rendered prior to October 1, 2000. For cost reporting periods beginning on or after October 1, 2000, enter only the charges associated with osteoporosis drugs which continue to be cost reimbursed. For services rendered on or after January 1, 2003, enter the charges for



applicable Medicare covered pneumococcal and influenza vaccines (from worksheet H-6, Part I, line 16, column 7.01 (column 7 for cost reporting periods ending on or after 4/30/2005 **as column 7.01 is eliminated**)).

Line 2--Enter from your records in the applicable column the program charges for Part A, Part B not subject to deductibles and coinsurance, and Part B subject to deductibles and coinsurance.

Lines 3 through 6--These lines provide for the reduction of program charges when the provider does not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fails to make reasonable efforts to collect such charges from those patients. If line 5 is greater than zero, multiply line 2 by line 5, and enter the result on line 6. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 3, 4, and 5, but enter on line 6 the amount from line 2. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 6 exceed the actual charges on line 2.

Line 7--Enter in each column the excess of total customary charges (line 6) over the total reasonable cost (line 1). In situations when, in any column, the total charges on line 6 are less than the total cost on line 1 of the applicable column, enter zero on line 7.

Line 8--Enter in each column the excess of total reasonable cost (line 1) over total customary charges (line 6). In situations when, in any column, the total cost on line 1 is less than the customary charges on line 6 of the applicable column, enter zero on line 8.

Line 9--Enter the amounts paid or payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer. There are several situations under which program payment is secondary to a primary payer. Some of the most frequent situations in which the Medicare program is a secondary payer include:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are considered to be nonprogram services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. The provider notes this on no-pay bills submitted in these situations.) The patient visits and charges are included in total patient visits and charges, but are not included in program patient visits and charges. In this situation, no primary payer payment is entered on line 9.

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 payer payment does not satisfy the beneficiary's liability, include the covered days and charges in both program visits and charges and total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 9 the primary

payer payments that are credited toward the beneficiary's deductible and coinsurance. The primary payer rules are more fully explained in 42 CFR 411.

3648.2 Part II - Computation of HHA Reimbursement Settlement.--

Line 10--Enter in column 1 the amount in Part I, column 1, line 1 less the amount in column 1, line 9. Enter in column 2 the sum of the amounts from Part I, columns 2 and 3, line 1 less the sum of the amounts in columns 2 and 3 on line 9. For services rendered on or after October 1, 2000 this line will only include the osteoporosis drug reduced by primary payor amounts.

Lines 10.01 through 10.14--Enter in column 1 only for lines 10.01 through 10.06, as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 only on lines 10.07 through 10.10, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter on lines 10.12 through 10.14 the total DME, oxygen, prosthetics and orthotics payments, respectively, associated with home health PPS services (bill types 32 and 33). For lines 10.12 through 10.14 do not include any payments associated with services paid under bill type 34X. Obtain these amounts from your PS&R report.

Line 11--Enter in column 2 the Part B deductibles billed to program patients. Include any amounts of deductibles satisfied by primary payer payments.

**NOTE:** If the component qualifies as a nominal charge provider, enter 20 percent of costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 11 and primary payment amounts in column 3, line 9 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 13--If there is an excess of reasonable cost over customary charges in any column on line 8, enter the amount of the excess in the appropriate column.

Line 15--Enter in column 2 all coinsurance billable to program beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act.

**NOTE:** If the component qualifies as a nominal charge provider, enter 20 percent of the costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 11 and primary payment amounts in column 3, line 9 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 17--Enter the reimbursable bad debts in the appropriate columns. If recoveries exceed the current year's bad debts, line 17 will be negative.

Line 17.01--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 17. (4/1/2004b)

Line 19--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.) Enter the amount of any excess depreciation taken as a negative amount.

Line 20--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in program utilization. Submit the work papers which have developed this amount. (See CMS Pub. 15-I, §132.)

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.

3660. WORKSHEET L - CALCULATION OF CAPITAL PAYMENT

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. In addition, for cost reporting periods *beginning* on or after July 1, 2005, if the hospital received additional IME FTE resident cap slots under 42 CFR §413.79(c)(4) (Worksheet S-2, line 25.06, column 2, is "Y") add the amount reported on Worksheet E-3, Part VI, line 18). *For cost reporting periods that overlap July 1, 2005, multiply the FTE count from Worksheet E-3, Part VI, line 18 by line 1 in order to prorate the number of days in the cost reporting period occurring after July 1, 2005.*

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 amount of the Federal rate portion of the additional capital payment amounts relating to the disproportionate share adjustment. Complete these lines if you answered yes to line 36.01 on

**3662. WORKSHEET M-1 - ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS**

For services rendered on and after January 1, 1998, use this worksheet only if you operate a certified rural health clinic (RHC) or Federally qualified health center (FQHC). Use only those cost centers that represent services for which the facility is certified. If you have more than one provider-based RHC and/or FQHC, complete separate worksheets for each RHC and FQHC facility, *unless the facility has received prior FI approval to file a consolidated cost report (see CMS Pub. 100-4, chapter 9, §30.8).*

This worksheet is for the recording of direct RHC and FQHC costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. The worksheet also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations.

Column Descriptions

Columns 1 through 3--The expenses listed in these columns must be in accordance with your accounting books and records. If the cost elements of a cost center are maintained separately on your books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained by you and are subject to review by your intermediary.

Enter on the appropriate lines in columns 1 through 3 the total expenses incurred during the reporting period. Detail the expenses as Compensation (column 1) and Other (column 2). The sum of columns 1 and 2 must equal column 3.

Column 4--Enter any reclassifications among the cost center expenses listed in column 3 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. See §3611 for examples of reclassifications that may be needed. Submit with the cost report copies of any work papers used to compute the reclassifications reported in this column.

The net total of the entries in column 4 must equal zero on line 30 if no reclassifications were reported on worksheet A, column 4, of the appropriate subscribed line of line 63.

Column 5--Add column 4 to column 3, and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 30, if no reclassifications were reported on worksheet A, column 4, of the appropriate subscribed line of line 63.

Column 6--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.) Submit with the cost report copies of any work papers used to compute the adjustments reported in this column.

**NOTE:** The allowable cost of the services furnished by National Health Service Corp (NHSC) personnel may be included in your facility's costs. Obtain this amount from your intermediary, and include this as an adjustment to the appropriate lines on column 6.

Column 7--Adjust the amounts in column 5 by the amounts in column 6, and extend the net balance to column 7. The total facility costs on line 32 must equal the net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center.

Line Descriptions

Lines 1 through 9--Enter the costs of your health care staff .

Line 10--Enter the sum of the amounts on lines 1 through 9.

Line 11--Enter the cost of physician medical services furnished under agreement.

Line 12--Enter the expenses of physician supervisory services furnished under agreement.

Line 14--Enter the sum of the amounts on lines 11 through 13.

Lines 15 through 20--Enter the expenses of other health care costs.

Line 20--If you answered yes on Worksheet S-8, line 16, report on this line for services rendered on or after January 1, 1999 the amount of reimbursable graduate medical education costs from Worksheet B, Part I, sum of columns 22 and 23, lines 63.50–63.99 for RHC/FQHC as applicable. To claim GME the RHC/FQHC must have provided a "substantial amount" toward the cost of the intern and residents.

Line 21--Enter the sum of the amounts on lines 15 through 20.

Line 22--Enter the sum of the amounts on lines 10, 14, and 21. Reduce that result by the amount reported on line 20 if you are entitled to claim GME costs on line 20. Transfer this amount to Worksheet M-2, line 10.

Lines 23 through 27--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 27--If you have incurred non-allowable costs associated with graduated medical education, report on line 26 the non-allowable costs.

Line 28--Enter the sum of the amounts on lines 23 through 27. Transfer the total amount in column 7 to Worksheet M-2, line 11.

Line 29--Enter the overhead expenses directly costed to the facility. These expenses may include rent, insurance, interest on mortgage or loans, utilities, depreciation of buildings and fixtures, depreciation of equipment, housekeeping and maintenance expenses, and property taxes. Submit with the cost report supporting documentation to detail and compute the facility costs reported on this line.

Line 30--Enter the expenses related to the administration and management of the RHC/FQHC that are directly costed to the facility. These expenses may include office salaries, depreciation of office equipment, office supplies, legal fees, accounting fees, insurance, telephone service, fringe benefits, and payroll taxes. Submit with the cost report supporting documentation to detail and compute the administrative costs reported on this line.

Line 31--Enter the sum of the amounts on lines 29 and 30. Transfer the total amount in column 7 to Worksheet M-2, line 14.

Line 32--Enter the sum of the amounts on lines 22, 28, and 31 Do not include the amount reported on line 20 for GME. This is the total facility cost. This amount should agree with the amount reported for RHC and FQHC on Worksheet A, column 7 reduced by any amounts claimed on line 20 above.