CMS Manual System

Pub 100-19 Demonstrations

Transmittal 45

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: APRIL 14, 2006

Change Request 5020

SUBJECT: Method of Cost Settlement for Inpatient Services for Rural Hospitals Participating Under Demonstration Authorized by Section 410A of the Medicare Modernization Act

I. SUMMARY OF CHANGES:

This Change Request provides instructions for the settlement process for the first and second years of the five-year Rural Community Hospital Demonstration, mandated by Section 410A of the Medicare Modernization Act. Initial instructions for changing the method of calculating and administering interim payments were given in CR 3707. CR 5020 specifies the methods of settlements in accordance with the legislation.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : October 1, 2004

IMPLEMENTATION DATE : July 14, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title

III. FUNDING:

Funding for Medicare contractors is available through the regular budget process for costs required for implementation.

IV. ATTACHMENTS:

One-Time Notification

Unless otherwise specified, the effective date is the date of service.

Attachment – One-Time Notification

Pub. 100-19	Transmittal: 45	Date: April 14, 2006	Change Request 5020

SUBJECT: Method of Cost Settlement for Inpatient Services for Rural Hospitals Participating Under Demonstration Authorized by Section 410A of the Medicare Modernization Act.

This Change Request (CR) references CR 3707, which has changed the method of reimbursement for inpatient services for rural hospitals participating under the demonstration authorized by § 410A of the Medicare Modernization Act by changing the way interim payments are calculated and administered for the project. This CR provides further instructions on the settlement process for the first and second years of the demonstration.

I. GENERAL INFORMATION

A. Background: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), mandates a demonstration that establishes rural community hospitals. An eligible hospital is located in a rural area, has fewer than 51 acute care beds, makes available 24-hour emergency services, and is not eligible for Critical Access Hospital designation. Thirteen hospitals participated in the first year of the demonstration. Of these, four terminated their participation in December 2005.

B. Policy: For each chosen hospital:

1. In the first cost reporting period on or after implementation, the hospital's payment for covered inpatient services, excluding services in a psychiatric or rehabilitation unit that is a distinct part of the hospital, will be the reasonable cost of providing such services. Swing-bed services are included among the covered services for which the hospital receives payment on the basis of reasonable costs.

2. Reimbursement for the reasonable cost of services to beneficiaries is made according to the principles stated in 42 CFR 413 and Chapter 21of Part I of the Provider Reimbursement Manual. As stated in these documents, only costs that can be directly attributed to patient care will be reimbursed.

3. One hundred percent of bad debt will be included in the determination of reasonable cost.

4. Capital costs will be included in the determination of reasonable cost.

5. Costs of outpatient services performed within 72 hours prior to the inpatient admission will be bundled, as appropriate, as part of the cost of the inpatient service.

6. The reasonable cost payment for the first cost reporting year applies to all 13 hospitals that initially participated in the program. For the 4 hospitals that discontinued participation, payment will be made according to this methodology during the period when they participated.

7. In subsequent cost reporting periods of the demonstration program, payment for covered inpatient services is the lesser of the reasonable costs of providing such services or the target amount. This methodology applies to the 9 hospitals that are continuing.

8. The payment methodology for covered inpatient services during subsequent cost reporting periods, i.e., Years 2 through 5, is described in Attachment A.

9. If a hospital offers swing bed services, the fiscal intermediary will calculate two separate target amounts for the purpose of calculating reimbursement:

    - for acute care services; and
    - for swing-bed services.

10. If a hospital provides only acute care services, then there will be only one target amount - for acute care services.

11. Each of target amounts for acute care services and swing bed services will be case-mix adjusted according to methodologies explained in Attachment A. The goal of case-mix adjustment is to reduce the financial risk to the hospitals from sicker patients. However, a reduction in case-mix for either acute care or swing bed services will lead to decreased payment.

12. CMS will select a contractor to assist in calculating the case-mix adjustment for swing bed services. The case-mix adjustment will be based on swing bed Minimum Data Set (MDS) data provided by hospitals.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5020.1	Effective for cost reports beginning on or after 10/01/04, for each participating hospital, the FIs shall make payment for inpatient services and ONLY inpatient services for the 13 identified demonstration hospitals as the reasonable cost of providing the services.	X								
5020.2	Each year of the demonstration, for cost reports beginning 10/1/04 or after, the FI shall continue to pay each hospital under the IPPS method on a claim-by-claim basis.	X								
5020.2.1	For each participating hospital, i.e., a demonstration hospital identified in Tables A and B, effective for cost reports beginning on or after 10/01/04, the FI shall adjust interim payments for acute care services to reflect the reasonable cost of providing these services.	X								
5020.2.2	Using the latest finalized or tentatively settled cost report, whichever is from the later period, the FI shall determine what payments the hospital would have received under the PPS method and also under a reasonable cost method of reimbursement.	X								
5020.2.3	The FI shall calculate the variance between the PPS and reasonable cost methods, and adjust the interim payments for the hospital. This adjustment should be made in the form of a bi-weekly level payment, based on a per discharge calculation as for periodic interim payment (PIP) providers.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5020.2.4	The FI should target this adjustment to interim payments across the cost report period for each hospital so as to approximate the amount to be paid under cost-based reimbursement for the cost reporting period.	X								
5020.2.5	Participating hospitals with certified swing-beds will also receive cost-based reimbursement for swing-bed services.	X								
5020.2.6	The FI shall continue to pay swing-bed services under the SNF PPS method on a claim-by-claim basis. The FI shall calculate the variance between the SNF PPS and reasonable cost methods, making bi-weekly level payments as described above for the hospital acute care services.	X								
5020.3	For each of the 13 identified hospitals, the respective FI shall conduct an audit of the first cost report, beginning with cost report start date 10/1/04 and going through 7/1/05.	X								
5020.3.1	The FI will conduct these audits according to the principles expressed in Chapter 8 of the CMS Publication 100-06, "Medicare Financial Management Manual.	X								
5020.4	The FI shall reimburse the hospitals for the reasonable cost of services to beneficiaries according to the principles stated in 42 CFR 413 and Chapter 21 of Part I of the Provider Reimbursement Manual. As stated in these documents, only costs that can be directly attributed to patient care will be reimbursed.	X								
5020.5	As appropriate, the FI shall bundle the costs of outpatient services performed within 72 hours prior to the inpatient admission as part of the cost of the inpatient service.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5020.6	From the audit for each hospital in Table A and B, the respective FI will determine an amount for the reasonable costs for providing acute care services in the first cost report year.	X								
5020.6.1	From the audit for each hospital in Table A and B that provides swing bed services, the respective FI will determine an amount for the reasonable costs for providing swing bed services in the first cost report year.	X								
5020.7	For each hospital in Table A and B, the FI shall add the amount of reasonable costs for acute care and swing beds to arrive at an amount of the total reasonable costs for the hospital.	X								
5020.8	For each hospital in Table A and B, for the first cost report period, the FI shall compare the amount of total reasonable costs for the hospital to the amount paid in interim payments for the cost report period.	X								
5020.8.1	If the amount of interim payments is greater, then the hospital shall pay the difference to the FI.	X								
5020.8.2	If the amount of total reasonable costs is greater, then the FI shall pay the difference to the hospital.	X								
5020.9	At any time, the FI may change the amount of interim payments, depending on its calculation of the hospital's reasonable costs.	X								
5020.10	For each hospital in Table A, after the cost report for the second year is submitted, the FI shall conduct an audit of reasonable cost according to the same principles as in 5020.3.1 and 5020.4.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5020.11	From the audit for each hospital in Table A, the respective FI shall determine an amount for the reasonable costs of providing acute care services in the second cost report year.	X								
5020.12	The FI shall define discharges for both acute care and swing beds to include all patient status codes.	X								
5020.13	The respective FI shall calculate a target amount for acute care services for the second cost report year for each hospital in Table A according to the following formula: a. Calculate a ratio from first year cost report data of the cost of acute care services per discharge; b. Divide by case-mix index for Year 1; c. Multiply this amount by the number of acute care discharges on the second year cost report; d. Multiply by the case-mix index for Year 2 acute care services. e. Multiply by the acute care prospective payment update factor.	X								Hospital
5020.14	If the amount of reasonable costs for acute care services is less than the target amount, then the FI payment for acute care services for Year 2 is the reasonable cost amount.	X								
5020.15	If the target amount is less than the amount of reasonable costs for Year 2, then the FI payment for acute care services for Year 2 is the target amount.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5020.15.1	The FI shall conduct a settlement between the second year payment amount and interim payments paid out in the second cost report year according to the same principles in 5020.8.1 and 5020.8.2.	X								
5020.16	CMS/ORDI shall select a contractor to develop case-mix adjustment for swing bed services.									CMS/ORDI staff
5020.16.1	The CMS contractor shall extract MDS data from State data for each hospital on Table A that has swing beds.									CMS/ Contractor
5020.17	For the first two cost report periods, the CMS contractor shall determine the resource utilization group RUG code for each assessment for each patient receiving swing bed services for each hospital in Table A with swing beds.									CMS/Contractor
5020.18	For each patient, the CMS contractor shall measure how many days from admission to swing bed each assessment is made.									CMS/Contractor

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5020.19	CMS contractor shall calculate a RUG payment amount for each patient's discharge by examining data on the MDS assessments that occur in each patient stay: -Multiply the number of days between the date of each assessment and the following assessment (inclusive of the earlier assessment) by the RUG payment amount associated with the earlier assessment. The RUG payment for the last assessment in the patient's stay is multiplied by the number of remaining days in the stay. -Calculate a weighted average by dividing the sum of these products by the total number of days in the stay.									CMS/Contractor
5020.20	For each hospital, for each of the first two cost report years, the CMS contractor will calculate an average RUG payment amount per discharge, which is calculated by summing the payment amounts calculated in 5020.19 for each patient stay and dividing this sum by the total number of swing-bed discharges used in the calculation. (This is NOT a weighted average.) This calculation yields a RUG payment amount per discharge for each hospital for each of cost report years 1 and 2, respectively.									CMS/Contractor
5020.21	CMS will give these averages for each hospital to the respective FI.									CMS-ORDI

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5020.22	The FIs shall instruct the hospitals in Table A that it is their choice whether to have swing bed payment adjusted by case-mix. If a hospital with swing beds does not submit the MDS or does not choose case-mix adjusted payment, the FI shall apply no case-mix factor in calculating the target amount for swing beds.	X								Hospital
5020.22.1	For each hospital in Table A that provides swing bed services, the respective FI shall determine an amount for the reasonable costs of providing swing bed services in the second cost report year.	X								
5020.23	If the hospital elects the case-mix adjustment method, but does not begin MDS reporting until the second year, then the FI payment to the hospital for swing beds in the second year will be the reasonable costs for swing bed services in the second year.	X								Hospital

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5020.24	For each hospital in Table A that has swing beds and reports the MDS for Years 1 and 2 and chooses the case-mix adjustment, the FI shall calculate the target amount for swing bed services by: a. Calculating a ratio from the data on the first year's cost report of the cost of swing-bed services to the number of swing-bed discharges; b. Dividing the ratio obtained in step a by the RUG payment amount per discharge for Year 1; c. Multiplying the amount obtained in step b by the number of swing-bed discharges on the second year cost report; d. Multiplying the amount obtained in step c by the RUG payment amount per discharge for Year 2; and e. Multiplying the amount obtained in step d by the acute care prospective payment adjustment factor.	X								
5020.25	If the amount of reasonable costs for swing bed services for Year 2 is less than the target amount, then the FI payment for swing bed services for Year 2 is the reasonable cost amount.	X								
5020.25.1	If the target amount is less than the amount of reasonable costs for Year 2, then the FI payment for acute care services for Year 2 is the target amount.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5020.26	The FI shall conduct a settlement for Year 2 swing bed payments and the interim payments in the second year according to the principles in 5020.8.1 and 5020.8.2	X								
5020.27	For each cost reporting period, the FI shall collect necessary data from each hospital for the provider-specific file in order to be able to report disproportionate share percentages.	X								Hospital
5020.28	For the purposes of payment under this demonstration, acute care services shall be defined as those billed by the hospital with a type of bill code of "11X". Swing-bed services shall be defined as those billed with the type of bill code of "18".	X								Hospital
5020.29	The date of discharge shall determine into what cost reporting period a claim falls.	X								
5020.30	Claims that overlap cost reporting periods shall not be split. The FI shall assign them to the cost reporting period for the date of discharge.	X								
5020.31	Hospitals shall be able to terminate participation prior to the official end of the demonstration, effective at the beginning of the cost report period.	X								Hospital

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5020.32	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2004 **Implementation Date:** July 14, 2006 **Pre-Implementation Contact(s):** Sid Mazumdar, (410) 786-6673 **Post-Implementation Contact(s):** Sid Mazumdar**,** (410) 786-6673	**Funding for Medicare contractors is available through the regular budget process for costs required for implementation.**

***Unless otherwise specified, the effective date is the date of service.**

Attachments

Attachment A-Payment Methodology for Years 2 through 5

A) The payment methodology for inpatient services for Years 2 through 5 applies to the 9 hospitals that are continuing. Payment in each year is the lesser of reasonable costs or the target amount.

B) The amounts of reasonable cost for Year 1 and subsequent years acute care and swing bed services will be determined as distinct values. These values will be used to determine the target amounts for acute care and swing bed services, respectively, for Year 2.

C) To calculate the base-year target amount per-discharge for the hospital's acute care services:

a) In the first cost reporting period of the demonstration, the hospital's acute care target amount is calculated according to the following steps.

i) calculate the cost per discharge by dividing the total cost of acute care services by the total number of acute care discharges. Discharges are defined to include all patient status codes.

ii) divide this amount by the case mix index of the hospital's acute care patients.

b) The base-year target amount per-discharge will be updated in years 2 through 5 by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act) in the market basket percentage increase for each particular cost reporting period.

c) To calculate the target amount limitation for Years 2 through 5, the updated target amount per-discharge will be multiplied by:

i) the case-mix index of the hospital's acute care patients for the particular cost reporting period;
ii)the hospital's Medicare acute care discharges for the particular cost reporting period.

D) The hospital has the choice whether to have its swing bed payment adjusted by case-mix. To have its swing bed payment adjusted by a case-mix, the hospital must submit the minimum data set (MDS) for its Medicare swing bed patients.

E) To calculate the base-year target amount per-discharge of the swing-bed services:

a) In the first cost reporting period of the demonstration, the swing-bed target amount is calculated according to the following steps:

i) calculate an amount per swing bed discharge by dividing the total costs of swing bed services by the total number of swing bed discharges. Discharges are defined to include all patient status codes.

ii) divide this amount by the case mix index of the swing-bed's patients.

b) The base-year target amount per-discharge will be updated in years 2 through 5 by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act) in the market basket percentage increase for each particular cost reporting period.

c) To calculate the target amount limitation for Years 2 through 5, the updated target amount per-discharge will be multiplied by:

i) the case-mix index of the swing-bed patients for the particular cost reporting period;
ii)the Medicare swing-bed discharges for the particular cost reporting period.

d) If the hospital elects the case-mix adjustment method, but does not begin MDS reporting until the second year, then the target amount limitation for the second year will be calculated without case-mix adjustment. The target amount limitation for Year 2 will be the reasonable cost amount for swing beds in Year 2 (Year 2 becomes the base year).

e) For a hospital that elects the case-mix adjustment method but does not begin MDS reporting until the second year, the target amount limitations for Years 3 through 5 will be determined as follows:
i) calculate the per discharge amount for swing bed costs based on Year 2's cost report,
ii) Divide this amount by the Year 2 case-mix adjustment of the swing-bed patients
iii) Update in years 3 through 5 by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act) in the market basket percentage increase in each of the particular cost reporting periods.
iv) multiply by the case-mix of the swing-bed patients for the particular cost reporting period;
v) multiply by the swing-bed discharges for the particular cost reporting period.

f) The case mix adjustment for swing bed services will be calculated by CMS with the assistance of a contractor. It will be based on swing bed MDS data provided by hospitals. The contractor will calculate the case mix adjustment based on the MDS assessments for swing bed patients beginning with hospital cost report years beginning in FY 2005. The contractor will begin this work in FY 2007, using MDS data for hospitals' first and second cost report years. This accords with the schedule for settlement for the hospitals' Year 1 cost reports, which will begin in FY 2007.

F) For the calculation of both the acute care and swing bed target amounts, if the case-mix adjustment declines from the previous to the later year, the corresponding factor used in the payment methodology will also decline. It is possible that payment for either acute care or swing beds will decline for the hospital.

i) The case-mix adjustment is determined by calculating 1 + the percent variance between the base year case-mix index and the current year case-mix index. For example, a base year case-mix of 1.25 and a current year case-mix index of 1.5 results in a variance of .25 and a percent variance of .20. The case-mix adjustment is 1 + the difference between current and base year case mix divided by the base year case mix = 1 + (1.5 -1.25)/ 1.25] = 1.20.

ii) If a provider's current year case-mix is less than that in the base year, the target amount will be adjusted downward. For example, if the case-mix in the base year is 1.5 and in the current year it is 1.25, the case-mix adjustment = 1 + [(1.25-1.5)/1.5] = .8333.

G) Each hospital currently participating will be able to participate for 5 consecutive cost reporting periods.

H) For participating hospitals under the demonstration, payment change will begin with cost report periods beginning on or after October 1, 2004. Per the instructions in CR 3707, each hospital's fiscal intermediary has established an interim payment rate effective for those providers with fiscal years beginning on or after October 1, 2004. All 13 of the originally chosen hospitals began receiving interim payments from their respective fiscal intermediaries according to their cost report start dates, which are dispersed through the Federal fiscal year.

I) The fiscal intermediary will not make any Medicare disproportionate share payment in addition to the cost-based payment for inpatient

services. For each cost reporting period, the fiscal intermediary shall collect necessary data from each hospital for the provider specific file in order to calculate disproportionate share percentages. The fiscal intermediary will not make any payment for Medicare disproportionate share in addition to the cost-based payment for inpatient services. The purpose of this data collection is that hospitals will use these percentages to potentially be eligible for non-Medicare benefit programs tied to the disproportionate share percentage or status.

J) Hospitals participating in the demonstration will be able to participate in other CMS demonstrations.

K) Hospitals will receive Medicare inpatient payment from their current fiscal intermediary.
The following table lists the 9 hospitals selected for and still participating in the demonstration along with their fiscal intermediaries:

TABLE A

Provider No.	Hospital Name	City, State	Contractor Number	Contractor Name	Cost Report End
20024	Central Peninsula General Hospital	Soldotna, Alaska	00322	Noridian	6/30
20008	Bartlett Regional Hospital	Juneau, Alaska	00322	Noridian	6/30
270002	Holy Rosary Healthcare	Miles City, Montana	250	BCBS of Montana	5/31
270032	Northern Montana Hospital	Havre, Montana	250	BCBS of Montana	6/30
280111	Columbus Community Hospital	Columbus, Nebraska	52280	Mutual of Omaha	4/30
290006	Banner Churchill Community Hospital	Fallon, Nevada	52280	Mutual of Omaha	12/31
320013	Holy Cross Hospital	Taos, New Mexico	400	Trailblazers	5/31
430048	Lookout Memorial Hospital	Spearfish, South Dakota	11	Cahaba	6/30
460033	Garfield Memorial Hospital	Panguitch, Utah	350	Noridian	12/31

L) The following table lists the 4 hospitals that withdrew from the demonstration in December 2005. These hospitals will undergo audit and cost report settlement for the period they participated in the demonstration. However, since the hospitals will not continue to participate, their settlement amounts will not be used to calculate payment amounts for future years.

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TABLE B

280117	Tri-County Area Hospital District	Lexington, Nebraska	260	BCBS of Nebraska 6/30

280054	Beatrice Community Hospital and Health Center	Beatrice, Nebraska	52280	Mutual of Omaha 9/30
280108	Phelps Memorial Health Center	Holdredge, Nebraska	260	BCBS of Nebraska 12/30
280021	Community Hospital	McCook, Nebraska	260	BCBS of Nebraska 6/30

M) For each hospital, the respective fiscal intermediary will conduct an audit of the hospital's cost report and settlements in accordance with Chapter 8 of the CMS Publication #100-06, "Medicare Financial Management Manual." In each settlement, the fiscal intermediary will make a calculation of the reasonable cost of the hospital's acute care and swing bed services for the respective cost reporting period. The calculation of reasonable cost amounts will be made separately for acute care and swing bed services. The FI will compare this amount to the amount of interim payments made to the hospital during that period. From this calculation, the fiscal intermediary will determine whether Medicare owes the hospital money or vice versa.

ATTACHMENT I

		Inpatient Routine	Swing-bed SNF	
		1	2	
	Cost Reimbursement			
1	Medicare Inpatient Routine Costs (Worksheet D-1, Part II, Line 49)			1
2	Inpatient Routine Services - Swing-Bed SNF (Worksheet E-2, column 1, line 1)			2
3	Inpatient Ancillary Services - Swing-Bed SNF (Worksheet E-2, column 1, line 3)			3
4	Total			4
5	Total Acute Care/Swing-bed SNF Medicare Discharges			5
6	Case-Mix Adjustment			6
	Computation of Demonstration Target Amount Limitation (Not applicable in first year of demonstration)			
7	Medicare Target Amount			7
8	Case-Mix Adjusted Target Amount (line 7 x line 6)			8
9	Medicare Inpatient Routine Cost Cap (line 5 x line 8)			9
	Adjustment to Worksheet E, Part A Reimbursement			
10	Program reimbursement under the RCH demonstration (First year line 4, subsequent years, lower of line 4 or 9)			10
11	Amount from Worksheet E, Part A, line 16			11
12	Amount from Worksheet E-2, column 1, sum of lines 1 and 3)			12
13	Adjustment to Program PPS payments (line 10 less line 11 or 12, transfer column one to Worksheet E, Part A, line 24 and column 2 to Worksheet E-2, column 1, line16)			13