Medicare

Department of Health and Human Services (DHHS)

Provider Reimbursement Manual

Centers for Medicare and Medicaid Services (CMS)

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS 2552-10

Transmittal 3 **Date: October 2012**

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NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Ending on or After June 30, 2012.

This transmittal updates Chapter 40, Hospital and Hospital Health Care Complex Cost Report, (Form CMS-2552-10). This transmittal clarifies and corrects the existing instructions. This transmittal also incorporates select Federal Register provisions as well as select legislative provisions. The effective dates for instructional changes will vary due to various implementation dates.

Significant Revisions:

- Worksheet S-2, Part I - Clarifies lines 3 through 17 to instruct on the assembly of core based statistical area (CBSA) codes for rural providers.
    - Adds column 2 to line 27 to facilitate the collection of a geographic reclassification date, if applicable.
    - Clarifies line 46 to ask if providers are eligible for the additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f).
    - Clarifies lines 63 through 65 to collect data associated with residents training in nonprovider settings in accordance with section 5504 of the Patient Protection and Affordable Care Act of 2010 (ACA).
    - Adds lines 118.01 and 118.02 to collect non-propriety malpractice information and removes the requirement to answer the malpractice question on line 119.
    - Revises line 120 to implement section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 and section 3002 the Middle Class Tax Relief and Job Creation Act of 2012, extending outpatient hold harmless payments for services rendered through February 29, 2012 regardless of bed size for sole community hospitals (SCHs) (and essential access community hospitals (EACHs)) and for services from March 1, 2012 through December 31, 2012 for all SCHs and EACHs with 100 or fewer beds.
- Worksheet S-2, Part II - Adds lines 41 through 43 to capture cost report preparer information.
- Worksheet S-3, Part II - Adds lines 4.01 and 7.01 as hardcoded lines to capture the costs of Part A teaching physicians and, contracted interns and residents in an approved program, respectively.
    - Adds line 22.01 as a hardcoded line to capture the wage related costs for Part A teaching physicians.
- Worksheet S-3, Part III - Revises line 1 instructions to include lines 4.01 and 7.01 in the calculation.
- Worksheet S-3, Part IV - Revises line 4 to provide guidance for developing pension cost for the wage index in the form of a new exhibit (Exhibit 3 - Wage Index Pension Cost Schedule) that must be used in the calculation of such costs. The result of this schedule is input on line 4 of Worksheet S-3, Part IV. Additionally, lines 3 (non-qualified defined benefit pension plan cost) and 21 (executive deferred compensation) are effective retroactive to transmittal 1.
- Worksheet S-3, Part V - Clarifies the instructions for contract labor costs and benefit costs.
- Worksheet S-8 - Revises line 15 by adding column 5 to capture the total visits performed by interns and residents.
- Worksheet S-10 - Revises line 1 calculation to deduct the observation bed costs from total costs to ensure that observation bed costs are only included once. This is effective retroactive to transmittal 1.
    - Revises lines 8, 12 and 16 to ensure the proper arithmetic operation for the calculation for net revenues and costs.
- Worksheet A - Revises column 1 instructions to reflect the inclusion of all salary amounts paid for vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay to eliminate the necessity of applying adjustments to Worksheet S-3, Part II, column 1.
- Worksheet D, Part IV - Eliminates the use of column 1 as certified registered nurse anesthetists (CRNA) services are billed and paid through claims processing and are now included on Worksheet D, Part V.
- Worksheet D, Part V - Revises the instructions for column 2 (and applicable subscripts) to accommodate section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 and section 3002 the Middle Class Tax Relief and Job Creation Act of 2012, extending outpatient hold harmless payments for services for SCHs and EACHs.
    - Revises the instructions for columns 2 and 5, respectively, and applicable subscripts to accommodate section 3138 of ACA establishing the use of a predetermined payment to cost ratio (PCR) for cancer hospitals to calculate the transitional outpatient payment (TOPS) effective for services rendered beginning January 1, 2012. The PCR will be published and is subject to change each calendar year.

- Worksheet D-1, Part I - Revises line 4 (semi-private room days) to automate the calculation of semi-private room days to ensure that line 4 is exclusive of swing bed semi-private room days and observation bed days.
- Worksheet E, Part A - Adds line 33 (allowable disproportionate share percentage) to the lines that may subscript column 1 for SCH and Medicare dependent hospital (MDH) status change and/or geographical reclassification.
    - Adds subscripted line 2.01 to accommodate the operating outlier reconciliation amount from line 92. This line is for use by contractors only.
    - Revises line 47 instructions to include line 2.01 in the calculation.
    - Revises line 69 instructions to exclude and relocate the operating outlier reconciliation to line 2.01, and to include the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses.
    - Adds a new exhibit (Exhibit 4 - Low Volume Cost Adjustment Calculation Schedule) and corresponding instructions to facilitate final settlement and provide guidance for the low volume adjustment calculation in accordance with sections 3125 and 10314 of ACA, for discharges occurring during Federal fiscal years 2011 and 2012. The result of the exhibit will be applied to other adjustment lines 70.96, 70.97, and/or 70.98, as applicable.
- Worksheet E, Part B - Revises the instructions to subscript column 1 to accommodate section 3138 of ACA establishing the use of a predetermined PCR for cancer hospitals to calculate the TOPS effective for services rendered beginning January 1, 2012. The PCR will be published and is subject to change each calendar year.
    - Revises line 1 to accommodate the TOPS calculation for EACHs regardless of bed size and rural hospitals with 100 or fewer beds whose cost report overlaps December 31, 2011.
    - Revises line 5 to indentify the PCR for calendar year 2012.
    - Revises line 8 to perform the actual TOPS calculation for SCHs and EACHs in accordance with the revision indicated on Worksheet S-2, line 120 above.
- Worksheet E-1, Part I - Revises line 8 instructions to include the notice of program reimbursement (NPR) date in column 2.
- Worksheet E-1, Part II - Revises the opening instructions to convey that this section is to be completed by contractor if the cost reporting period is a nonstandard fiscal year.
- Worksheet E-3, Part II - Adds line 4.01 (cap increase) to accommodate the input of the unweighted full time equivalent (FTE) count for residents displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2). Effective for cost reporting periods beginning on or after July 1, 2011.
    - Revises line 8 to include line 4.01 and applicable subscripts in the calculation of the resident count for the medical education adjustment.
    - Revises line 27 to convey completion for freestanding inpatient psychiatric facilities (IPF) only, not an IPF unit.
- Worksheet E-3, Part III - Adds line 5.01 (cap increase) to accommodate the input of the unweighted full time equivalent (FTE) count for residents displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2). Effective for cost reporting periods beginning on or after October 1, 2011.
    - Revises line 9 to include line 5.01 and applicable subscripts in the calculation of the resident count for the medical education adjustment.
    - Revises line 28 to convey completion for freestanding inpatient rehabilitation facilities (IRF) only, not an IRF unit.
- Worksheet E-3, Part IV - Revises line 18 instructions to convey completion for freestanding long-term care hospitals (LTCH) only.
- Worksheet E-3, Part VI - Revises line 5 instructions to convey that it is not to be used since vaccine costs are included on line 1 of Worksheet E, Part B.
- Worksheet E-3, Part VII - Revises lines 5, 8-11, 17, 18, 21, 27, 29, 31 instructions and adds a note prior to line 22 to clarify the instructions for the calculation of the Medicaid reimbursement.

- Worksheet E-4, Revises line 26 instructions to append title XIX instructions for inpatient days to facilitate the computation of patient load.
    - Clarifies line 27 instructions to indicate that the amount input in columns 1 and 2 must be identical.
    - Clarifies line 30 instructions to indicate the amount on this line is the reduction for direct graduate medical education (GME) payments for Medicare managed care (Medicare+Choice).
- Worksheet H-5, Part I - Revises line 8 instructions to include the NPR date in column 2.
- Worksheet I-5, Part I - Clarifies the computation of line 10.
- Worksheet J-4, Part I - Revises line 8 instructions to include NPR date in column 2.
- Worksheets L, Part III and L-1, Part I - Clarifies the reference to the additional payment exception for extraordinary circumstances is 42 CFR 412.348(f).
- Worksheet M-3 - Clarifies the instructions for lines 15, 16 - 16.05, 19 and 20.
- Worksheet M-5 - Revises line 8 instructions to include the NPR date in column 2.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after June 30, 2012.

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.

CHAPTER 40
HOSPITAL AND HOSPITAL
HEALTH CARE COMPLEX COST REPORT
FORM CMS-2552-10

Section

Section

3. Round to 4 decimal places:
   a. Wage adjustment factor
   b. Medicare SSI ratio

4. Round to 5 decimal places:
   a. 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.

4000.2 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.

ACA	-	Affordable Care Act
A&G	-	Administrative and General
AHSEA	-	Adjusted Hourly Salary Equivalency Amount
ARRA	-	American Recovery and Reinvestment Act of 2009
ASC	-	Ambulatory Surgical Center
BBA	-	Balanced Budget Act
BBRA	-	Balanced Budget Reform Act
BIPA	-	Benefits Improvement and Protection Act
CAH	-	Critical Access Hospitals
CAPD	-	Continuous Ambulatory Peritoneal Dialysis
CAP-REL	-	Capital-Related
CBSA	-	Core Based Statistical Areas
CCN	-	CMS Certification Number
CCPD	-	Continuous Cycling Peritoneal Dialysis
CCU	-	Coronary Care Unit
CFR	-	Code of Federal Regulations
CMHC	-	Community Mental Health Center
CMS	-	Centers for Medicare & Medicaid Services
COL	-	Column
CORF	-	Comprehensive Outpatient Rehabilitation Facility
CRNA	-	Certified Registered Nurse Anesthetist
CT	-	Computer Tomography
CTC	-	Certified Transplant Center
DEFRA	-	Deficit Reduction Act of 1984
DPP	-	Disproportionate Patient Percentage
DRA	-	Deficit Reduction Act of 2005
DRG	-	Diagnostic Related Group
DSH	-	Disproportionate Share
EACH	-	Essential Access Community Hospital
ECR	-	Electronic Cost Report
EHR	-	Electronic Health Records
ESRD	-	End Stage Renal Disease
FQHC	-	Federally Qualified Health Center
FR	-	Federal Register
FTE	-	Full Time Equivalent
GME	-	Graduate Medical Education

HCERA	-	Health Care and Education Reconciliation Act of 2010
HCPCS	-	Healthcare Common Procedure Coding System
HCRIS	-	Healthcare Cost Report Information System
HFS	-	*Health Financial Systems*
HRSA	-	Health Resources and Services Administration
HHA	-	Home Health Agency
HIT	-	Health Information Technology
HMO	-	Health Maintenance Organization
HSR	-	Hospital Specific Rate
I & Rs	-	Interns and Residents
ICF/MR	-	Intermediate Care Facility Mentally Retarded
ICU	-	Intensive Care Unit
IME	-	Indirect Medical Education
INPT	-	Inpatient
IOM	-	Internet Only Manual
IPF	-	Inpatient Psychiatric Facility
IPPS		Inpatient Prospective Payment System
IRF	-	Inpatient Rehabilitation Facility
KPMG	-	*Klynveld, Peat, Marwick, & Goerdeler*
LDP	-	Labor, Delivery and Postpartum
LIP	-	Low Income Patient
LOS	-	Length of Stay
LCC	-	Lesser of Reasonable Cost or Customary Charges
LTCH	-	Long Term Care Hospital
MA	-	Medicare Advantage (previously known as M+C)
M+C	-	Medicare + Choice (also known as Medicare Part C, Medicare Advantage and Medicare HMO)
MCP	-	Monthly Capitation Payment
MDH	-	Medicare Dependent Hospital
MED-ED	-	Medical Education
MIPPA	-	Medicare Improvements for Patients and Providers Act of 2008
MMA	-	Medicare Prescription Drug Improvement and Modernization Act of 2003
MMEA	-	Medicare and Medicaid Extenders Act of 2010
MRI	-	Magnetic Resonance Imaging
MS-DRG	-	Medicare Severity Diagnosis-Related Group
MSP	-	Medicare Secondary Payer
NF	-	Nursing Facility
NPI	-	National Provider Identifier
NPR	-	Notice of Program Reimbursement
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 System
OPT	-	Outpatient Physical Therapy
OSP	-	Outpatient Speech Pathology
ORF	-	Outpatient Rehabilitation Facility
PCR	-	*Payment to Cost Ratio*
PCRE	-	Primary Care Residency Expansion Program
PBP	-	Provider-Based Physician
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PRA	-	Per Resident Amount
PS&R	-	Provider Statistical and Reimbursement Report (or System)
PT	-	Physical Therapy

Form CMS	Work-sheet	Part	Health Care Program (Title)	Component
2552-10	E-1	II	HIT	Hospital and CAH
2552-10	E-2		V	Swing Bed SNF
2552-10	E-2		V	Swing Bed NF
2552-10	E-2		XVIII	Swing Bed SNF
2552-10	E-2		XIX	Swing Bed SNF
2552-10	E-2		XIX	Swing Bed NF
2552-10	E-3	I - V	XVIII	Hospital
2552-10	E-3	I - III or V	XVIII	Subprovider
2552-10	E-3	IV	XVIII	LTCH
2552-10	E-3	VI	XVIII	SNF
2552-10	E-3	VII	V & XIX	Hospital
2552-10	E-3	VII	V & XIX	NF, ICF/MR
2552-10	E-3	VII	V & XIX	SNF
2552-10	G			
2552-10	G-1			
2552-10	G-2			
2552-10	G-3			
2552-10	H			Hospital-based HHA
2552-10	H-1	I & II		Hospital-based HHA
2552-10	H-2	I & II		Hospital-based HHA
2552-10	H-3	I & II	V, XVIII, & XIX	Hospital-based HHA
2552-10	H-4	I & II	V, XVIII, & XIX	Hospital-based HHA
2552-10	H-5		XVIII	Hospital-based HHA
2552-10	I-1 - I-5			Renal Dialysis
2552-10	I-1 - I-5			Home Program Dialysis
2552-10	J-1 - J-2	I & II		CMHC
2552-10	J-3		V, XVIII, & XIX	CMHC
2552-10	J-4		XVIII	CMHC
2552-10	K			Hospital-based Hospice
2552-10	K-1			Hospital-based Hospice
2552-10	K-2			Hospital-based Hospice
2552-10	K-3			Hospital-based Hospice
2552-10	K-4	I & II		Hospital-based Hospice
2552-10	K-5	I - III		Hospital-based Hospice
2552-10	K-6		XVIII, XIX	Hospital-based Hospice
2552-10	L	I - III	V, XVIII, & XIX	Hospital
2552-10	L	I - III	V, XVIII, & XIX	Subprovider
2552-10	L-1	I		Hospital
2552-10	L-1	II	V, XVIII, & XIX	Hospital
2552-10	L-1	III	V, XVIII, & XIX	Hospital
2552-10	L-1	III	V, XVIII, & XIX	Subprovider
2552-10	M-1		V, XVIII, &XIX	Hospital-based RHC/FQHC
2552-10	M-2		V, XVIII, &XIX	Hospital-based RHC/FQHC
2552-10	M-3		V, XVIII, &XIX	Hospital-based RHC/FQHC
2552-10	M-4		V, XVIII, &XIX	Hospital-based RHC/FQHC
2552-10	M-5		V, XVIII, &XIX	Hospital-based RHC/FQHC

4003. WORKSHEET S - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

4003.1 Part I - Cost Report Status.--This section is to be completed by the provider and fiscal intermediary (FI)/Medicare administrative contractor (MAC) (hereafter referred to as contractor) as indicated on the worksheet.

Lines 1 - 3, column 1--The provider must check the appropriate box to indicate on line 1 or 2, respectively, whether this cost report is being filed 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 contractor and is archived accordingly. This file is your original submission and is not to be modified. If this is an amended cost report, enter on line 3 the number of times the cost report has been amended.

Line 4, Column 1--The provider must enter an "F" if this is full cost report or an "L" for low Medicare utilization (requires prior contractor approval, see Pub. 15-2, chapter 1, section 110).

Line 5, Column 1--Enter the Healthcare Cost Report Information System (HCRIS) cost report status code on line *5*, column 1 of Worksheet S that corresponds to the filing status of the cost report: 1=As submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 6, Column *2*--Enter the date (mm/dd/yyyy) an accepted cost report was received from the provider.

Line 7, Column *2*--Enter the 5 position *c*ontractor *n*umber.

Lines 8 and 9, Column *2*-- *If this is an initial cost report, enter "Y" for yes in the box on line 8. If this is a final cost report, enter "Y" for yes in the box on line 9.* If neither, *enter "N".*

An initial report is the very first cost report for a *particular* provider *CCN*. *A final cost report is a terminating cost report for a particular provider CCN.*

If the cost report is both initial and terminating in the same year, for example, the provider started Medicare and decided to leave the program in the same year, and if the cost report is a full Medicare utilization report, please submit to HCRIS an as submitted and a final settled report. The as submitted extract should be the initial report, and the final settled should be the final report.

If the cost report is both initial and terminating in the same year, and if the cost report is No or Low Medicare utilization, please only submit to HCRIS a final settled with or without audit report. This would be the only situation in which a HCRIS extract would be both initial and final.

Line 10, Column *3*--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 or 3.

Line 11, Column *3*--Enter software vendor code of the cost report software used by the contractor to process this *HCRIS* cost report file. *Use "4" for HFS or "3" for KPMG.*

Line 12, Column *3*--If this is a reopened cost report (response to line *5*, column 1 is "4"), enter the number of times the cost report has been reopened. This field *is* only be completed if the cost report status code in line *5*, column 1 is 4.

4003.2 Part II - Certification.--This certification is read, prepared, and signed by an officer or administrator of the provider after the cost report has been completed in its entirety.

4004. WORKSHEET S-2 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

This worksheet consists of two parts:

Part I - Hospital and Hospital Health Care Complex Identification Data
Part II - Hospital and Hospital Health Care Complex Reimbursement Questionnaire

4004.1 Part I - 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.

Line Descriptions

Lines 1 and 2--Enter the street address, post office box (if applicable), the city, State, *ZIP* code, and county of the hospital.

Lines 3 - 17--Enter on the appropriate lines and columns indicated the component names, CMS certification numbers (CCN), core based statistical area (CBSA) *codes (non-CBSA (rural) codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the state of Maryland the Non-CBSA code is 99921)*, provider type, and certification dates of the hospital and its various components, if any. Indicate for each health care program (titles V, XVIII, or XIX) the payment system applicable to the hospital and its various components by entering P, T, O, or N in the appropriate column to designate PPS, TEFRA, OTHER, *or NOT APPLICABLE, respectively. The "OTHER" payment system includes critical access hospitals (CAHs) and cost reimbursed providers.*

Column 4--Indicate, as applicable, the number listed below which best corresponds with the type of services provided.

1 = General Short Term
2 = General Long Term
3 = Cancer
4 = Psychiatric
5 = Rehabilitation
6 = Religious Non-Medical Health Care Institution
7 = Children
8 = Alcohol and Drug
9 = Other

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 *average* lengths of stay greater than 25 days. Some hospitals may be certified as other than long term care hospitals, but also have *average* 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 3--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 4--The distinct part inpatient psychiatric facility (IPF) is a portion of a general hospital which has been issued a subprovider CCN because it offers a clearly different type of service from the remainder of the hospital with such services reimbursed under inpatient psychiatric PPS. *(See 42 CFR 412.25)* While an excluded unit (excluded from IPPS) in a hospital subject to IPPS may not meet the definition of a subprovider, treat it as a subprovider for cost reporting purposes.

Line 5--The distinct part inpatient rehabilitation facility (IRF) is a portion of a general hospital which has been issued a subprovider CCN because it offers a clearly different type of service from the remainder of the hospital with such services reimbursed under inpatient rehabilitation PPS. *(See 42 CFR 412.25)* While an excluded unit (excluded from IPPS) in a hospital subject to IPPS may not meet the definition of a subprovider, treat it as a subprovider for cost reporting purposes.

Line 6--This is a portion of a general hospital *defined as non-Medicare certified not included in lines 4 through 18 which offers* a clearly different type of service from the remainder of the hospital.

Line 7--Medicare swing-bed services are 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. Rural hospitals with fewer than 100 beds may be 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. 15-1, §§2230-2230.6.)

Line 8--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. 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.

Line 9--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 cannot contain more than one hospital-based SNF or hospital-based NF.

Line 10--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. The contractor will reject a cost report attempting to report more than one nursing facility.

If the facility operates an Intermediate Care Facility/Mental Retarded (ICF/MR) subscript line 10 to 10.01 and enter the data on that line. Note: Subscripting is allowed only for the purpose of reporting an ICF/MR.

Line 11--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 12--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 13--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 14--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 6, 7, and 8.

Lines 15 and 16--Enter the applicable information for rural health clinics (RHCs) on line 15 and for federally qualified health clinics (FQHCs) on line 16. These lines are used by RHCs and/or FQHCs 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 them on subscripts of line 15. If you have more than one FQHC, report them on subscripts of line 16. Report the required information in the appropriate column for each. (See Exhibit 2, Table 4) RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-*0*4, chapter 9, §30.8. Do not subscript this line if you elect to file under the consolidated cost reporting method. See section 4010 for further instructions.

Line 17--This line is used by hospital-based community mental health centers (CMHCs). Subscript this line as necessary to accommodate multiple CMHCs (lines 17.00-17.09). Also subscript this line to accommodate CORFs (lines 17.10-17.19), OPTs (lines 17.20-17.29), OOTs (lines 17.30-17.39) and OSPs (lines 17.40-17.49). (See Exhibit 2, Table 4, Part III.)

Line 18--If this facility operates a renal dialysis facility (CCN 2300-2499), a renal dialysis satellite (CCN 3500-3699), and/or a special purpose renal dialysis facility (CCN 3700-3799), enter in column 2 the applicable CCN. Subscript this line as applicable.

Line 19--For any component type not identified on lines 3 through 19, enter the required information in the appropriate column.

Line 20--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. 15-2, §§102.1-102.3 for situations where you may file a short period cost report.)

Line 21--Indicate the type of control or auspices under which the hospital is conducted as indicated:

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

Line 22--Does your facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR 412.106? Enter on column 1 "Y" for yes or "N" for no. Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle Amendment hospitals)? Enter in column 2 "Y" for yes or "N" for no.

Line 23--Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3"

if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.

NOTE: For lines 24 and 25, columns 1 through 6 are mutually exclusive. For example, if patient days are entered in column 1, those days may not be entered in any other columns.

Line 24--*If this is an IPPS provider, in accordance with 42 CFR 412.106(b)(4),* enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible but unpaid days in column 2, the out-of-state Medicaid paid days in column 3, the out-of-state Medicaid eligible but unpaid days in column 4, Medicaid HMO *paid and eligible but unpaid* days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days. *Do not include swing-bed, observation or hospice days in any columns on this line.*

Line 25--*If this provider is an IRF, in accordance with 42 CFR 412.106(b)(4),*enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible *but unpaid* days in column 2, the out-of-state Medicaid paid days in column 3, the out-of-state Medicaid eligible *but unpaid* days in column 4, Medicaid HMO *paid and eligible but unpaid* days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.

Line 26--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.

Line 27--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. *If applicable, enter the effective date of the geographic reclassification in column 2.*

Lines 28 - 34--Reserved for future use.

Line 35--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 36. Subscript line 36 if more than 1 period is identified for this cost reporting period and enter multiple dates. 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 1/1/2010-6/30/2010 and 9/1/2010-12/31/2010.

Line 37--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 38. Subscript line 38 if more than 1 period is identified for this cost reporting period and enter multiple dates.

Lines 39 - 44--Reserved for future use.

Line 45--Does your facility qualify and receive capital payments for disproportionate share in accordance with 42 CFR 412.320? Enter "Y" for yes and "N" for no.

Line 46--Are you eligible for the *exception payment for extraordinary circumstances* pursuant to 42 CFR 412.348(*f*)? Enter "Y" for yes or "N" for no. If yes, complete Worksheets L, Part III and L-1.

Line 47--Is this a new hospital under 42 CFR 412.300*(b)* (PPS capital)? Enter "Y" for yes or "N" for no for the respective programs.

Line 48--If line 47 is yes, do you elect full federal capital payment. Enter "Y" for yes or "N" for no for the respective programs.

Lines 49 - 55--Reserved for future use.

NOTE: CAHs complete question 107 in lieu of question *57*.

Line 56--Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.

Line 57--If line 56 is yes, is this the first cost reporting period in which you are training residents in approved programs. Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, were residents training during the first month of the cost reporting period. Enter "Y" for yes or "N" for no in column 2. If column 2 is yes, complete Worksheet E-4. If column 2 is "N" complete Worksheets D, Parts III and IV and D-2, Part II, if applicable.

Line 58--As a teaching hospital, did you elect cost reimbursement for teaching physicians as defined in CMS Pub. 15-1, §2148? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-5.

Line 59--Are you claiming costs of intern & resident in unapproved programs on line 100, column 7, of Worksheet A? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-2, Part I.

Line 60--Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 42 CFR 413.85? Enter "Y" for yes or "N" for no. If yes, you must identify such costs in the applicable column(s) of Worksheet D, Parts III and IV to separately identify nursing and allied health (paramedical education) from all other medical education costs.

Line 61--Did your hospital receive FTE slots under section 5503 of the ACA? Enter "Y" for yes or "N" for no in column 1. If yes, complete columns 2 and 3. If "N" for no do not complete columns 2 or 3. Effective for portions of cost reporting periods occurring on or after July 1, 2011, enter the average number of primary care FTE residents from the hospital's 3 most recent cost reports ending and submitted to the contractor before March 23, 2010. Enter the 3 year primary care average for IME in column 2. Compute the IME 3 year average primary care FTE counts from the rotation schedules for the 3 most recent cost reporting periods ending and submitted to the contractor prior to March 23, 2010. This primary care average is based on the hospital's total primary care FTE count that would otherwise be allowable if not for the FTE resident *c*ap. Exclude OB/GYN FTE residents.

Enter the average number of primary care FTE residents for direct GME in column 3. This primary care average is based on the hospital's total unweighted primary care FTE count that would otherwise be allowable if not for the FTE resident cap. If the hospital did not train any OB/GYN residents in its 3 most recent cost reporting periods ending and submitted prior to March 23, 2010, convert the weighted primary care FTE counts from line 3.19 of Worksheet E-3, Part IV of Form CMS 2552-96, to unweighted FTE counts, compute a 3 year average, and report the average in column 3. If the hospital did train OB/GYN FTE residents in its 3 most recent cost reporting periods ending and submitted prior to March 23, 2010, subtract the OB/GYN FTE counts from line 3.19 of Worksheet E-3, Part IV of Form CMS 2552-96, convert the remaining primary care FTE counts to unweighted FTE counts, compute a 3 year average, and report the average in column 3.

Lines 62 - 62.01--Affordable Care Act Provisions Affecting the Health Resources and Services Administration (HRSA)--These provisions are effective for a five year period for the Health Resources and Services Administration (HRSA) Primary Care Residency Expansion (PCRE) program and the Teaching Health Center (THC) program.

Line 62--Effective for services rendered during September 30, 2010 through September 29, 2015, of the HRSA PCRE program, enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding. (Sections 4002 and 5301 of the ACA.)

Line 62.01--Effective for services rendered during October 1, 2010, through September 30, 2015, enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during this cost reporting period under the HRSA THC program. (Section 5508 of the ACA.)

Line 63--*Has* your facility trained residents in a non-provider setting during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. See Federal Register, Vol. 75, number 226, dated November 24, 2010, page 72139-40. If column 1 is "Y" for yes, complete lines *64* through 67 and applicable subscripts. If "N" for no, *but your facility trained residents in a non-provider setting during the base year period (cost reporting period that begins on or after July 1, 2009 and before June 30, 2010),* complete lines *64 and 65* and applicable subscripts effective for cost reporting periods beginning on or after July 1, 2010.

Lines 64 - 65--Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--The base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.

Line 64--If line 63 is *yes or your facility trained residents in the base year period*, enter in column 1, *for* cost reporting period*s* that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.

Line 65-- If line 63 is yes *or your facility trained residents in the base year period*, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. *If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.*

NOTE: The sum of the FTE counts on line 64, columns 1 and 2, and line 65, columns 3 and 4, should approximate the sum of the FTE counts on Form CMS 2552-96, Worksheet E-3, part IV, lines 3.05 and 3.11 for your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.

Lines 66 and 67--Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010.

Line 66--If line 63 is yes, enter in column 1 the unweighted number of nonprimary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3 the ratio of column 1 divided by the sum of columns 1 and 2.

Line 67-- If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 *through 67.50 for each additional primary care program.*

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If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.

NOTE: The sum of the FTE counts on line 66, columns 1 and 2, and line 67, columns 3 and 4, should approximate the sum of the FTE counts on Worksheet E-4, lines 6 and 10 for this current cost reporting period.

Lines 68 - 69--Reserved for future use.

Line 70--Are you an IPF or do you contain an IPF subprovider? Enter in column 1 "Y" for yes or "N" for no.

Line 71--If this facility is an IPF or contains an IPF subprovider (response to line 70, column 1 is "Y" for yes), were residents training in this facility **in the most recent cost report 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)(D)? 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.

Lines 72 - 74--Reserved for future use.

Line 75--Are you an IRF or do you contain an IRF subprovider? Enter in column 1 "Y" for yes and "N" for no.

Line 76--If this facility is an IRF or contains an IRF subprovider (response to line 75, 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.

Lines 77 - 79--Reserved for future use.

Line 80--Are you a *freestanding long term care hospital* (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. *To be considered as independent or a freestanding facility, a LTCH located within another hospital* must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)

Lines 81 - 84--Reserved for future use.

Line 85--Is this a new hospital under 42 CFR 413.40(f)(1)(i) (TEFRA)? Enter "Y" for yes or "N" for no in column 1.

Line 86--Have you established a new "Other" subprovider (excluded unit) under 42 CFR 413.40 (f)(1)(ii)? Enter "Y" for yes or "N" for no in column 1. If there is more than one subprovider, subscript this line. *Do not complete this line.*

Line 87 - 89--Reserved for future use.

Lines 90--Do you provide title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.

Line 91--Is this hospital reimbursed for title V and/or XIX through the cost report in full or in part? Enter "Y" for yes or "N' for no in the applicable column.

Line 92--If all of the nursing facility beds are certified for title XIX, and there are also title XVIII certified beds (dual certified), are any of the title XVIII beds occupied by title XIX patients? Enter "Y" for yes or "N" for no in the applicable column. You must complete a separate Worksheet D-1 for title XIX for each level of care.

Line 93--Do you operate an ICF/MR facility for purposes of title XIX? Enter "Y" for yes or "N" for no.

Line 94--Does title V and/or XIX reduce capital costs? Enter "Y" for yes or "N" for no in the applicable column.

Line 95--If line 94 of the corresponding column is "Y" for yes, enter the percentage by which capital costs are reduced.

Line 96--Does title V and/or XIX reduce operating costs? Enter "Y" for yes or "N" for no in the applicable column.

Line 97--If line 96 of the corresponding column is "Y" for yes, enter the percentage by which operating costs are reduced.

Lines 98 - 104--Reserved for future use.

Line 105--If this hospital qualifies as a CAH, enter "Y" for yes in column 1. Otherwise, enter "N" for no, and skip to line 108. (See 42 CFR 485.606ff.)

Line 106--If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? Enter "Y" for yes or "N" for no. If yes, an adjustment for the professional component is still required on Worksheet A-8-2.

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 107--If this facility qualifies as a CAH, is it eligible for 101 percent reasonable cost reimbursement for I&R in approved training programs? Enter a "Y" for yes or an "N" for no in column 1. If yes, the GME elimination is **not** made on Worksheet B, Part I, column 25 and the program is cost reimbursed. If yes, complete Worksheet D-2, Part II.

If this facility qualifies as a CAH, do I&R in approved medical education programs train in the CAH's excluded IPF and/or IRF unit? Enter a "Y" for yes or an "N" for no in column 2. If yes, complete Worksheet E-4. CAHs are reimbursed for GME in subproviders on Worksheet E-4; and are reimbursed for GME in the rest of the CAH at 101 percent of reasonable cost. The CAH must maintain adequate documentation to support the FTE *resident* count and time spent for the excluded IPF and/or IRF units.

Line 108--Is this a rural hospital qualifying for an exception to the certified registered nurse anesthetist (CRNA) fee schedule? (See *42* CFR 412.113(c).) Enter "Y" for yes in column 1. Otherwise, enter "N" for no.

Line 109--If this hospital qualifies as a critical access hospital (CAH) (response to line 105 is yes) or is a cost reimbursed provider, are therapy services provided by outside suppliers? Enter "Y" for yes or "N" for no under the corresponding physical, occupational, speech and/or respiratory therapy services as applicable in columns 1 through 4.

Lines 110 - 114--Reserved for future use.

Line 115--*Is this* an all inclusive rate provider (see instructions in CMS Pub. 15-1, §2208*). Enter "Y" for yes or "N" for no in column 1. If yes,* enter the applicable method (A, B, or E only) in column 2. *If column 2 is "E", enter the inpatient Medicare calculation percentage in column 3. Enter "93" for short-term hospitals where over 50 percent of all patients admitted stay less than 30 days or "98" for long-term hospitals where over 50 percent of all patients stay 30 days or more. (See CMS Pub. 15-1, §2208.1.E.)*

Line 116--Are you classified as a referral center? Enter "Y" for yes or "N" for no. See 42 CFR 412.96.

Line 117--Are you legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no. Malpractice insurance, sometimes referred to as professional liability insurance, is insurance purchased by physicians and hospitals to cover the cost of being sued for malpractice.

Line 118--Is the malpractice insurance a claims-made or occurrence policy? A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a "claims-made" contract. The occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. If the policy is claims-made, enter 1. If the policy is occurrence, enter 2.

Line 118.01--Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.

Line 118.02--Indicate if malpractice premiums and paid losses are reported in a cost center other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.

Malpractice insurance premiums are money paid by the provider to a commercial insurer to protect the provider against potential negligence claims made by their patients/clients. Malpractice paid losses is money paid by the healthcare provider to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the provider where the healthcare provider acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often providers will manage their own funds or purchase a policy referred to as captive insurance, which protects providers for excess protection that may be unavailable or cost-prohibitive at the primary level.

Line 119--*This question is eliminated and this line must not be used.*

Line 120--If this is an SCH (or EACH), *that qualifies for the outpatient hold harmless provision in accordance with ACA section 3121, enter "Y" for yes or "N" for no in column 1. If this is a rural hospital with 100 or fewer beds, that qualifies for the outpatient hold harmless provision in accordance with ACA section 3121, enter "Y" for yes or "N" for no in column 2.* ACA section

3121, *w*as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108*; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002. Note that for SCHs and EACHs the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012, regardless of bed size and from March 1, 2012 through December 31, 2012, for SCHs and EACHs with 100 or fewer beds. Rural hospitals with 100 or fewer beds are also extended through December 31, 2012.* These responses impact the TOPs calculation on Worksheet E, Part B, line 8.

Line 121--Did this facility incur and report costs in the "Implantable Devices Charged to Patients" (line 72) cost center as indicated in the Federal Register, Vol. 73, number 161, dated August 19, 2008, page 48462 under the following revenue codes: code 0275 - pacemaker, code 0276 - intraocular lens, code 0278 - other implants and code 0624 - Food and Drug Administration (FDA) investigational devices. Enter "Y" for yes or "N" for no in column 1.

Lines 122 - 124--Reserved for future use.

Line 125--Does your facility operate a transplant center*(s)*? Enter "Y" for yes or "N" for no in column 1. If yes, enter the *all the applicable* certification dates below.

Line 126--If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date in column 2. Also complete Worksheet D-4.

Line 127--If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date in column 2. Also complete Worksheet D-4.

Line 128--If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date in column 2. Also complete Worksheet D-4.

Line 129--If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date in column 2. Also, complete Worksheet D-4.

Line 130--If Medicare pancreas transplants are performed, enter the more recent date of July 1, 1999 (coverage of pancreas transplants) or the certification date in column 1 for kidney transplants and termination date in column 2. Also, complete Worksheet D-4.

Line 131--If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2. Also, complete Worksheet D-4.

Line 132--If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2. Also, complete Worksheet D-4.

Line 133--Use this line if your facility contains a Medicare certified transplant center not specifically identified on lines 126 through 132. Enter the certification date in column 1 and termination date in column 2. Subscript this line as applicable and complete a separate Worksheet D-4 for each Medicare certified transplant center type.

Line 134--If this is an organ procurement organization (OPO), enter the OPO CCN number in column 1 and termination date, if applicable, in column 2.

Lines 135 - 139--Reserved for future use.

Line 140--Are there any related organization or home office costs claimed as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, complete Worksheet A-8-1. If this facility is part of a chain and you are claiming home office costs, enter in column 2 the home office chain number; and enter the chain name, home office number, contractor number, street

address, post office box (if applicable), the city, State, zip code of the home office on lines 141 through 143. Also, enter on line 141, column 2, the contractor name, who receives the Home Office Cost Statement and in column 3, the contractor number. See CMS Pub. 15-1, §2150 for a definition of a chain organization.

Line 141--Enter the name of the Home Office.

Line 142--Enter the street address and P. O. Box (if applicable) of the Home Office.

Line 143--Enter the city, State and *ZIP* code of the Home Office.

Line 144--Are provider based physicians' costs included in Worksheet A? Enter "Y" for yes or "N" for no. If yes, complete Worksheet A-8-2.

Line 145--If you are claiming costs for renal services on Worksheet A, *line 74,* are they inpatient services only? Enter "Y" for yes or "N" for no. If yes, do not complete Worksheet S-5 and the Worksheet I series.

Line 146--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 147--Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.

Line 148--Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.

Line 149--Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.

Lines 150 - 154--Reserved for future use.

Lines 155 - 161--If you are a hospital (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 for *titles V, XVIII and XIX* that qualify for the exemption by entering in the corresponding box a "Y" for yes, if you qualify for the exemption or an "N" for no if you do not qualify for the exemption. Subscript as needed for additional components. *For title XVIII providers, a response of "Y" does not subject the provider to LCC.*

Lines 162 - 164--Reserved for future use.

Line 165--Is the hospital part of a multi-campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.

Line 166--If you responded "Y" for yes to question 165, enter information for each campus (including the main campus) as follows: name in column 0, county in column 1, State in column 2, zip code in column 3, CBSA in column 4, and the FTE count for this campus in column 5. If additional campuses exist, subscript this line as necessary.

Line 167--Is this hospital/campus a meaningful user of electronic health record (EHR) technology in accordance section 1886(n) of the Social Security Act as amended by the section 4102 of the American Recovery and Reinvestment Act (ARRA) of 2009? Enter "Y" for yes or "N" for no.

Line 168--If this provider is a CAH (line 105 is "Y" for yes) and is also a meaningful EHR technology user (line 167 is "*Y*" for yes) enter, if applicable, the reasonable acquisition cost incurred *for EHR assets either purchased or initially rented under a virtual purchase lease (see PRM-1, §110.B.1.b)* in the current cost reporting period. *If applicable, also enter the un-depreciated cost (i.e., net book value), as of the beginning of the current cost reporting period, for assets purchased or initially rented under a virtual purchase lease in prior cost reporting period(s) which were used for EHR purposes in the current cost reporting period. Do not enter on this line any cost for EHR assets which was already claimed for the same assets in previous cost reporting period(s). The reasonable acquisition cost incurred is for* depreciable assets such as computers and associated hardware and software necessary to administer certified EHR technology. *(*See Federal Register, Vol. 75, number 144, dated July 28, 2010, pages 44*461 and 42 CFR 495.106(a) and (c)(2).)*

Additionally, if the amount on this line is greater than zero, submit a listing of the EHR assets showing the following information for each asset: (1) nature of each asset and acquisition cost; (2) an annotation whether the asset was purchased or leased under a virtual purchase lease (42 CFR 413.130(b)(8)); (3) date of purchase or date the virtual purchase lease was initiated; (4) name(s) of original purchaser (e.g., CAH, CAH's home office, group of unrelated providers); (5) information regarding the asset's use (i.e., indication whether the asset (hardware of software) will be shared with CAH's non-EHR systems); and (6) tag number and location (department unit).

Line 169--If this is a §1886(d) provider that responded "N" for no to question 105 and "Y" for yes to question 167, enter the transition factor to be used in the calculation of your HIT incentive payment. See Federal Register, Vol. 75, number 144, dated July 28, 2010, pages 44458-60. The transition factor equals:

If a hospital first becomes a meaningful EHR user in fiscal year 2011, 2012 or 2013

- The first year transition factor is 1.00
- The second year transition factor is 0.75
- The third year transition factor is 0.50
- The fourth year transition factor is 0.25
- Any succeeding transition year is 0

If a hospital first becomes a meaningful EHR user in fiscal year 2014

- The first year transition factor is 0.75
- The second year transition factor is 0.50
- The third year transition factor is 0.25
- Any succeeding transition year is 0

If a hospital first becomes a meaningful EHR user in fiscal year 2015

- The first year transition factor is 0.50
- The second year transition factor is 0.25
- Any succeeding transition year is 0

This page is reserved for future use.

4004.2 Part II - Hospital and Hospital Health Care Complex Reimbursement Questionnaire.--The information required on Part II of this worksheet (formerly Form CMS-339) must be completed by all hospitals submitting cost reports to the Medicare contractor under Title XVIII of the Social Security Act (hereafter referred to as "The Act"). Its purpose is to assist you in preparing an acceptable cost report, to minimize the need for direct contact between you and your contractor, and to expedite review and settlement of cost reports. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost reports and to gather information necessary to support certain financial and statistical entries on the cost report. The questionnaire is a tool used in arriving at a prompt and equitable settlement of your cost report.

Where the instructions for this worksheet direct you to submit documentation/information, mail or otherwise transmit to the contractor immediately after submission of the ECR. The contractor has the right under §§1815(a) and 1883(e) of the Act to request any missing documentation required to complete the desk review.

To the degree that the information in the questionnaire constitutes commercial or financial information which is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act. If there is any question about releasing information, the contractor should consult with the CMS Regional Office.

NOTE: The responses on all lines are Yes or No unless otherwise indicated. If in accordance with the following instructions, you are requested to submit documentation, indicate the line number for each set of documents you submit.

Line Descriptions

Lines 1 through 21 are required to be completed by all hospitals.

Line 1--Indicate whether the hospital has changed ownership immediately prior to the beginning of the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2--Indicate whether the hospital has terminated participation in the Medicare program. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date of termination in column 2, and "V" for voluntary or "I" for involuntary in column 3.

Line 3--Indicate whether the hospital is involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

Note: A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See Pub. 15-1, Chapter 10 and 42 CFR §413.17.)

Line 4--Indicate whether the financial statements were prepared by a Certified Public Accountant. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "A" for audited, "C" for compiled, or "R" for reviewed in column 2. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report enter the date they will be available in column 3.

If you answer no in column 1, submit a copy of the financial statements you prepared, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5--Indicate whether the total expenses and total revenues reported on the cost report differ from those on the filed financial statements. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a reconciliation with the cost report.

Line 6--Indicate whether costs were claimed for Nursing School. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "Y" for yes or "N" for no in column 2 to indicate whether the provider is the legal operator of the program .

Line 7--Indicate whether costs were claimed for Allied Health programs. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a list of the program(s) with the cost report and annotate for each whether the provider is the legal operator of the program.

Note: For purposes of lines 6 and 7, the provider is the legal operator of a nursing school and/or allied health programs if it meets the criteria in 42 CFR §413.85(f)(1) or (f)(2).

Line 8--Indicate whether approvals and/or renewals were obtained during the cost reporting period for Nursing School and/or Allied Health programs. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a list of the program(s), and copies of the approvals and/or renewals with the cost report.

Line 9--Indicate whether Intern-Resident costs were claimed on the current cost report. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit the current year Intern-Resident Information System (IRIS) on diskette with the cost report.

Line 10--Indicate whether Intern-Resident program(s) have been initiated or renewed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit copies of the certification(s)/program approval(s) with the cost report. (See 42 CFR §413.79(l) for the definition of a new program.)

Line 11--Indicate whether Graduate Medical Education costs were directly assigned to cost centers other than the Intern-Resident Services in an Approved Teaching Program on Worksheet A of form CMS-2552-10. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a listing of the cost centers and amounts with the cost report.

Line 34--Indicate whether services are furnished at your facility under an arrangement with provider-based physicians. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit Exhibit 1, where applicable.

You may submit computer generated substitutes for these schedules provided they contain, at a minimum, the same information as in Exhibit 1. (This includes the signature on a substitute Exhibit 1.)

Allocation agreements (Exhibit 1) are required if physician compensation is attributable to both direct patient care and provider services. Allocation agreements are also required if all of the provider-based physician's compensation is attributable to provider services (i.e., departmental supervision and administration, quality control activities, teaching and supervision of Interns-Residents and/or Allied Health Students, and in the case of teaching hospitals electing cost reimbursement for teaching physicians' services, for compensation attributable to direct medical and surgical services furnished to individual patients, and the supervision of intern and residents furnishing direct medical and surgical services to individual patients. However, Exhibit 1 is not required if all of the provider-based physician's compensation is attributable to direct medical and surgical services to individual patients.

Physicians' compensation information is considered to be confidential, and therefore, qualifies for exemption from disclosure under the Freedom of Information Act, and specifically under 5 U.S.C. 552(b)(4). The compensation information also qualifies for exemption from disclosure under 5 U.S.C. 552(b)(6) which covers "personnel and medical files, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." An individual's compensation is a personal matter and its release would be an invasion of privacy. Accordingly, CMS will not release, or make available to the public, compensation information collected.

Instructions for completing Exhibit 1:

Exhibit 1, Allocation of Physician Compensation Hours:

- Complete this exhibit in accordance with CMS Pub. 15-1, §2182.3. The data elements shown are physicians' hours of service providing a breakdown between the professional and provider component.

- Prepare a physician time allocation for each physician by department, who receives payment directly from you or a related organization for services rendered. This includes physicians paid through affiliated agreements. A weighted average for the entire department may be used where all physicians in the department are in the same specialty. Where a weighted average is submitted, individual time allocations need not be submitted. The physician or department head supplying this information must sign the schedule.

Line 35--If you answered "Y" on line 34, indicate whether new agreements or amendments to existing agreements were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit copies of the new agreements or the amendments to existing agreements with the cost report.

Line 36--Indicate whether home office costs are claimed on the cost report. Enter "Y" for yes or "N" for no in column 1.

Line 37--If you answered "Y" on line 36, indicate whether a home office cost statement was prepared by the home office. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a schedule displaying the entire chain's direct, functional, and pooled costs as provided to the designated home office contractor as part of the home office cost statement.

Line 38--If you answered "Y" on line 36, indicate whether the fiscal year end of the home office is different from that of the provider. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the fiscal year end of the home office in column 2.

Line 39--If you answered "Y" on line 36, indicate whether the provider renders services to other components of the chain. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a schedule listing the names of the entities, the services provided, and cost incurred to provide these services with the cost report.

Line 40--If you answered "Y" on line 36, indicate whether the provider renders services to the home office. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a schedule listing the services provided, and cost incurred to provide these services with the cost report.

Cost Report Preparer Contact Information:

Line 41--Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.

Line 42--Enter the employer/company name of the cost report preparer.

Line 43--Enter the telephone number and email address of the cost report preparer.

NOTE: Exhibits 1 and 2 must be completed either manually (in hard copy) or via separate electronic/digital media as this information is not captured in the ECR file.

4005. WORKSHEET S-3 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA AND HOSPITAL WAGE INDEX INFORMATION

This worksheet consists of five parts:

Part I	-	Hospital and Hospital Health Care Complex Statistical Data
Part II	-	Hospital Wage Index Information
Part III	-	Hospital Wage Index Summary
Part IV	-	Hospital Wage Related Costs
Part V	-	Hospital Contract Labor and Benefit Costs

4005.1 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--Enter the Worksheet A line number that corresponds to the Worksheet S-3 component line description.

Column 2--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 ICU bed (excluding newborn bassinets) 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. 15-1, §§2200.2 C and 2205.)

Column 3--Enter the total bed days available. Bed days are computed by multiplying the number of beds available throughout the period in column 2 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.

Column 4--CAHs accumulate the aggregate number of hours all CAH patients spend in each category on lines 1 and 8 through 12. This data is for informational purposes only.

Columns 5 through 7--Enter the number of inpatient days or visits, where applicable, for each component by program. Do not include HMO days except where required (lines 2 through 4, columns 6 and 7), organ acquisition, or observation bed days in these columns. Observation bed days are reported in columns 7 (title XIX) and 8 (total), line 28. For LTCH, enter in column 6 on the applicable line the number of covered Medicare days (from the PS&R) and enter in column 6, line 33 the number of noncovered days (from provider’s books and records) for Medicare patients.

Report the program days for PPS providers (acute care hospital, IPF, IRF, and LTCH) 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. Medicaid HMO days are reported on lines 2 through 4 in accordance with *42* CFR 412.106(b)(4)(ii). Therefore, Medicaid patient days reported on line 1, column 7 do not include days for Medicaid patients who are also members of an HMO.

Column 8--Enter the number of inpatient days for all classes of patients for each component. Include organ acquisition and HMO days in this column. This amount will not equal the sum of columns 5 through 7 when the provider renders services to other than titles V, XVIII, or XIX patients.

Column 9--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 16 or 17, respectively, 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.

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.) Enter the XVIII M+C HMO discharges in column 13, line 2.

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 5, 6, 7 and 8, enter the number of adult and pediatric hospital days excluding the SNF and NF swing bed, observation bed, and hospice days. In columns 6 and 7 also exclude HMO days. **Do not include in column 6 Medicare Secondary Payer/Lesser of Reasonable Cost (MSP/LCC) days**. Include these days only in column 8. However, do not include employee discount days in column 8.

Labor and delivery days (as defined in the instructions for line 32 of Worksheet S-3, Part I) must not be included on this line.

Line 2--Enter *in column 6 the* title XVIII M+C *days and days for individuals enrolled in section 1876 Medicare cost plans. Enter in column 7 the title XIX HMO days and other Medicaid eligible days not included on line 1, column 7.*

Line 3--Enter *in column 6 the* title XVIII M+C days *and days for individuals enrolled in section 1876 Medicare cost plans which pertain to* IPF subprovider *patients*. *Enter in column 7 the* title XIX HMO days *and other Medicaid eligible days not included on line 16, column 7*.

Line 4--Enter *in column 6 the* title XVIII M+C days *and days for individuals enrolled in section 1876 Medicare cost plans which pertain to* IRF subprovider *patients*. *Enter in column 7 the* title XIX HMO days *and other Medicaid eligible days not included on line 17, column 7*.

Line 5--Enter the Medicare covered swing bed days (which are considered synonymous with SNF

swing bed days) for all Title XVIII programs where applicable. See 42 CFR 413.53(a)(2). Exclude all M+C days from column 6, include the M+C days in column 8.

Line 6--Enter the non-Medicare covered swing bed days (which are considered synonymous with NF swing bed days) for all programs where applicable. See 42 CFR 413.53(a)(2).

Line 7--Enter the sum of lines 1, 5 and 6.

Lines 8 - 13--Enter the appropriate statistic applicable to each discipline for all programs.

Line 14--Enter the sum of lines 7 - 13 for columns 2 - 8, and for columns 12 - 15, enter the amount from line 1. For columns 9 - 11, enter the total for each from your records.

Labor and delivery days (as defined in the instructions for line 32 of Worksheet S-3, Part I) must not be included on this line.

Line 15--Enter the number of outpatient visits for CAHs by program and total. An outpatient CAH visit is defined in 42 CFR 413.70(b)(3)(iii).

Line 16--Enter the applicable data for the IPF subprovider.

Line 17--Enter the applicable data for the IRF subprovider.

Line 18--Enter the applicable data for other than IPF or IRF subproviders. If you have more than one subprovider, subscript this line.

Line 19--If your State recognizes one level of care, complete this line for titles V, XVIII, and XIX, however, do not complete line 20. If you answered yes to line 92 of Worksheet S-2, Part I, complete all columns.

Line 20--Enter nursing facility days if you have a separately certified nursing facility for Title XIX or you answered yes to line 92 of Worksheet S-2, Part I. Make no entry if your State recognizes only SNF level of care. If you operate an ICF/MR, subscript this line to 20.01 and enter the ICF/MR days. Do not report any nursing facility data on line 20.01.

Line 21--Enter data for an other long term care facility.

Line 22--If you have more than one hospital-based HHA, subscript this line.

Line 23--Enter data for an ASC. If you have more than one ASC, subscript this line.

Line 24--Enter days applicable to hospice patients in a distinct part hospice.

Line 25--CMHCs enter the number of partial hospitalization days as applicable. For reporting of multiple facilities follow the same format used on Worksheet S-2, Part I, line 17.

Line 26--Enter the number of outpatient visits for FQHC and RHC. If you have both or multiples of one, subscript the line.

Line 28--Enter the total observation bed days in column 8. 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.

Line 29--Enter in column 6 the total number of ambulance trips, as defined by section 4531(a)(1) of the BBA. Do not subscript this line.

Line 30--Enter in column 8 the employee discount days if applicable. These days are used on Worksheet E, Part A, line 31 in the calculation of the DSH adjustment and Worksheet E-3, Part III, line 3 in the calculation of the LIP adjustment.

Line 31--Enter in column 8 the employee discount days, if applicable, for IRF subproviders.

Line 32--Indicate in column 7 the count of labor/delivery days for Title XIX and in column 8 the total count of labor/delivery days for the entire facility.

For the purposes of reporting on this line, labor and delivery days are defined as days during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking, and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission (see Pub. 15-1, section 2205.2). In the case where the maternity patient is in a single multipurpose labor, delivery and postpartum (LDP) room, hospitals must determine the proportion of each inpatient stay that is associated with ancillary services (labor and delivery) versus routine adult and pediatric services (post partum) and report the days associated with the labor and delivery portion of the stay on this line. An example of this would be for a hospital to determine the percentage of each stay associated with labor/delivery services and apply that percentage to the stay to determine the number of labor and delivery days of the stay. Alternatively, a hospital could calculate an average percentage of time maternity patients receive ancillary services in an LDP room during a typical month, and apply that percentage through the rest of the year to determine the number of labor and delivery days to report on line 32. Maternity patients must be admitted to the hospital as an inpatient for their labor and delivery days to be included on line 32. These days must not be reported on Worksheet S-3, Part I, line 1 or line 14.

Line 33--See instructions for columns 5 through 7 of this worksheet.

4005.2 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, III and IV 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 *Worksheet S-3, Parts II, III and IV* 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 2

Line 1--Enter from Worksheet A, column 1, line 200, the wages and salaries paid to hospital. *All salary amounts for paid* vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay *must be included in column 1 of Worksheet A. See Worksheet A instructions (§ 4013).*

NOTE: *Lines 4 and 22 apply to physician's Part A administrative costs.*

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

NOTE: Capital related salaries, hours, and wage-related costs associated with lines 1 and 2 of Worksheet A must not be included on Worksheet S-3, Parts II and III.

NOTE: Methodology for including vacation/sick/other PTO accruals in the wage index:

PTO salary cost--The required source for costs on Worksheet A is the General Ledger (see Provider Reimbursement Manual, Part *2*, section 4013 and 42 CFR 413.24(e)). Worksheet S-3, Part II (wage index) data are derived from Worksheet A; therefore, the proper source for costs for the wage index is also the General Ledger. A hospital's current year General Ledger includes both costs that are paid during the current year and costs that are expensed in the current year but paid in the subsequent year (current year accruals). Hospitals and contractors are to include on Worksheet S-3, Part II the current year PTO cost incurred as reflected on the General Ledger; that is, both the current year PTO cost paid and the current year PTO accrual. (Costs that are expensed in the prior year but paid in the current year (prior year accruals) are not included on a hospital's current year General Ledger and should not be included on the hospital's current year Worksheet S-3, Part II.)

PTO hours--The source for PTO paid hours on Worksheet S-3, Part II is the Payroll Report. Hours are included on the Payroll Report in the period in which the associated PTO expense is paid. Hospitals and contractors are to include on Worksheet S-3, Part II the PTO hours that are reflected on the current year Payroll Report, which includes hours associated with PTO cost that was expensed in the prior year but paid in the current year. The time period must cover the weeks that best matches the provider's cost reporting period. (Hours associated with PTO cost expensed in the current year but not paid until the subsequent year (current year PTO accrual) are not included on the current year Payroll Report and should not be included on the hospital's current year Worksheet S-3, Part II.)

Although this methodology does not provide a perfect match between paid PTO cost and paid PTO hours for a given year, it should approximate an actual match between cost and hours. Over time, any variances should be minimal.

Lines 2 - 10--The amounts to be reported must be adjusted for vacation, holiday, sick, other paid time off, severance, and bonus pay if not already included. Do not include in lines 2 through *8* the salaries for employees associated with excluded areas lines 9 and 10.

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 9 and 10. Additionally, contract CRNA cost must be included on line 11. Report in column 5 the hours that are associated with the costs in column 4 for directly employed and contract Part A CRNAs.

Do not include physician assistants, clinical nurse specialists, nurse practitioners, and nurse midwives.

Line 3--Enter the non-physician anesthetist salaries included in line 1, subject to the fee schedule and paid under Part B by the contractor. Do not include salary costs for physician assistants, clinical nurse specialists, nurse practitioners, and nurse midwives.

Line 4--Enter the physician Part A *administrative* 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 7. *Subscript this line and report salaries for Part A teaching physicians on line 4.01.*

Lines 5 and 6--Enter the total physician, physician assistant, nurse practitioner and clinical nurse specialist salaries billed under Part B that are included in line 1. 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 (RHC) and Federally qualified health clinics (FQHC) included on Worksheet A, column 1, lines 88 and/or 89 as applicable. Report on line 6 the non-physician salaries reported for Hospital-based RHC and FQHC services included on Worksheet A, column 1, lines 88 and/or 89 as applicable. *Do not include on these lines amounts that are included on lines 9 and 10 for the SNF or excluded area salaries.*

Line 7--Enter from Worksheet A the salaries reported in column 1 of line 21 for interns and residents. *Subscript this line and report salaries for contracted interns and residents in an approved program on line 7.01.* 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 9 and 10. Additionally, contract intern and resident costs must be included on line 11. DO NOT include contract intern and residents costs on line 13. Report in column 5 the hours that are associated with the costs in column 4 for directly employed and contract interns and residents.

Line 8--If you are a member of a chain or other related organization as defined in CMS Pub 15-1, §2150, enter, from your records, the wages and salaries for home office related organization personnel that are included in line 1.

Lines 9 and 10--Enter on line 9 the amount reported on Worksheet A, column 1 for line 44 for the SNF. On line 10, enter from Worksheet A, column 1, the sum of lines 20, 23, 40 through 42, 45, 45.01, 46, 94, 95, 98 through 101, 105 through 112, 114, 115 through 117, and 190 through 194. DO NOT include on lines 9 and 10 any salaries for general service personnel (e.g., housekeeping) which, on Worksheet A, Column 1, may have been included directly in the SNF and the other cost centers detailed in the instructions for Line 10.

Line 11--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, and top level management services as defined below. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs). Do not include costs applicable to excluded areas reported on line 9 and 10. Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and *7.01* respectively). Include on this line contract pharmacy and laboratory wage costs as defined below.

In general, for contract labor, the minimum requirement for supporting documentation is the contract itself. If the wage costs, hours, and non-labor costs are not clearly specified in the contract, then other documentation is necessary, such as a representative sample of invoices which specify the wage costs, hours, and non-labor costs or a signed declaration from the vendor in conjunction with a sample of invoices. Hospitals must be able to provide such documentation when requested by the contractor. A hospital's failure to provide adequate supporting documentation may result in the cost being disallowed for the wage index.

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 **top level 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 top level management services DO NOT include the following: other management or administrative services (to be included on lines 12 or 28; see instructions), 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 top level management contracts listed above. Per instructions on Worksheet S-2, Part II, for direct patient care, pharmacy and laboratory contracts, submit to your Medicare contractor the types of services, wages, and associated hours; for top level management contracts, submit the aggregate wages and hours.

If you have no contracts for direct patient care or management services as defined above, enter a zero in column 2. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 2.

Contract pharmacy services are 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 Worksheet S-2, Part II, submit to your contractor the following for direct patient care pharmacy contracts: the types of services, wages, and associated hours.

Contract laboratory services are 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 Worksheet S-2, Part II, submit to your contractor the following for direct patient care laboratory contracts: the types of services, wages, and associated hours.

Line 12--Enter the amount paid for ***contract*** **management and administrative services** furnished under contract, rather than by employees. Include on this line contract management and administrative services associated with cost centers other than those listed on lines 26 through 43 (and their subscripts) of this worksheet that are included in the wage index.

Examples of contract management and administrative services that would be reported on line 12 include department directors, administrators, managers, ward clerks, and medical secretaries. Report only those personnel costs associated with the contract. DO NOT include on line 12 any contract labor costs associated with lines 26 through 43 and subscripts for these lines. DO NOT include the costs for contract top level management: chief executive officer, chief operating officer, chief financial officer and nurse administrator; these services are included on line 11. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items.

Line 13--Enter from your records the amount paid under contract (as defined on line 11) for Part A physician services - *administrative*, excluding teaching physician services. DO NOT include

contract I & R services (to be included on line 7). 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 15). Also, DO NOT include Part A physician contracts for any of the management positions reported on line 11.

Line 14--Enter the salaries and wage-related costs (as defined on lines 17 and 18) 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 8 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 15.

If a wage related cost associated with the home office is not "core" (as described in the Worksheet S-3, Part IV) and is not a category included in "other" wage related costs on line 18 (see Worksheet S-3, Part IV and line 18 instructions below), the cost cannot be included on line 14. For example, if a hospital's employee parking cost does not meet the criteria for inclusion as a wage-related cost on line 18, any parking cost associated with home office staff cannot be included on line 14.

Line 15--Enter from your records the salaries and wage-related costs for Part A physician services - *administrative*, excluding teaching physician Part A services from the home office allocation and/or related organizations.

Line 16--Enter from your records the salaries and wage-related costs for Part A teaching physicians from the home office allocation and/or related organizations. *Also report on this line Part A teaching physicians salaries under contract.*

Lines 17 - 25--In general, the amount reported for wage-related costs must meet the "reasonable cost" provisions of Medicare. *For pension and executive deferred compensation costs see the instructions below in Part IV.*

For those wage-related costs that are not covered by Medicare reasonable cost principles, a hospital shall use generally accepted accounting principles (GAAP). For example, for purposes of the wage index, disability insurance cost should be developed using GAAP. Hospitals are required to complete Worksheet S-3, Part IV, a reconciliation worksheet to aid hospitals and contractors in implementing GAAP when developing wage-related costs. Upon request by the contractor 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 Worksheet S-3, Part IV, or, the hospital is unable, when requested, to provide a copy of the standard used in developing the wage-related costs, the contractor may remove the cost from the hospital's Worksheet S-3 due to insufficient documentation to substantiate the wage-related cost relevant to GAAP.

NOTE: All costs for any related organization must be shown as the cost to the related organization. (For Medicare cost reporting principles, see Pub. 15 15-1, §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 contractor, the contractor may apply the hospital's cost to charge ratio to reduce the related party expenses to cost.

NOTE: All wage-related costs, including FICA, workers compensation, and unemployment compensation taxes, associated with physician services are to be allocated according to the services provided; that is, those taxes and other wage-related costs attributable to Part A administrative services must be placed on line 22, *to* Part A teaching services *must be placed on line 22.01*, and *to* Part B (patient care services) *must be placed* on line 23. Line 17 must not include wage-related costs that are associated with physician services.

Line 17--Enter the core wage-related costs from Worksheet S-3, Part IV, line 24. (See note below for costs that are not to be included on line 17). Only the wage-related costs reported on Worksheet S-3, Part IV, line 24 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 9 and 10. Instead, these costs are reported on line 19. 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 14, 15, and 20 through 25.)

Health Insurance and Health-Related Wage Related Costs:

Hospitals and contractors 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.

Line 18--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 18.) 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 Worksheet S-3, Part IV,

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 4, 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 9 and 10. Instead, these costs are reported on line 19. 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 19--Enter the total (core and other) wage-related costs applicable to the excluded areas reported on lines 9 and 10.

Lines 20 - 25--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 19. *Subscript line 22 and report* the wage related costs for Part A teaching physicians *reported on line 4.01*, on line *22.01*. On line 23, 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, lines 88 and/or 89, as applicable. These wage-related costs are reported separately on line 24.

Lines 26 - 43--Enter the direct wages and salaries from Worksheet A column 1 for the appropriate cost center identified on lines 26 through 43. *These amounts must include* amounts paid for vacation, holiday, sick, and PTO *and must be* reported *on Worksheet A,* column 1. 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 5, sum of lines 9 and 10 divided by the result of column 5, line 1 minus the sum of lines 2, 3, *4.01,* 5, 6, 7, *7.01* and 8 equals or exceeds a threshold of 15 percent. However, all hospitals with a ratio greater than 5 percent must complete line 7 of Part III for all columns. Calculate the percent to two decimal places for purposes of rounding.

Lines 28, 33, and 35--Enter the amount paid for services performed **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 27, 32, and 34), the amounts paid for services rendered by employees not under contract.

Line 28--A&G costs are expenses a hospital incurs in carrying out its administrative and/or general management functions. Include on line 28 the contract services that are included on Worksheet A, line 5 and subscripts, column 2 ("Administrative and General"). Contract information and data processing services, legal, tax preparation, cost report preparation, and purchasing services are examples of contract labor costs that would be included on Worksheet S-3, Part II, line 28. Do not include on line 28 the costs for top level management contracts (these costs are reported on line 11).

NOTE: Do not include overhead costs on lines 11 and 12.

Column 3--Enter on each line, as appropriate, the **salary** portion of any reclassifications made on Worksheet A-6.

Column 4--Enter on each line the result of column 2 plus or minus column 3.

Column 5--Enter on each line the number of **paid** hours corresponding to the amounts reported in column 4. 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 15 (including subscripts), lines 26 through 43 (including subscripts), and Part III, line 7, if the hours cannot be determined, then the associated salaries must not be included in columns 2 through 4.

NOTE: The hours must reflect any change reported in column 3; For employees who work a regular work schedule, on call hours are not to be 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 7 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.

NOTE: For workers who are contracted solely for the purpose of providing services on-call, the wages and associated hours must be included on the appropriate contract labor line on Worksheet S-3.

Column 6--Enter on all lines (except lines 17 through 25) the average hourly wage resulting from dividing column 4 by column 5.

4005.3 Part III - Hospital Wage Index Summary.--This worksheet provides for the calculation of a hospital's average hourly wage (without overhead allocation, occupational mix adjustment, and inflation adjustment) as well as analysis of the wage data.

Columns 1 through 6--Follow the same instructions discussed in Part II, except for column 6, line 5.

Line 1--From Part II, enter the result of line 1 minus the sum of lines 2, 3, *4.01,* 5, 6, 7, *7.01,* and 8. Add to this amount line*s*: 28, 33, and 35.

Line 2--From Part II, enter the sum of lines 9 and 10.

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

Line 4--From Part II, enter the sum of lines 11, 12, 13, 14, and 15. (Line 16 is omitted from Part III, line 4 because physicians' teaching services are excluded from the wage index.)

Line 5--From Part II, enter the sum of lines 17, 18, and 22. Enter on this line in column 6 the wage-related cost percentage computed by dividing Part III, column 4, line 5, by Part III, column 4, line 3. Round the result to 2 decimal places.

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

Line 7--Enter from Part II above, the sum of lines 26 through 43. 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 26 through 43 for calculating the percentage.)

4005.4 Part IV - Wage Related Costs.--The hospital must provide the contractor with a complete list of all core wage related costs included in Part II (section 4005.2), lines 17 and 19 through 25. This worksheet provides for the identification of such costs.

The hospital must determine whether each wage related cost "other than core", reported on line 25, exceeds one (1) percent of the total adjusted salaries net of excludable salaries and meets all of the following criteria:

- The costs are not listed on lines 1 through 23, "Wage Related Costs Core"
- If any of the additional wage related cost applies to the excluded areas of the hospital, the cost associated with the excluded areas has been removed prior to making the 1 percent threshold test.
- The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS.
- The individual wage related cost is not included in salaries reported on Worksheet S-3, Part II, Column 3, Line 17.
- The wage related cost is not being furnished for the convenience of the employer.

For wage related costs not covered by Medicare reasonable cost principles *(excluding the reporting of certain defined benefit pension costs; see instructions below),* a hospital shall use GAAP in reporting wage related costs. In addition, some costs such as payroll taxes, which are reported as a wage related cost(s) on Worksheet S-3, Part IV, are not considered fringe benefits for Medicare cost finding.

Enter on each line as applicable the corresponding amount from you*r* accounting books and/or records.

Line 3--Report pension cost for defined benefit pension plans than do not meet the applicable requirements for a qualified pension plan under section 401(a) of the Internal Revenue Code. The

policy adopted in the federal fiscal year (FFY) 2012 IPPS final rule (CMS-1518-F; 76 FR 51586 - 51590, August 18, 2011) does not change the reporting basis for these costs.

NOTE: *These plans generally are not funded by a funding vehicle that is for exclusive benefit of employees or their beneficiaries and qualifies for special tax benefits, such as tax deferral of employer contributions. For such unfunded defined benefit plans, the costs of these plans are reported on a cash basis which recognizes benefit payments made during the current period. Typically these plans supplement the basic qualified defined benefit plan or provide benefits to a select class of employees, such as executives.*

Line 4--Commencing with cost reporting periods used for the FFY 2013 wage index, report pension cost for defined benefit pension plans which meet the applicable requirements for a qualified pension plan under section 401(a) of the Internal Revenue Code for the wage index. The allowable pension costs to be reported for these defined benefit pension plans shall be determined in accordance with the policy adopted in the FY 2012 IPPS final rule (CMS-1518-F; 76 FR 51586 - 51590, August 18, 2011) and as discussed below. Enter the pension costs from your records or from the Wage Index Pension Cost Schedule (Exhibit 3) below.

NOTE: *The policy adopted in the FFY 2012 IPPS final rule replaces and supersedes the provisions of PRM-1, section 2142.*

Policy

Defined Benefit Pension Plan: A defined benefit pension plan is a type of deferred compensation plan, which is established and maintained by the employer primarily to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Pension plan benefits are generally measured by, and based on, such factors as age of employees, years of service, and compensation received by employees. This section applies only to defined benefit pension plans which meet the applicable requirements for a qualified pension plan under section 401(a) of the Internal Revenue Code. A qualified pension plan is for the exclusive benefit of employees or their beneficiaries and qualifies for special tax benefits, such as tax deferral of employer contributions.

Pension Contributions: Pension costs for a defined benefit pension plan are allowable only to the extent that costs are actually incurred by the provider Such costs are found to have been incurred only if paid directly to participants or beneficiaries under the terms of the plan or paid to a pension fund which meets the applicable tax qualification requirements under section 401(a) of the Internal Revenue Code. For purposes of the wage index, provider pension payments shall be measured on a cash-basis without regard to §2305 of PRM-1. Payment must be made by check or other negotiable instrument, cash, or legal transfer of assets such as stocks, bonds, real property, and etcetera. A contribution payment shall be deemed to occur on the date it is credited to the fund established for the pension plan, or for provider payments made directly to a plan participant or beneficiary, on the date the provider's account is debited. Contributions made under a pension plan that covers multiple providers or employers shall be allocated on a basis consistent with plan records. If the plan records do not show a separate accounting of the actuarially determined cost estimates, contribution deposits, and/or assets attributable to each participating provider or employer, the allocation basis must represent a reasonable approximation of the funding attributable to each employer.

Source of Documentation for Pension Contributions: Providers are required to obtain contribution data from the pension trustee, insurance carrier, Schedule B or SB of IRS Form 5500, and if applicable, from accounting records showing the allocation of total plan contributions to each participating provider. These records must be maintained as needed for subsequent periods.

Reasonable Compensation: In order for pension costs to be allowable, the benefits payable under the plan (attributable to employer contributions) together with all other compensation paid to the employee must be reasonable in amount.

Defined Benefit Pension Plan Costs for the Wage Index: *The annual pension to be included in the wage index shall be the average annual employer contributions made by or on behalf of the provider (on a cash basis) to all defined benefit plans covered under this section during the averaging period. Contribution payments must satisfy the allowability requirements outlined above; see "Pension Contributions" and "Reasonable Compensation" above. A reversion of plan assets shall be treated as a negative contribution payment and a negative pension cost resulting from a reversion of plan assets shall offset a provider's other wage related costs.*

The averaging period is generally the 36 consecutive calendar month period centered on the midpoint of the cost reporting period used for the wage index (the cost reporting period used for the wage index shall hereafter be referred to as the wage index cost reporting period). If the midpoint of the wage index cost reporting period is not the first day of a calendar month, use the first day of the midpoint month or the first day of the following month as the midpoint. The same averaging period must be used for all defined benefit plans sponsored by a provider.

A provider who adopts a new defined benefit pension plan and has no other defined benefit plan in existence during the averaging period may elect to exclude from the averaging period all cost reporting periods ending prior to the date the new plan was adopted. No defined benefit pension cost is reportable for a wage index cost reporting period that is excluded from the averaging period in accordance with this paragraph. An election to claim costs for a newly adopted plan based on an averaging period of less than 36 months must be applied on a consistent basis for all wage index cost reporting periods for which the 36 month averaging period contains the plan effective date.

If the wage index cost reporting period does not represent a 12 month period, the annual pension cost otherwise determined in accordance with this section shall be prorated to reflect the number of months in the wage index cost reporting period.

NOTE: *For the FY 2013 through FY 2022 wage index only, a provider may include a prefunding installment as a component of pension cost regardless of whether or not the plan(s) which gave rise to the prefunding balance are still in existence. The annual prefunding installment shall equal 1/10th of the prefunding balance. A prefunding installment that is not reflected in the pension cost for a wage index cost reporting period may not be reassigned and added to the pension cost reported for wage index purposes in any subsequent period. The prefunding balance equals the excess, if any, of (i) provider contributions made (on a cash-basis) to its defined benefit pension plans during the look-back period over (ii) the pension costs included in the wage-index for the same look-back period. A provider's share of the total contributions made under a pension plan that covers multiple providers or employers shall be determined on a basis consistent with the methodology used to determine the wage index pension costs for the cost reporting periods included in the prefunding balance. The look-back period shall consist of consecutive provider cost reporting periods commencing no earlier than October 1, 2002 and ending with the provider's cost reporting period immediately prior to the FY 2013 wage index cost reporting period. The look-back period may not include any cost reporting period for which the provider is unable to provide documentation of the contributions made or the pension costs included in the wage index; all prior cost reporting periods must also be excluded in order to satisfy the requirement that the look-back period consist of consecutive cost reporting periods. A provider who establishes a prefunding balance must submit documentation to the Medicare contractor to support the calculation of the prefunding balance and annual prefunding installment.*

Examples

Example 1 (prefunding balance and prefunding installment):

- *Provider's FY 2013 wage index cost reporting period is 01/01/2010-12/31/2009. The look-back period therefore ends with the cost reporting period ending 12/31/2008*

(immediately prior to the FY 2013 wage index cost reporting period.) Assuming the provider has always reported costs on a calendar year basis, the earliest possible cost reporting period in the look-back period is the period commencing 01/01/2003 (first cost reporting period commencing on or after 10/01/2002).

- *The provider is able to document its pension contributions (on a cash basis) and the pension costs included in the wage index for all cost reporting periods except for the 2004 year. Therefore, 2004 and all prior cost reporting periods must be excluded from the look-back period. The data for 2005 through 2008 is as follows:*

Cost Reporting Year	Cash Basis Contributions	Wage-Index Pension Costs
2005	$400,000	$500,000
2006	$800,000	$0
2007	$0	$600,000
2008	$650,000	$700,000

- *Because the pension cost reported in the wage index for 2005 was higher than the cash contributions made during that same period, the provider may elect to drop 2005 (and all prior periods) from the look-back period.*

- *Although the contributions made in 2007 were also less than the pension cost reported for that same period, the provider cannot exclude 2007 without also excluding 2006 (look-back period must consist of consecutive cost reporting periods).*

- *Although the contributions made in 2008 were less than the pension cost reported in that same period, the provider cannot exclude 2008 since the look-back period must end with 2008 because that is the cost reporting period immediately prior to the FY 2013 wage index cost reporting period.*

- *The prefunding balance based on a 2006-2008 look-back period is $150,000 ($1,450,000 [$800,000+$0+$650,000] total contributions - $1,300,000 [$0 + $600,000 + $700,000] in wage index pension costs reported for the same period). The annual prefunding installment is $15,000 (1/10th of $150,000).*

Example 2 (pension cost for a 12 month wage index cost reporting period):

- *Provider's FY 2013 wage index cost reporting period is 12 months (01/01/2009 – 12/31/2009); the midpoint of wage index cost reporting period is 07/01/2009; the 36 month averaging period is 01/01/2008 to 12/31/2010 (begins 18 months prior to midpoint and ends 18 months following the midpoint).*

- *Contributions made in wage index cost reporting period 01/01/2009 – 12/31/2009 = $500,000.*

- *Contributions made during 01/01/2008 – 12/31/2008 = $300,000.*

- *Contributions made during 01/01/2010 – 12/31/2010 = $600,000.*

- *Total contributions made during the 36 month averaging period = $1,400,000.*

- *The provider has no prefunding balance or prefunding installment.*

- *The pension cost for the FY 2013 wage index cost reporting period is $466,667 ($1,400,000 total contributions divided by 36 months in the averaging period multiplied by 12 months in the wage index cost reporting period).*

Example 3 (pension cost for a 7 month wage index cost reporting period):

- *Provider's FY 2013 wage index cost reporting period is 7 months (01/01/2009 – 07/31/2009); the midpoint of the wage index cost reporting period is 04/15/2009; since the midpoint must be adjusted to the first of the month (either preceding or following); the provider elects to use 04/01/2009 as the midpoint; the 36 month averaging period is 10/01/2007 to 09/30/2010 (begins 18 months prior to midpoint and ends 18 months following the midpoint).*

- *Contributions made in wage index cost reporting period 01/01/2009 – 07/31/2009 = $300,000.*

- *Contributions made during 10/01/2007 – 12/31/2008 = $500,000.*

- *Contributions made during 08/01/2009 – 09/30/2010 = $600,000.*

- *Total contributions made during the 36 month averaging period = $1,400,000.*

- *The provider has documented a prefunding balance of $1,000,000; the annual prefunding installment is therefore $100,000 (1/10th of prefunding balance).*

- *The pension cost for the FY 2013 wage index cost reporting period is $330,555 ($272,222 average pension cost [$1,400,000 total contributions divided by 36 months in the averaging period multiplied by 7 months in the in wage index cost reporting period] plus $58,333 pro-rata prefunding installment [$100,000 annual prefunding installment multiplied by 7/12ths to reflect a 7 month wage index cost reporting period]).*

Example 4 (pension cost for a new plan):

- *Provider's FY 2015 wage index cost reporting period is 12 months (01/01/2011 – 12/31/2011); the midpoint of the wage index cost reporting period is 07/01/2011; the 36 month averaging period is 01/01/2010 to 12/31/2012 (begins 18 months prior to midpoint and ends 18 months following the midpoint).*

- *The provider adopted a new pension plan effective 07/01/2011 and had no other pension plan in effect prior to that date; therefore, there is no prefunding balance or prefunding installment.*

- *Contributions made during 01/01/2010 - 12/31/2010 =$0 (no plan in existence)*

- *Contributions made in the wage index cost reporting period 01/01/2011 - 12/31/2011 = $500,000.*

- *Contributions made during 01/01/2012 - 12/31/2012 = $1,200,000.*

- *Total contributions during the 36 month averaging period = $1,700,000.*

- *The provider did not report a pension cost attributable to the new plan based on a 36 month averaging period during any prior wage index cost reporting period; therefore it may elect to exclude cost reporting periods ending prior to the 07/01/2011 plan effective date from the averaging period; the 36 month averaging period is, therefore, shortened to 24 months and excludes the period 01/01/2010 to 12/31/2010. The pension cost for the FY 2015 wage index cost reporting period would then be $850,000 ($1,700,000 total contributions divided by 24 months in the averaging period multiplied by 12 months in the wage index reporting period).*

- *Alternatively, the provider may have reported a pension cost for the FY 2014 wage index (2010 wage index cost reporting period) based on a full 36 month averaging period of 01/01/2009 to 12/31/2011. The pension cost for that prior period would have been $166,667 ($500,000 total contributions divided by 36 month averaging period, multiplied by 12 months in wage index cost reporting period). If the provider reported a pension cost for the new plan based on a full 36 month averaging period for the FY 2014 wage index, it must also compute pension costs for the FY 2015 wage index (2011 wage index cost reporting period) using a 36 month averaging period. The pension cost for the 2011 wage index cost reporting period is $566,667 ($1,700,000 total contributions divided by 36 months in averaging period, multiplied by 12 months in the wage index cost reporting period).*

NOTE: *Fees paid to external organizations (for example, actuarial fees, claim administration fees, IRS form preparation fees) for providing services that are directly associated with a provider's wage-related costs, including a provider's defined benefit pension plan(s), may be included in wage-related costs on Worksheet S-3, Part II for the period in which the expense is incurred (see Worksheet S-3, Part IV, line 6). Such expenses are to be reported as additional costs only if they are paid directly by the provider and NOT out of the plan assets.*

Wage Index Pension Cost Schedule:

Use the following instructions and schedule (exhibit 3) to calculate your wage index pension cost and enter the result of line 19 below on Worksheet S-3, Part IV, line 4.

Step 1:

Line 1--Enter the wage index FY for which pension costs are to be determined. This schedule applies to wage index FYs starting with 2013.

Line 2--Enter the provider cost reporting period to be used for the wage index year in line 1. This cost period must commence in the Medicare FY (10/1-9/30) four years prior to the wage index year shown in line 1. For example, the provider cost reporting period for the FY 2013 wage index must commence in the Medicare FY ending September 30, 2009.

Line 3--Enter the midpoint of the provider cost reporting period shown in line 2. This should always be the first day of a calendar month. If the midpoint occurs in the middle of a month, enter either the first day of the midpoint month or the first day of the following month.

Line 4--Enter the date (1st of a month) that occurs 18 months prior to the midpoint date shown in line 3. (Note: This date will not necessarily coincide with the beginning of a cost reporting period.)

Line 5--Enter the date (last day of a month) that occurs 18 months after the midpoint date shown in line 3. (Note: This date will not necessarily coincide with the end of a cost reporting period.)

Step 2:

STEP 2 IS OPTIONAL. Complete step 2 only if all of the following apply:

- *The provider has a new defined benefit plan that was effective during the averaging period determined in step 1;*
- *The provider had no other defined benefit plan in effect during the averaging period;*
- *The provider did not report pension costs for the new plan in a prior period based on a 36 month averaging period which included cost reporting periods ending prior to the plan effective date;*
- *The provider elects to report costs for the new pension plan based on a shortened averaging period excluding all cost reporting periods which ended prior to the plan effective date.*

Line 6--Enter the effective date of the new plan that occurs within the averaging period determined in step 1.

Line 7--Enter the first day of the provider's cost reporting period in which the plan was effective. For example, if the plan was effective during the provider's cost reporting period that began on 01/01/2010, enter 01/01/2010.

Line 8--Enter the date from line 7 if it is the first of a calendar month; otherwise enter the first of the month immediately preceding or following the date in line 7.

Step 3:

Line 9--Enter the beginning date of the averaging period from line 4 or line 8, as applicable.

Line 10--Enter the ending date of the averaging period from line 5.

Line 11--Complete the table to show the total provider contributions made (on a cash basis) during the averaging period commencing on the date shown on line 9 and ending on the date shown on line 10. Contributions may be grouped to correspond with the periods shown in supporting documentation. Contributions made under a pension plan that covers multiple providers or employers shall be allocated on a basis consistent with plan records. If the plan does not provide for a separate accounting of the costs, contributions, and/or assets attributable to each participating provider or employer, the allocation basis must represent a reasonable approximation of the costs attributable to each employer. Supporting documentation must show the amounts and dates of deposit for all contributions reported and the data to support the allocation of total plan contributions, if applicable. Examples of acceptable documentation to support the total deposits include pension trust or insurance statements, or Schedule SB of IRS Form 5500.

Line 12--Enter the total number of calendar months included in the averaging period (enter "36" unless Step 2 was completed for a new plan).

Line 13--Total the contributions listed in the table under line 11.

Line 14--The average monthly contribution during the averaging period is line 13 divided by line 12.

Line 15--Enter the number of (full or partial) months in the provider's cost reporting period shown on line 2.

Line 16--The average pension contributions equals line 14 multiplied by line 15.

Step 4:

Line 17--If the provider has established a prefunding balance, enter the annual prefunding installment from line 8 of the Pension Prefunding Worksheet. If the provider has not elected to establish a pension prefunding balance, enter zero (0).

Line 18--The reportable prefunding installment is the amount shown on line 17 multiplied by line 15 divided by 12.

Line 19--The reportable pension cost for the wage index equals line 18 plus line 16. Enter the result on Worksheet S-3, Part, IV, line 4.

Exhibit 3

Wage Index Pension Cost Schedule

Provider Name: _____ *Provider Number:* _____

Step 1: Determine the 3-Year Averaging Period

1. *Wage Index fiscal year ending.* _____
2. *Provider cost reporting period used for Wage Index year shown on Line 1. from:* _____ *to:* _____
3. *Midpoint of provider's cost reporting period shown on line 2. (adjust response to first of month)* _____
4. *Date beginning the 3-year averaging period. (subtract 18 months from midpoint shown on line 3)* _____
5. *Date ending the 3-year averaging period. (add 18 months to midpoint shown on line 3)* _____

Step 2: Adjust Averaging Period for a New Plan (See instructions)
(Leave this section blank if the provider has not elected to use an adjusted averaging period)

6. *Effective date of pension plan.* _____
7. *First day of the provider cost reporting period containing the pension plan effective date.* _____
8. *Starting date of the adjusted averaging period. (date on line 7 if first of the month, otherwise adjust response to first of month)* _____

If this date occurs after the period shown on line 2 (Step 1), stop here and see instructions. No cost is reportable for a period which is excluded from the averaging period.

Step 3: Average Pension Contributions During the Averaging Period

9. *Beginning date of averaging period from Line 4 or Line 8.* _____
10. *Ending date of averaging period from Line 5.* _____
11. *Enter provider contributions made during the averaging period shown on lines 9 & 10. Add additional lines as necessary if more than 15 contributions are made during the cost reporting period.*
(Data may be grouped within the averaging period to agree with documentation records (enter beginning date of grouped date range))

	Deposit Date(s)	Contributions		Deposit Date(s)	Contributions
1.			16.		
2.			17.		
3.			18.		
4.			19.		
5.			20.		
6.			21.		
7.			22.		
8.			23.		
9.			24.		
10.			25.		
11.			26.		
12.			27.		
13.			28.		
14.			29.		
15.			30.		

12. *Total number of months included in the averaging period.* _____
13. *Total contributions made during averaging period.* _____
14. *Average monthly contribution. (line 13 divided by line 12)* _____
15. *Number of months in provider cost reporting period on line 2.* _____
16. *Average pension contributions. (line 14 multiplied by line 15)* _____

Step 4: Total Pension Cost for Wage Index

17. *Annual prefunding installment from line 8 of pension prefunding worksheet, if applicable.* _____
18. *Reportable prefunding installment. (line 17 multiplied by line 15 divided by 12)* _____
19. *Total Pension Cost for Wage Index. (line 16 plus line 18)* _____

Prepared By: _____ *Date:* _____

(Continuation of Worksheet S-3, Part IV Instructions)

Line 21--Report costs of executive deferred compensation plans and awards for executives. The policy adopted in the FFY 2012 IPPS final rule (CMS-1518-F; 76 FR 51586 - 51590, August 18, 2011) does not change the reporting basis for these costs. Examples of executive deferred compensation include special stock option or bonus plans and sum certain postemployment awards that are not available to other employees.

NOTE: *Costs reported on Line 21 excludes costs of executive deferred compensation that are defined contribution pension plans, tax-sheltered annuity plans, nonqualified defined benefit plans and qualified defined benefit plans that are available to other employees that is reportable on Lines 1 through 4, respectively.*

4005.5 Part V - Contract Labor and Benefit Costs.--This section identifies the contract labor costs and benefit costs for the hospital complex and applicable subproviders and units.

Definitions:

Contract Labor Costs--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, and top level management services as defined in the instructions for Worksheet S-3, Part II, line 11. The amount of Contract Labor report on S-3, Part II, line 11 should agree with the amount reported on S-3, Part V, line 2. This is only for the hospital (not including excluded areas). The remainder of S-3, Part V should reflect Contract Labor as defined on S-3, Part II, line 11 (direct patient care and top level management for all of the excluded areas) with the aggregate total reported on line 1.

Benefit Costs--Enter the amount of employee benefit costs, also referred to as wage-related costs. Worksheet S-3, Part IV provides a list of core wage-related costs. The core wage-related costs reported on S-3, Part IV, line 24, which is spread on S-3, Part II, lines 17 and 19-25, must be reported by component on S-3, Part V. The amount reported on S-3, Part V, line 1 must agree to the allowable amount reported on S-3, Part IV, line 24. S-3, Part V, line 2 must agree to the amount reported on S-3, Part II, line 17. Each excluded area must contain their share of wage related costs so that lines 19 through 25 on S-3, Part II will agree to S-3, Part V, lines 3 through 18.

Indentify the contract labor costs and benefit costs for each component on the applicable line.

4006. 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 CBSA, 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.

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

Enter the number of hours in your normal work week.

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

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

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

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

Line 19--Enter in column 1 the number of CBSAs that you serviced during this cost reporting period.

Line 20--Identify each CBSA where the reported HHA visits are performed by entering the 5 digit CBSA code and Non-CBSA (rural) code as applicable. Subscript the lines to accommodate the number of CBSAs you service. 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.

PPS Activity Data--Applicable for Medicare Services.

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

4010. WORKSHEET S-8 - HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER 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 separate statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based federally qualified health centers (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility. RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-4, chapter 9, §30.8.

Lines 1 and 2--Enter the full address of the RHC/FQHC.

Line 3--For FQHCs only, enter your appropriate designation of "R" for rural or "U" for urban. See §505.2 of the RHC/FQHC Manual for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor. RHCs do not complete this line.

Lines 4 - 9--In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 10--If the facility provides other than RHC or FQHC services (e.g., laboratory or physician services), answer "Y" for yes and enter the type of operation on subscripts of line 11, otherwise enter "N" for no.

Line 11 --Enter in columns 1 through 14 the starting and ending hours in the applicable columns for the days that the facility is available to provide RHC/FQHC services. Enter the starting and ending hours in the applicable columns 1 through 14 for the days that the facility is available to provide other than RHC/FQHC services. When entering time do so as military time, e.g., 2:00 p.m. is 1400.

Line 12--Have you received an approval for an exception to the productivity standards? Enter a "Y" for yes or an "N" for no.

Line 13--Is this a consolidated cost report as defined in the Rural Health Clinic Manual? If yes, enter in column 2 the number of providers included in this report, complete line 14, and complete only one worksheet series M for the consolidated group. If no, complete a separate *W*orksheet S-8 for each component accompanied by a corresponding *W*orksheet M series.

Line 14--Identify provider's name and CCN number filing the consolidated cost report.

Line 15--Are you claiming allowable GME costs as a result of your substantial payment for interns and residents. Enter a "Y" for yes or an "N" for no in column 1. If yes, enter in the appropriate column the number of program visits *(columns 2-4) and total visits (column 5)* performed by interns and residents.

4011. WORKSHEET S-9 - HOSPICE IDENTIFICATION DATA

In accordance with 42 CFR 418.310 hospice providers of service participating in the Medicare program are required to submit annual information for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.24(f) requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a hospital-based hospice. Complete a separate Worksheet S-9 for each hospital-based hospice.

4011.1 Part I - Enrollment Days.--

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

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

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

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

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

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

Inpatient Respite Care Day - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

General Inpatient Care Day - A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

COLUMN DESCRIPTIONS

Column 1--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Column 2--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 5 the total unduplicated Medicaid days.

Column 3--Enter only the unduplicated days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 5 the total unduplicated days.

Column 4--Enter only the unduplicated days applicable to the four types of care for all Medicaid hospice patients residing in a nursing facility. Enter on line 5 the total unduplicated days.

4012. Worksheet S-10 - Hospital Uncompensated and Indigent Care Data--Section 112(b) of the Balanced Budget Refinement Act (BBRA) requires that short-term acute care hospitals (§1886(d) of the Act) submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated. Charity care charge data, as referenced in section 4102 of American Recovery and Reinvestment Act of 2009, may be used to calculate the EHR technology incentive payments made to §1886(d) hospitals and critical access hospitals (CAHs). CAHs, as well as §1886(d) hospitals, *are* required to complete this worksheet. Note that this worksheet does not produce the estimate of the cost of treating uninsured patients required for disproportionate share payments under the Medicaid program.

Definitions:

Uncompensated care--Defined as charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances or discounts given to patients.

Charity care--Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. (Additional guidance provided in the instruction for line 20.)

Non-Medicare bad debt--Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim. (Additional guidance provided in the instruction for line 25.)

Non-reimbursable Medicare bad debt--The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are **not** reimbursed by Medicare under the requirements of §413.89 of the regulations and of Chapter 3 of the Provider Reimbursement Manual Part 1. (Additional guidance provided in the instruction for line 25.)

Net revenue--Actual payments received or expected to be received from a payer (including co-insurance payments from the patient) for services delivered during this cost reporting period. Net revenue will typically be charges (gross revenue) less contractual allowance. (Applies to lines 2, 9, and 13.)

Instructions:

Cost to charge ratio:

Line 1--Enter the cost-to-charge ratio resulting from Worksheet C, Part I, line *202*, column 3 divided by Worksheet C, Part I, line *202*, column 8.

For all inclusive rate providers that do not complete Worksheet C, Part I, enter your cost-to-charge ratio as calculated in accordance with CMS Pub. 15-1, section 2208.

Medicaid

NOTE: The amount on line 18 should not include the amounts on lines 2 and 5. That is, the amounts on lines 2 and 5 are mutually exclusive from the amount on line 18.

Line 2--Enter the inpatient and outpatient payments received or expected for Title XIX covered services delivered during this cost reporting period. Include payments for an expansion SCHIP program, which covers recipients who would have been eligible for coverage under Title XIX. Include payments for all covered services except physician or other professional services, and include payments received from Medicaid managed care programs. If not separately identifiable,

disproportionate share (DSH) and supplemental payments should be included in this line. For these payments, report the amount received or expected for the cost reporting period, net of associated provider taxes or assessments.

Line 3--Enter "Y" for yes if you received or expect to receive any DSH or supplemental payments from Medicaid relating to this cost reporting period. Otherwise enter "N" for no.

Line 4--If you answered yes to question 3, enter "Y" for yes if all of the DSH or supplemental payments you received from Medicaid are included in line 2. Otherwise enter "N" for no and complete line 5.

Line 5--If you answered no to question 4, enter the DSH or supplemental payments the hospital received or expects to receive from Medicaid relating to this cost reporting period that were not included in line 2, net of associated provider taxes or assessments.

Line 6--Enter all charges (gross revenue) for Title XIX covered services delivered during this cost reporting period. These charges should relate to the services for which payments were reported on line 2.

Line 7--Calculate the Medicaid cost by multiplying line 1 times line 6.

Line 8--Enter the difference between net revenue and costs for Medicaid by *subtracting the sum of lines 2 and 5 from line 7. If line 7 is less than the sum of lines 2 and 5, then enter zero.*

State Children's Health Insurance Program:

Line 9--Enter all payments received or expected for services delivered during this cost reporting period that were covered by a stand-alone SCHIP program. Stand-alone SCHIP programs cover recipients who are not eligible for coverage under Title XIX. Include payments for all covered services except physician or other professional services, and include any payments received from SCHIP managed care programs.

Line 10--Enter all charges (gross revenue) for services delivered during this cost reporting period that were covered by a stand-alone SCHIP program. These charges should relate to the services for which payments were reported on line 9.

Line 11--Calculate the stand-alone SCHIP cost by multiplying line 1 times line 10.

Line 12--Enter the difference between net revenue and costs for stand-alone SCHIP by subtracting *line 9 from line 11. If line 11 is less than line 9, then enter zero.*

Other state or local indigent care program:

Line 13--Enter all payments received or expected for services delivered during this cost reporting period for patients covered by a state or local government indigent care program (other than Medicaid or SCHIP), where such payments and associated charges are identified with specific patients and documented through the provider's patient accounting system. Include payments for all covered services except physician or other professional services, and include payments from managed care programs.

Line 14--Enter all charges (gross revenue) for services delivered during this cost reporting period for patients covered by a state or local government program, where such charges and associated payments are documented through the provider's patient accounting system. These charges should relate to the services for which payments were reported on line 13.

Line 15--Calculate the costs for patients covered by a state or local government program by multiplying line 1 times line 14.

Line 16--Calculate the difference between net revenue and costs for patients covered by a state or local government program by subtracting line *13 from line 15. If line 15 is less than line 13, then enter zero.*

Uncompensated care:

Line 17--Enter the value of all non-government grants, gifts and investment income received during this cost reporting period that were restricted to funding uncompensated or indigent care. Include interest or other income earned from any endowment fund for which the income is restricted to funding uncompensated or indigent care.

Line 18--Enter all grants, appropriations or transfers received or expected from government entities for this cost reporting period for purposes related to operation of the hospital, including funds for general operating support as well as for special purposes (including but not limited to funding uncompensated care). Include funds from the Federal Section 1011 program, if applicable, which helps hospitals finance emergency health services for undocumented aliens. While Federal Section 1011 funds were allotted for federal fiscal years 2005 through 2008, any unexpended funds will remain available after that time period until fully expended even after federal fiscal year 2008. If applicable, report amounts received from charity care pools net of related provider taxes or assessments. Do not include funds from government entities designated for non-operating purposes, such as research or capital projects.

Line 19--Calculate the total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs by entering the sum of lines 8, 12 and 16.

Line 20--Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria (measured at full charges), for care delivered during this cost reporting period for the entire facility. For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider (column 1), this is the patient's total charges. For patients covered by a public program or private insurer with which the provider has a contractual relationship (column 2), these are the deductible and coinsurance payments required by the payer. Include charity care for all services except physician and other professional services. Do not include charges for either uninsured patients given discounts without meeting the hospital's charity care criteria or patients given courtesy discounts. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.

Line 21--Calculate the cost of initial obligation of patients approved for charity care by multiplying line 1 times line 20. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 22--Enter payments received or expected from patients who have been approved for partial charity care for services delivered during this cost reporting period. Include such payments for all services except physician or other professional services. Payments from payers should not be included on this line. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 23--Calculate the cost of charity care by subtracting line 22 from line 21. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 24--Enter "Y" for yes if any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported in line 20, column 2, and complete line 25. Otherwise enter "N" for no.

Line 25--If you answered yes to question 24, enter charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program for services delivered during this cost reporting period. The amount must match the amount of such charges included in line 20, column 2.

Line 26--Enter the total facility (entire hospital complex) charges for bad debts (bad debt expense) written off or expected to be written off on balances owed by patients for services delivered during this cost reporting period. Include such charges for all services except physician and other professional services. Include the sum of all Medicare allowable bad debts appearing in the Worksheet E, H, I, J, and M series including: E, Part A, line 64; E, Part B, line 34; E-2, line 17; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; Part VII, line 34; H-4, Part II, line 27; I-5, line 5; J-3, line 21; and M-3, line 23. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.

Line 27--Enter the total facility (entire hospital complex) Medicare reimbursable (also referred to adjusted) bad debts as the sum of Worksheet E, Part A, line 65; E, Part B, line 35; E-2, line 17, columns 1 and 2; E-3, Part I, line 12; E-3, Part II, line 24; E-3, Part III, line 25; E-3, Part IV, line 15; E-3, Part V, line 26; E-3, Part VI, line 10; H-4, Part II, line 27; I-5, line 5; J-3, line 21; and M-3, line 23.

Line 28--Calculate the non-Medicare and non-reimbursable Medicare bad debt expense by subtracting line 27 from line 26.

Line 29--Calculate the cost of non-Medicare and non-reimbursable Medicare bad debt expense by multiplying line 1 times line 28.

Line 30--Calculate the cost of non-Medicare uncompensated care by entering the sum of lines 23, column 3 and line 29.

Line 31--Calculate the cost of unreimbursed and uncompensated care and by entering the sum of lines 19 and 30.

4013. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve using data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications 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 A, B, C, and D, the line numbers are consistent). While providers are expected to maintain their accounting books and general ledger in a manner consistent with the standard cost centers/departments identified on this worksheet, not all of the cost centers listed apply to all providers using these forms. For example, IPPS providers may contain a Burn Intensive Care Unit, where CAHs may not furnish this type of service.

Do not include on this worksheet items not claimed in the cost report because they conflict with the regulations, manuals, or instructions but which you wish nevertheless to claim and contest. Enter amounts on the appropriate settlement worksheet (Worksheet E, Part A, line 75; Worksheet E, Part B, line 44; Worksheet E-2, line 23; and Worksheet E-3, Parts I, II, III, IV, V, VI, and VII lines 22, 35, 36, 26, 34, 19, and 43, respectively). For provider based-facilities enter the protested amounts on line 35 of Worksheet H-4, Part II for home health agencies; line 30 of Worksheet J-3 for CMHCs; and line 30 of Worksheet M-3 for RHC/FQHC providers.

If the cost elements of a cost center are separately maintained on your books, maintain a reconciliation of the costs per the accounting books and records to those on this worksheet. This reconciliation is subject to review by your contractor.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If you need to use additional or different cost center descriptions, add (subscript) additional lines to the cost report. Where an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line. The added line is identified as a numeric subscript of the immediately preceding line. For example, if two lines are added between lines 7 and 8, identify them as lines 7.01 and 7.02. If additional lines are added for general service cost centers, add corresponding columns for cost finding.

Also, submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and is used as a basic summary for financial statements.

Do not use lines 24 through 29, 47 through 49, 77 through 87, 102 through 104, 119 through 189, and 195 through 199.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. Form CMS-2552-10 provides for preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. Additionally, nonstandard cost center descriptions have been identified through analysis of frequently used labels.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The five digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. You are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §4095, table 5**.**

Columns 1, 2, and 3--**The expenses listed in these columns must be the same as listed in your accounting books and records and/or trial balance.**

List on the appropriate lines in columns 1, 2, and 3 the total expenses incurred during the cost reporting period. These expenses are detailed between salaries (column 1) and other than salaries (column 2). *Include in column 1 as applicable all salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay.* The sum of columns 1 and 2 equals the sum of column 3. Record any needed reclassifications and/or adjustments in columns 4 and 6, as appropriate.

Column 4--With the exception of the reclassification of capital related costs which are reclassified via Worksheet A-7, all reclassifications in this column are made via Worksheet A-6. Worksheet A-6 need not be completed by all providers and is completed only to the extent that the reclassifications are needed and appropriate in the particular circumstance. Show reductions to expenses as negative numbers.

The net total of the entries in column 4 must equal zero on line 200.

Column 5--Adjust the amounts entered in column 3 by the amounts in column 4 (increase or decrease) and extend the net balances to column 5. Column 5, line 200 must equal column 3, line 200.

Column 6--Enter on the appropriate lines in column 6 the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The total on Worksheet A, column 6, line 200, equals Worksheet A-8, column 2, line 50.

Column 7--Adjust the amounts in column 5 by the amounts in column 6 (increase or decrease), and extend the net balances to column 7.

Transfer the amounts in column 7 to the appropriate lines on Worksheet B, Part I, column 0.

Line 75--Enter the cost of ASCs that are not separately certified as a distinct part but which have a separate surgical suite. Do not include the costs of the ancillary services provided to ASC patients. Include only the surgical suite costs (i.e., those used in lieu of operating or recovery rooms).

Lines 77 - 87--Reserved for future use.

Lines 88 - 93--Use these lines for outpatient service cost centers.

NOTE: For lines 88 *through 90 and 93* any ancillary service billed as clinic, RHC, and FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, *laboratory*.

Line 88--Use this line to report the costs of provider-based RHCs. If more than one is maintained, subscript the line. See Table 5 in §4095 for the proper cost center code for RHCs.

In accordance with CMS Pub. 100-02, chapter 13, §30.4A, compensation paid to a physician for RHC services rendered in a hospital-based RHC is cost-reimbursed. Where the physician agreement compensates for RHC services as well as non-RHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Line 89--Use this line to report the costs of provider-based FQHCs. If more than one is maintained, subscript the line. See Table 5 in §4095 for the proper cost center code for FQHCs.

In accordance with CMS Pub. 100-02, chapter 13, §30.4A, compensation paid to a physician for FQHC services rendered in a hospital-based FQHC is cost-reimbursed. Where the physician agreement compensates for FQHC services as well as non-FQHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Line 90--Enter the cost applicable to the clinic not included on lines 88 and 89. If you have two or more clinics which are separately costed, separately report each such clinic. Subscript this line to report each clinic. If you do not separately cost each clinic, you may combine the cost of all clinics on the clinic line.

Line 91--Enter the costs of the emergency room cost center.

Line 92--Do not use this line on this worksheet. If you have a *distinct part* area specifically designated for observation (e.g., where observation patients are not placed in a general acute care area bed), report this on a subscripted line 92.01.

NOTE: It is possible to have both a distinct observation bed area and a non-distinct area (for example, where your distinct part observation bed area is only staffed from 7:00 a.m. - 10:00 p.m. Patients entering your hospital needing observation bed care after 10:00 p.m. and before 7:00 a.m. are placed in a general inpatient routine care bed). If patients entering the distinct part observation bed area are charged differently than the patients placed in the general inpatient routine care bed, separate the costs into distinct observation bed costs and non-distinct observation bed costs. However, if the charge is the same for both patients, report all costs and charges as distinct part observation beds.

Line 93--Use this line to report the costs of other outpatient services not previously identified on lines 88 through 90. If more than one other service is offered, subscript the line. See Table 5 in §4095 for the proper cost center code for this line.

Lines 94 - 98 and 100--Use these lines for other reimbursable cost centers (other than HHA and CMHC).

Line 94--Use this line to accumulate the direct costs incurred for self-care home dialysis. For purposes of determining overhead attributable to the drugs Epoetin and Aranesp, include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

A Medicare beneficiary dialyzing at home has the option to deal directly with the Medicare program and make individual arrangements for securing the necessary supplies and equipment to dialyze at home. Under this arrangement, the beneficiary is responsible for dealing directly with the various suppliers and the Medicare program to arrange for payment. The beneficiary is also responsible to the suppliers for the deductible and 20 percent Medicare coinsurance requirement. You do not receive composite rate payment for a patient who chooses this option. However, if you provide any direct home support services to a beneficiary who selects this option, you are reimbursed on the same reasonable cost basis for these services as for other outpatient services. These costs are entered on line 93 and are notated as cost reimbursed. You may service Medicare beneficiaries who elect this option and others who deal directly with you. In this case, set up two home program dialysis cost centers (using a subscript for the second cost center) to properly classify costs between the two categories of beneficiaries (those subject to cost reimbursement and those subject to the composite rate).

Line 21--Enter the cash received from the imposition of interest, finance, or penalty charges on overdue receivables. Use this income to offset the allowable administration and general costs. (See CMS Pub. 15-1, §2110.2.)

Line 22--Enter the interest expense imposed by the contractor on Medicare overpayments. Also, enter interest expense on borrowing made to repay Medicare overpayments.

Line 23--Enter, if applicable, the amount from Worksheet A-8-3, line 65.

Line 24--Enter, if applicable, the amount from Worksheet A-8-3, line 65.

Line 25--This line pertains to the hospital-based SNF only. When the utilization review covers only Medicare patients or Medicare and title XIX patients, allocate 100 percent of the reasonable compensation paid to the physicians for their services on utilization review committees to the health care programs. Apportion all other allowable costs applicable to utilization review which cover only health care program patients among all users of the hospital-based SNF. Reclassify such other costs on Worksheet A-6. Enter the physicians' compensation for service on utilization review committees which cover only health care program patients in the hospital-based SNF. The amount entered equals the amount shown on Worksheet A, column 6, line 114. (See CMS Pub. 15-1, §2126.2.) If the utilization review costs pertain to more than one program, the amount entered on Worksheet E-2, column 1, line 7 must equal the amount adjusted on Worksheet A-8.

Lines 26 and 27--When depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on lines 26 and 27, as applicable. Use line 26 capital related buildings and fixtures costs and line 27 for new capital related movable equipment costs. Personal use of assets requires adjustment to depreciation expense, e.g., automotive used 50% for business and 50% personal.

Line 28--This adjustment is required for salaries and fringe benefits paid to nonphysician anesthetists reimbursed on a fee schedule. (See the instructions for Worksheet A, line 19.)

Line 29--Sections 1861(s)(2)(K), 1842(b)(6)(C), and 1842(b)(12) of the Act provide for coverage of and separate payment for services performed by a physician assistant. The physician assistant is an employee of the hospital and payment is made to the employer of the physician assistant. Make an adjustment on Worksheet A-8 for any payments made directly to the physician assistant for services rendered. This avoids any duplication of payments.

Line 30--Enter, if applicable, the amount from Worksheet A-8-3, line 65 for occupational therapy services rendered.

Line 31--Enter, if applicable, the amount from Worksheet A-8-3, line 65 for speech pathology services rendered.

Line 32--For CAHs, where applicable in accordance with ARRA *of* 2009, section 4102, remove the current year depreciation expense *associated with purchased assets for which the total cost or remaining un-depreciated cost was reimbursed either in the current or prior cost reporting period as EHR incentive payment if such depreciation was included on Worksheet A, line 2 (capital-related movable equipment) or any other line. This includes the depreciation expense for EHR assets purchased in the current cost reporting period, as well as depreciation expense related to the remaining net book value (i.e., un-depreciated basis) of EHR assets purchased in prior cost reporting periods which were not fully depreciated at the beginning of the current cost reporting period.*

Also, use this line to remove that portion of the annual rent/lease expense applicable to EHR assets leased under a virtual purchase lease which equals the depreciation expense for this asset since the

total cost of the asset (or the un-depreciated cost if the lease was initiated in a prior cost reporting period), was claimed as EHR incentive payment. Also remove any portion of the total rental charge which exceeds the actual cost of ownership of the EHR asset. (See PRM-1, section 110.B.2.) In accordance with PRM-1, section 110.B.2, the actual cost of ownership of an asset leased under a virtual purchase lease includes not only the depreciation expense, but insurance and interest as well. For example, if the depreciation for the asset is $50,000 per year, the insurance is $3,000 per year, the interest is $10,000 per year, and the rental charge is $70,000 per year, the rental expense must be limited to the cost of ownership which in this example is $63,000. Since the adjustment to limit the rent expense to the cost of ownership is $7,000, the actual adjustment on this line will be to reduce the allowable rent expense for this EHR asset by $57,000 (i.e., $50,000 depreciation portion and $7,000 excess rental charge over the cost of ownership).

Lines 33 - 49--Enter any additional adjustments which are required under the Medicare principles of reimbursement. Label the lines appropriately to indicate the nature of the required adjustments. If the number of blank lines is not sufficient, subscript lines 33 through 49. The grossing up of costs in accordance with provisions of CMS Pub. 15-1, §2314 is an example of an adjustment entered on these lines and is explained below.

If you furnish ancillary services to health care program patients under arrangements with others but simply arrange for such services for non-health care program patients and do not pay the non-health care program portion of such services, your books reflect only the costs of the health care program portion. Therefore, allocation of indirect costs to a cost center which includes only the cost of the health care program portion results in excessive assignment of indirect costs to the health care programs. Since services were also arranged for the non-health care program patients, allocate part of the overhead costs to those groups.

In the foregoing situation, do not allocate indirect costs to the cost center unless your contractor determines that you are able to gross up both the costs and the charges for services to non-health care program patients so that both costs and charges for services to non-health care program patients are recorded as if you had provided such services directly. See the instructions for Worksheet C, Part I for grossing up of your charges.

Meals furnished by you to an outpatient receiving dialysis treatment also require an adjustment. These costs are nonallowable for title XVIII reimbursement. Therefore, the cost of these meals must be adjusted.

In accordance with CMS Pub. 27, §501, compensation paid to a physician for RHC services rendered in a hospital-based RHC is cost reimbursed. Where the physician agreement compensates for RHC services as well as non-RHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

If the hospital performs ESRD services and costs are reported on either line 74, 94, or both, these costs should include the cost of the drugs Epoetin and Aranesp. Do not report the cost of these drugs claimed in any other cost center. These costs will be removed later on Worksheet B-2.

If the hospital pays membership dues to an organization that performs lobbying and political activities, the portion of the dues associated with these non-allowable activities must be removed from costs.

Line 50--Enter the sum of lines 1 through 49. Transfer the amounts in column 2 to Worksheet A, column 6, line as appropriate.

4023. WORKSHEET C - COMPUTATION OF RATIO OF COST TO CHARGES AND OUTPATIENT CAPITAL REDUCTION

4023.1 Computation of Ratio of Cost to Charges--This worksheet computes the ratio of cost to charges for inpatient services, ancillary services, outpatient services, and other reimbursable services. All charges entered on this worksheet must comply with Pub. 15-*1*, sections 2202.4 and 2203. This ratio is used on Worksheet D, Part V, for titles V and XIX and for title XVIII; Worksheet D-3; Worksheet D-4; Worksheet H-3, Part II; and Worksheet J-2, Part II, to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1 because of your status as IPPS, TEFRA, or other.

42 CFR 413.106(f)(3) provides that the costs of therapy services furnished under arrangements to a hospital inpatient are exempt from the guidelines for physical therapy and respiratory therapy if such costs are subject to the provisions of 42 CFR 413.40 (rate of increase ceiling) or 42 CFR Part 412 (inpatient prospective payment). However, therapy services furnished under arrangements to CAHs are subject to the provisions of 413.106.

42 CFR 415.70(a)(2) provides that RCE limits do not apply to the costs of physician compensation attributable to furnishing inpatient hospital services (provider component) paid for under 42 CFR Part 412ff.

To facilitate the cost finding methodology, apply the therapy limits and RCE limits to total departmental costs. This worksheet provides the mechanism for adjusting the costs after cost finding to comply with 42 CFR 413.106(f)(3) and 42 CFR 415.70(a)(2). This is done by computing a series of ratios in columns 9 through 11. In column 9, a ratio referred to as the “cost or other ratio” is computed based on the ratio of total reasonable cost to total charges. This ratio is used by you or your components not subject to IPPS or TEFRA (e.g., hospital-based SNFs and CAHs). Also use this ratio for Part B services still subject to cost reimbursement. In column 10, compute a TEFRA inpatient ratio. This ratio reflects the add-back of RT/PT limitations to total cost since TEFRA inpatient costs are not subject to these limits. (TEFRA inpatient services are subject to RCE limits.) In column 11, compute an IPPS inpatient ratio. This ratio reflects the add-back of RT/PT and RCE limitations to total cost since inpatient hospital services covered by IPPS are not subject to any of these limitations.

Column Descriptions

The following provider components may be subject to 42 CFR 413.40 or 42 CFR 412.1(a)ff:

- Hospital Part A inpatient services for title XVIII,
- Hospital subprovider Part A inpatient services for title XVIII,
- Hospital inpatient services for titles V and XIX, and
- Hospital subprovider services for titles V and XIX.

All components or portions of components not subject to IPPS, IPF PPS, IRF PPS, LTC PPS, or TEFRA, e.g., CAH services, are classified as “Cost or Other.”

The following matrix summarizes the columns completed for Cost or Other, TEFRA Inpatient, and IPPS:

	Columns		
Type of Service	Cost or Other	TEFRA Inpatient	IPPS, IPF-PPS, IRF-PPS Inpatient
Inpatient routine service cost centers (lines 30-46)	1-*3*	1-3	1-5

Inpatient ancillary (lines 50-93)	1, 8, 9	1-3, 8-10	1-9, 11
Other Reimbursable (lines 94-*98*)	1, 8, 9	1-3, 8-10	1-9, 11
Other Reimbursable (lines 99-101)	*1, 8*	*1-3, 8*	*1-8*
Special Purpose (lines 10*5*-117)	1, 8	1-3, *8*	1-*8*

Column 1--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 26. Transfer the amount on line 92 from Worksheet D-1, Part IV, line 89, if you do not have a distinct observation bed area. If you have a distinct observation bed area, subscript line 92 into line 92.01, and transfer the appropriate amount from Worksheet B, Part I, column 26. In a complex comprised of an acute care hospital with an excluded unit(s) (excluded from IPPS), only the acute care hospital may report observation bed costs. Any services provided by the RHC/FQHC outside the benefits package for those clinics are reported by the hospital in its appropriate ancillary cost center, but not in the RHC/FQHC cost center lines 88 and 89. Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 26.

Column 2--Enter the amount of therapy limits applied to the cost center on lines 65 to 68. Obtain these amounts from Worksheet A-8, lines 23, 24, 30 and 31 respectively.

NOTE: Complete this column only when the hospital or subprovider is subject to PPS or TEFRA rate of increasing ceiling (see 42 CFR, Part 412, subpart N and P and 42 CFR 413.40, respectively). If the hospital and all subproviders have correctly indicated that their payment system is in the "other" category on Worksheet S-2, do not complete columns 2 through 5, 10, and 11.

Column 3--Enter on each cost center line the sum of columns 1 and 2.

Column 4--Only complete this section if you or your subproviders are subject to IPPS, IPF PPS, IRF PPS, or LTC PPS. Enter on each line the amount of the RCE disallowance. Obtain these amounts from the sum of the amounts for the corresponding line on Worksheet A-8-2, column 17.

Column 5--Complete this section only if you or your subproviders are subject to a PPS. Enter on each cost center line the sum of the amounts entered in columns 3 and 4.

Columns 6 and 7--Enter on each cost center line the total inpatient and outpatient gross patient charges including *charges for* charity care *patients and, where applicable, standard customary charges for items reimbursed on a fee schedule (e.g., DME, oxygen, prosthetics, and orthotics). Also include the total inpatient and outpatient gross charges for cost centers which have a credit balance on Worksheet B, Part I, Column 26 and, therefore, do not contain "cost" in Column 1 of Worksheet C, Part I.*

Total charges on Worksheet C, Part I, for each department are for provider services only. Therefore, Medicare charges on Worksheets D, Parts II and IV, D-2, D-3, and D-4 must also include provider services only. When reporting charges for a complex, e.g., hospital, subprovider, SNF, charges for like services must be uniform. *(See CMS Pub. 15-1, §2203.)*

When certain services are furnished under arrangements and an adjustment is made on Worksheet A-8 to gross up costs, gross up the related charges entered on Worksheet C, Part I, in accordance with CMS Pub. 15-1, §2314. If no adjustment is made on Worksheet A-8, show only the charges you actually billed on Worksheet C, Part I.

NOTE: Any cost center that includes CRNA charges must exclude these charges unless the hospital qualifies for the rural exception as outlined in §4013. All cost centers for which CRNA costs are excluded on Worksheet A-8 must also exclude the charges associated with these costs.

NOTE: *Any charges for ancillary services provided to clinic, RHC and FQHC patients must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, laboratory. A similar adjustment must be made to program charges.*

Report on line 92 all charges for observation bed services provided in the inpatient routine care area of the hospital. The charges relate to all payer classes and include those observation bed charges for patients released as outpatients and those patients admitted as inpatients. If you have a distinct observation bed unit, report your gross charges on line 92.01 (which was subscripted on Worksheet A).

Column 8--Enter the total of columns 6 and 7.

Column 9 through 11--Cost to charge ratios are not calculated for lines 99 through 117. The corresponding locations on Worksheet C, Part I are shaded.

Column 9, lines 50 through 98--Always complete this column. Divide the cost for each cost center in column 1 by the total charges for the cost center in column 8 to determine the ratio of total cost to total charges (referred to as the "Cost or Other" ratio) for that cost center. Enter the resultant departmental ratios in this column. Round ratios to 6 decimal places.

Column 10, lines 50 through 98--Complete this section only when the hospital or its subprovider is subject to the TEFRA rate of increase ceiling. (See 42 CFR 413.40.) Divide the amount reported in column 3 (which represents the total cost adjusted for the add-back of amounts excluded on Worksheet A-8 for the RT/PT limits) for each cost center by the total charges for the cost center in column 8.

This computation determines the RT/PT adjusted ratio of cost to charges (referred to as the TEFRA inpatient ratio) for each cost center. Enter the resultant departmental ratio. Round ratios to 6 decimal places.

Column 11, lines 50 through 98--Complete this section only when the hospital is subject to IPPS or LTC PPS or when its subprovider is subject to its respective PPS reimbursement methodology. (See 42 CFR 412.1(a) through 412.125, 42 CFR, Part 412, subparts O, N, and P, respectively). Divide the amount reported in column 5 (which represents the total cost adjusted for the add-back of amounts excluded on Worksheet A-8 for the RT/PT and the RCE limits) for each cost center by the total charges for the cost center in column 8.

This computation determines the RCE/RT/PT adjusted ratio of cost to charges (referred to as the PPS inpatient ratio) for each cost center. Enter the resultant departmental ratio. Round ratios to 6 decimal places.

Line Descriptions

Lines 30 - 117--These cost centers have the same line numbers as the respective cost centers on Worksheets A, B, and B-1. This design facilitates referencing throughout the cost report.

Therefore, if you have subscripted any lines on those worksheets, you must subscript the same lines on this worksheet.

NOTE: The worksheet line numbers start at line 30 because of the line referencing feature.

Line 200--For each of the columns 1 through 5 (total costs), respectively, enter the sum of lines 30 through 199 for all unshaded lines in accordance with Worksheet C, Part I.

For each of the columns 6, 7, and 8 (total charges), respectively, enter the sum of lines 30 through 60 and 62 through 199 for all unshaded lines in accordance with Worksheet C, Part I. Since the charges on line 61 are also included on line 60 (laboratory), the charges on line 61 must be excluded to avoid overstating total charges.

Line 201--Enter the amounts from line 92 for columns 1, 3, and 5. Calculate the observation bed cost on line 92 using the routine cost per diem from Worksheet D-1 because it is part of routine costs and as such has been included in the amounts reported on line 30 for the hospital. Therefore, in order to arrive at the total allowable costs, subtract this cost to avoid reporting these costs twice.

Line 201, columns 6, 7, and 8, are shaded.

Line 202--For columns 1, 3, and 5, subtract line 201 from line 200, and enter the result.

Transfer Referencing

Costs--The costs of the inpatient routine service cost centers are transferred:

From Worksheet C (Columns 1, 3, or 5)	To
Line 30	Wkst. D-1, Part I, Line 21
Lines 31 - 35	Wkst. D-1, Part II, Lines 43 - 47
Line 40, 41, 42 and subscripts	Separate Wkst. D-1, Part I, Line 21
Line 43 (titles V and XIX only)	Wkst. D-1, Part II, Line 42
Line 44 (title XVIII only)	Separate Wkst. D-1, Part I, Line 21
Line 45 and subscripts (titles V and XIX only)	Separate Wkst. D-1, Part I, Line 21

Charges--Transfer the total charges for each of lines 50 through 98, column 8, to Worksheet D, Part IV, column 7, lines as appropriate.

Ratios

Cost or Other Ratios--The "Cost or Other" ratio is transferred from column 9:

For	To
Hospital, subprovider, SNF, NF, swing bed-SNF, and swing bed-NF:	
1. Inpatient ancillary services for titles V, XVIII, Part A, and XIX	Wkst. D-3, column 1, for each cost center
Ancillary services furnished by the hospital-based HHA	Wkst. H-3, Part II, column 1, line as appropriate

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. 15-1, §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 30, and decrease the appropriate intensive care or other special care unit by those days.

Column 7--Multiply the per diem in column 5 by the inpatient program days in column 6 to determine the program's share of capital costs applicable to inpatient routine services, as applicable.

4024.2 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 26.

Column 1--Enter on each line the capital-related costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 26. For the hospital component or subprovider, if applicable, enter on line 92 the amount from Worksheet D-1, Part IV, column 1, line 90.

Column 2--Enter on each line the total charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 3--Divide the capital cost of each cost center in column 1 by the charges in column 2 for each line to determine the cost to charge ratio. Round the ratios to six decimal places, e.g., round 0321514 to .032151. Enter the resultant departmental ratio in column 3.

Column 4--Enter on each line the appropriate title V, XVIII, Part A, or XIX inpatient charges from Worksheet D-3, column 2. For title XVIII, enter on line 92 the observation bed charges applicable to title XVIII patients subsequently admitted after being treated in the observation area. Enter on line 96 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--Multiply the capital ratio in column 3 by the program charges in column 4 to determine the program's share of capital costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

4024.3 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, hospital-based SNF and NF/ICF-MR (if applicable) information on the same worksheet, lines as appropriate. SNFs are now required to report medical education costs as a pass through cost.

Column 1--*Transfer from Worksheet B, Part I, column 20, for each applicable line, (*plus or minus post step down adjustments reported on Worksheet B-2, *if applicable*), *the* applicable medical education costs for nursing school *when* Worksheet S-2, Part I, line *60* is yes. *Do not transfer the costs if the response is no.*

Column 2--*Transfer from Worksheet B, Part I, column 23, for each applicable line, (*plus or minus post step down adjustments reported on Worksheet B-2, *if applicable*), *the* applicable medical education costs for paramedical education (allied health) *when* Worksheet S-2, Part I, line *60* is yes. *Do not transfer the costs if the response is no.*

Column 3--*Transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line,* plus or minus post step down adjustments (reported on Worksheet B-2), *the* applicable medical education costs for interns and residents *when* Worksheet S-2, Part I, line *57, column 1* is yes *and column 2 is no. Otherwise do not transfer the costs.*

NOTE: *If you qualify for the exception in 42 CFR 413.77(e)(1), because this is the first cost reporting period in which you are training residents in approved programs and the residents were not on duty during the first month of this cost reporting period, then all direct graduate medical education costs are reimbursed as a pass through based on reasonable cost.*

Column 4--Compute the amount of the swing bed adjustment. If you have a swing bed agreement, determine the amount for the cost center in which the swing beds are located by multiplying the sum of the amounts in columns 1 through 3 by the ratio of the amount entered on Worksheet D-1, Part I, line 26 to the amount entered on Worksheet D-1, Part I, line 21.

Column 5--Enter the sum of columns 1 through 3 (including subscripts) minus column 4.

Column 6--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 4. For SNFs enter total patient days from *W*orksheet S-3, Part I, column 8, line 19.

Column 7--Enter the per diem cost for each line by dividing the cost of each cost center in column 5 by the total patient days in column 6.

Column 8--Enter the program inpatient days for the applicable cost centers. Transfer these amounts from the appropriate Worksheet D, Part I, column 6. For SNF (line 44) enter the program days from *W*orksheet S-3, Part I, column 6, line 19.

Column 9--Multiply the per diem cost in column 7 by the inpatient program days in column 8 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 30 through 35 and 43 to Worksheet D-1, Part I, line 50 for the hospital. If you are a title XVIII hospital paid under IPPS, also transfer this sum to Worksheet E, Part A, line 57. Transfer the amounts on lines 40 through 42 to the appropriate

Worksheet D-1, *line 50 for the subprovider. Also transfer the amount on line 40 to Worksheet E-3,* Part II, line 28 and the amount on line 41 to Worksheet E-3, Part III, line 29. For hospital-based SNF, NF or ICF/MR that follow Medicare principles, transfer the amount in column 9, line 44 to Worksheet E-3, Part VI, line 2 or for NF or ICF/MR to Worksheet E-3, Part VII, line 26, as applicable.

4024.4 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 IPPS must also direct medical education costs as these costs are reimbursed separately. Determine capital-related inpatient ancillary costs on Worksheet D, Part II. 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 or ICF/MR (if applicable). Hospital payment for outpatient services are 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 26.

Column 1--*Do not use this column as CRNA services are billed and paid through claims processing and are included on Worksheet D, Part V.* 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 §4013, line 19 description for more information.) Obtain this amount from Worksheet B, Part I, column 19 plus or minus any adjustments reported on Worksheet B, Part I, column 25 for nonphysician anesthetist.

Column 2--*Transfer from Worksheet B, Part I, column 20, for each applicable line, (*plus or minus post step down adjustments made on Worksheet B, Part I, column 25, *if applicable), the* applicable medical education costs for nursing school *when* Worksheet S-2, Part I, line *60* is yes. *Do not transfer the costs if the response is no.* For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 91.

Column 3--*Transfer from Worksheet B, Part I, column 23, for each applicable line, (*plus or minus post step down adjustments made on Worksheet B, Part I, column 25, *if applicable), the* applicable medical education costs for paramedical education (allied health) *when* Worksheet S-2, Part I, line *60* is yes. *Do not transfer the costs if the response is no.* For the hospital component only, enter on line 92 the observation bed amount from Worksheet D-1, Part IV, column 5, line 92.

Column 4--*Transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, (plus or minus post step down adjustments made on Worksheet B, Part I, column 25), the applicable medical education costs for interns and residents when Worksheet S-2, Part I, line 57, column 1 is yes and column 2 is no, otherwise do not transfer the costs.* For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 93.

NOTE: If you qualify for the exception in 42 CFR 413.77(e)*(1)* because this is the first cost reporting period in which you are training residents in approved programs and the residents were not on duty during the first month of this cost reporting period, then all direct graduate medical education costs for interns and residents in approved programs are reimbursed as a pass through based on reasonable cost.

Column 5--This column represents total inpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 1 through 4 and applicable subscripts.

Column 6--This column represents outpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 2, 3 and 4 and applicable subscripts.

Column 7--Enter on each line the charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 8--Divide the cost of each cost center in column 5 by the charges in column 7 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 8.

Column 9--This column computes the outpatient ratio of cost to charges. Divide the cost of each cost center in column 6 by the charges in column 7 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 9.

Column 10--Enter on each line titles V, XVIII, Part A, or XIX inpatient charges from Worksheet D-3. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 11--Multiply the ratio in column 8 by the charges in column 10 to determine the program's share of pass through costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

For hospitals, CAHs and subproviders transfer column 11, line 200 to Worksheet D-1, Part II, column 1, line 51. If you are an IPPS hospital or subprovider, also transfer this amount to Worksheet E, Part A, line 58. For SNFs for title XVIII transfer the amount on line 200 to Worksheet E-3, Part VI, line 3 or titles V and XIX, SNFs, NFs and ICF/MRs to Worksheet E-3, Part VII, line 26, as applicable.

Column 12--Enter on each line titles XVIII, Part B, V or XIX (if applicable) outpatient charges from Worksheet D, Part V, column 2 and applicable subscripts. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 13--Multiply the ratio in column 9 by the charges in column 12 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.

For hospitals, IPPS hospitals, CAHs and subproviders transfer column 13, line 200 to Worksheet E, Part B, line 9.

4024.5 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. Title XVIII is reimbursed in accordance with 42 CFR 413.53. For services rendered on and after August 1, 2000, outpatient services are subject to outpatient PPS.

Enter in the appropriate cost center the program charges from the PS&R or from provider records.

Providers exempt from outpatient PPS (i.e., CAHs), complete columns 3, 4, 6 and 7. All other providers subscript columns 2 and 5 as necessary. Include charges for vaccine, i.e., pneumococcal, flu, hepatitis, and osteoporosis as indicated on line 73 below.

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.

NOTE: Do not enter CORF, OPT, OSP, OOT, or CMHC charges on Worksheet D, Part V. Report only charges for CMHCs 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 5 through 7 of this worksheet for any cost centers with a negative balance on Worksheet B, Part I, column 26. However, complete columns 1 through 4 for such cost centers.

In accordance with ACA, section 3121 as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108, *the Temporary Payroll Tax Cut Continuation Act of 2011, section 308, and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, hold harmless payments are extended for rural hospitals with 100 or fewer beds through December 31, 2012;* SCHs and *EACHs* regardless of bed size *through February 29, 2012;* and *SCHs and EACHs with 100 or fewer beds through December 31, 2012*. As such, *rural hospitals and* SCH*s or EACHs that qualify and* whose cost report*ing period* overlaps *the effective date*, (Worksheet S-2, Part I, line 120, column 1 *or 2* is yes), must *subscript column 2 and* enter the applicable charges *that* correspond to the respective portion of the cost reporting period.

In accordance with ACA 2010, section 3138, cancer hospitals must utilize a predetermined payment to cost ratio (PCR) to calculate the corresponding transitional outpatient payment effective for services rendered beginning January 1, 2012. The PCR may be revised each calendar year. Where the cost reporting period overlaps a PCR revision date, subscript column 2 and the corresponding column 5 to represent the portion of the cost reporting period that corresponds to each unique PCR. See section 4030.2 for further instruction/information.

Column 1--Enter on each line in column 1 the ratio from the corresponding line on Worksheet C, column 9.

Columns 2 through 4--General Instructions--Do not include in Medicare charges any charges identified as MSP/LCC.

Column 2--PPS Reimbursed Services--Enter the charges for services rendered which are 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. 2.01, 2.02) when a cost reporting period overlaps the effective dates for the various transitional corridor payments and/or 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. The subscripting of this column will directly correspond to the subscripts of Worksheet E, Part B, lines 2 through 8.

Do not include in any column services excluded from OPPS because they are paid under another fee schedule, e.g., rehabilitation services and clinical diagnostic lab.

Column 3--Cost Reimbursed Services Subject to Deductibles and Coinsurance--Enter the charges for services rendered which are subject to cost reimbursement. This includes services rendered by CAHs.

Include the charges for drugs and supplies related to ESRD dialysis (excluding EPO and Aranesp, and any drugs or supplies paid under the composite rate), and corneal tissue on line 73.

Column 4--Cost Reimbursed Services Not Subject to Deductibles and Coinsurance--Vaccine Cost Apportionment--This column provides for the apportionment of costs which are not subject to deductible and coinsurance i.e., Pneumococcal, Influenza, Hepatitis B and Osteoporosis. Enter such charges for services which are not subject to deductible and coinsurance.

Column 5--Multiply the charges in column 2 and subscripts, if necessary, by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Column 6--Multiply the charges in column 3 by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Column 7--Multiply the charges in column 4 by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Line Descriptions

Line 60--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 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, 2010, but before July 1, 2012 (Patient Protection and Affordable Care Act of 2010, section 3122, amended by the MMEA, §109). For title V and XIX purposes, follow applicable State program instructions.

For CAHs, outpatient clinical laboratory diagnostic tests are paid at 101 percent of reasonable costs, and the beneficiary is not required to be physically present in the CAH at the time the specimen is collected. As such, enter the corresponding charges on this line. See MIPPA 2008, section 148 and CR 6395, transmittal 1729, dated May 8, 2009.

Line 61--Enter the program charges for provider clinical laboratory tests for which the provider reimburses the pathologist. See §4013 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 61 are also included on line 60, laboratory, reduce the total charges to prevent double counting. Make this adjustment on line 201.

Line 71--Enter in columns 2 and 3 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 72--Enter in columns 2 and 3 the charges for implantable devices charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics.

Line 73--Enter the program charges for drugs charged to patients. Enter in column 2 charges for vaccines and drugs reimbursed at 100 percent under OPPS. Include in column 3 charges for drugs paid at 80 percent of cost subject to deductibles and coinsurance, such as osteoporosis drugs and drugs paid under OPPS such as hepatitis vaccines. Include in column 4 vaccine charges for vaccines reimbursed at 100 percent of cost such as pneumococcal and influenza vaccines not subject to deductibles and coinsurance.

Line 74--The only renal dialysis services entered on this line are for inpatients that 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 3. Enter the related costs in column 6.

Line 75--Enter in column 3 the outpatient ASC facility charges and Part B 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.

Lines 88 - 93--Use these lines for outpatient service cost centers.

NOTE: For lines 88, 89 and 90, 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 92--Enter in column 2 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 94--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 95--For PPS hospital providers ambulance services are reimbursed under the ambulance fee schedule. As such, do not report charges for ambulance services rendered (column 2 for non PPS hospitals).

However, for CAHs eligible for cost reimbursement for ambulance services (billed as exempt from the ambulance fee schedule), charges for ambulance services on line 95 are transferred from your records or PS&R report type 85C. Enter charges in column 3 and multiply column 1 times column 3. Enter the result in column 6.

Lines 96 and 97--For title XVIII, DME is paid on a fee schedule through the contractor and, therefore, is not paid through the cost report.

Line 200--Enter the sum of lines 50 through 98.

Line 201--Enter in columns 3 and 4 program charges for provider clinical laboratory tests where the physician bills the provider for program patients only. Obtain this amount from line 61.

Line 202--Enter in columns 3, 4, 6 and 7 and subscripts, the amount on line 200 plus or minus the amounts on line 201, if applicable.

Transfer Referencing: For title XVIII, transfer the sum of the amounts in columns 3 and 4 and applicable subscripts, line 202 to Worksheet E, Part B, line 12 (ancillary services charges). Make no transfers of swing bed charges to Worksheet E-2 since no LCC comparison is made.

For titles V and XIX (other than IPPS), transfer the sum of the amounts in columns 2, 3 and /or 4 plus subscripts as applicable, line 202 plus the amount from Worksheet D-3, column 2, line 202 to the appropriate Worksheet E-3, Part VII, line 9.

For titles V and XIX (under IPPS), transfer the amount in columns 2, 3 and /or 4 plus subscripts as applicable, line 202 to the appropriate Worksheet E-3, Part VII, line 9.

Transfer References

From Wkst. D, Part V	Title XVIII, Part B Swing Bed To	Titles V or XIX or Title XVIII, Part B
Column 6, line 202 and column 7, line 73 and subscripts	N/A	Wkst. E, Part B, col. 1 (& subscripts), line 1
Columns 5, line 202	N/A	Wkst. E, Part B, col. 1 (& subscripts), line 2
Sum of columns 2, 3 and 4 as applicable (SNF only), line 202	N/A	Wkst. E, Part B, line 12 or Wkst. E-3, Part VII, col. 1, line 9 for titles V or XIX
Sum of column 6 and 7 (SNF only) line 202	Wkst E-2 col. 2, line 3	Wkst. E, Part B, line 1 or Wkst. E-3, Part VII, col. 1, line 2 for titles V or XIX

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 8 for the component and lines as indicated: hospitals from lines 7 and 28; subproviders from lines 16 through 18, as applicable, and 28, if applicable; SNFs from line 19; and NFs from line 20. If you answered yes to line 92 of Worksheet S-2, the NF days come from line 19 for the SNF level of care and line 20 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.

Line 2--Enter the total general routine inpatient days. Include private room days and exclude swing bed and newborn days. Hospitals enter the sum of the days entered on Worksheet S-3, Part I, column 8, lines 1 and 28. 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 and observation bed days. *If you have only private room days, do not complete this line.*

Line 4--*Enter the result of line 2, minus line 3, minus total observation bed days from Worksheet S-3, Part I, column 8, line 27. The result will be semi-private room days exclusive of swing bed semi-private room days and observation bed days. If you have only private room days, such days will be included in this line.*

NOTE: For purposes of this computation, the program does not distinguish between semi-private and ward accommodations. (See CMS Pub. 15-1, §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 5, column 8.

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

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

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

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

Type of Provider	From
Hospital	Wkst. S-3, Part I, cols. 5, 6, or 7, line 1
Subprovider	Wkst. S-3, Part I, cols. 5, 6, or 7, line 16, 17, or 18 as applicable
SNF	Wkst. S-3, Part I, cols. 5, 6, or 7, line 19
NF	Wkst. S-3, Part I, cols. 5, 6, or 7, for SNF only level of care; line 19. If line 92 of Wkst S-2, Part I is a "Y", two D-1s must be completed for title XIX using line 19 for SNF level of care and line 20 for the NF level of care; or line 20 only for NF level of care.

Include private room days and exclude swing bed and newborn days for each provider component. Add any program days for general care patients of the component who temporarily occupied beds in an intensive care or other special care unit. (See CMS Pub. 15-1, §2217.)

NOTE: If Worksheet S-2, line 92 columns 1 or 2, as applicable is "Y" for yes, then Worksheet D-1 for title XIX (for the SNF and NF component) must be completed. The results are to be combined and transferred to title XIX SNF, Worksheet E-3, Part VII, line 1.

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

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

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

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

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

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

Line 15--Enter, for titles V or XIX only, the total nursery inpatient days from Worksheet S-3, Part I, column 8, line 13.

Line 16--Enter, for titles V or XIX only, the total nursery inpatient days applicable to the program from Worksheet S-3, Part I, columns 5 and 7, respectively, line 13.

Lines 17 - 27--These lines provide for the carve out of reasonable cost of extended care services furnished by a swing bed hospital. Under the carve out method, the total costs attributable to SNF type and NF type routine services furnished to all classes of patients are subtracted from total general inpatient routine service costs before computing the average cost per diem for general routine hospital care. The rates on lines 17 through 20 are supplied by your contractor.

Line 17--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 5 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-1, §2230ff.) Critical access hospitals do not complete this line.

Line 18--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 6 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-1, §2230ff.) Critical access hospitals do not complete this line.

Line 19--Enter the average Statewide rate per patient day paid under the State Medicaid plan for routine services furnished by nursing facilities (other than NFs for the mentally retarded) in that State. This rate is approximated by taking the average rate from the prior calendar year (i.e. the calendar year preceding the year relating to inpatient days reported on line 7), updated to approximate the current year rate. Obtain the proper rate from your contractor.

Line 20--Enter the average Statewide rate per patient day paid under the State Medicaid plan for routine services furnished by nursing facilities (other than NFs for the mentally retarded) in that State. This rate is approximated by taking the average rate from the prior calendar year (i.e. the calendar year preceding the year relating to inpatient days reported on line 8), updated to approximate the current year rate. Obtain the proper rate from your contractor.

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

For titles V, XVIII, and XIX, enter the amounts from Worksheet C, Part I, line 30 for adults and pediatrics or lines 40, 41, or 42, as applicable for the subprovider, as appropriate:

COST or OTHER	Inpatient - Column 1 (includes CAHs)
TEFRA	Inpatient - Column 3 (includes cancer and children's hospitals)
PPS	Inpatient - Column 5 (includes acute, IPFs, IRFs, & LTCHs)

SNF/NF Inpatient Routine--For title XVIII, transfer this amount from Worksheet C, Part I, column 5, line 44 (SNF). For titles V and XIX, transfer this amount from Worksheet B, Part I, column 26, line 45 (NF) or 45.01 ICF/MR.

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

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

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

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

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

For critical access hospitals, subtract the sum of lines 24 and 25 from the amount reported on line 21. Divide that result by the patient days equal to lines 2, 5, and 6 above to arrive at a per diem (Retain this amount for the calculation required on lines 38, 64 and 65). Multiply the per diem by the total days reported on lines 5 and 6. Add that result to the amounts reported on lines 24 and 25.

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

Lines 28 - *36*--All providers must complete lines 28 through *36*. PPS providers complete these lines for data purposes only. However, if line *4* 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 *and observation bed days* (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 *and observation bed days* (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 *4* equals line 2, enter the amount from line 27 above.

4025.2 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.

CAHs are also required to complete this worksheet.

Line Descriptions

Line 38--For non-IPPS providers, (includes CAHs), 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, IPFs, and LTCHs under 100 percent PPS), divide the sum of lines 36 and 37 by the inpatient days reported on line 2.

Line 73--Calculate the medically necessary private room cost applicable to the program by multiplying the days shown in Part I, line 14 by the per diem in Part I, line 35.

Line 74--Add lines 72 and 73 to determine the total reasonable program general inpatient routine service cost.

Lines 75 - 82--Apportionment of Inpatient Operating Costs for Other Nursing Facilities (NF)--These lines are used for titles V and/or XIX only. For title XVIII Medicare, skip lines 75 through 82 and continue with line 83.

Line 75--Enter the capital-related cost allocated to the general inpatient routine service cost center. For titles V and XIX, transfer this amount from Worksheet B, Part II, column 26, line 45 (NF).

Line 76--Calculate the per diem capital-related cost by dividing the amount on line 75 by the days in Part I, line 2.

Line 77--Calculate the program capital-related cost by multiplying line 76 by the days in Part I, line 9.

Line 78--Calculate the inpatient routine service cost by subtracting line 77 from line 74.

Line 79--Enter the aggregate charges to beneficiaries for excess costs obtained from your records.

Line 80--Enter the total program routine service cost for comparison to the cost limitation. Obtain this amount by subtracting line 79 from line 78.

Line 81--Enter the inpatient routine service cost per diem limitation. This amount is provided by your state contractor.

Line 82--Enter the inpatient routine service cost limitation. Obtain this amount by multiplying the number of inpatient days shown on Part I, line 9 by the cost per diem limitation on line 81.

Line 83--For titles V and XIX, enter the amount of reimbursable inpatient routine service cost determined by adding line 77 to the lesser of line 80 or line 82. If you are a provider not subject to the inpatient routine service cost limit, enter the sum of lines 77 and 80. For title XVIII, enter the amount from line 74.

Line 84-- Enter the program ancillary service amount from Worksheet D-3, column 3, line 200.

Line 85--Enter (only when Worksheet D-1 is used for a hospital-based SNF and NF) the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees to an SNF and/or NF. Include the amount eliminated from total costs on Worksheet A-8, line 25. If the utilization review costs are for more than one program, the sum of all the Worksheet D-1 amounts reported on this line must equal the amount adjusted on Worksheet A-8, line 25.

Line 86--Calculate the total program inpatient operating cost by adding the amounts on lines 83 through 85. Transfer this amount to the appropriate Worksheet E-3, Part VII, line 1 except for SNFs subject to SNF PPS. For NF and ICF/MR, transfer this amount to Worksheet E-3, Part VII, line 1 for titles V and XIX.

4025.4 Part IV - Computation of Observation Bed Pass Through Cost--This part provides for the computation of the total observation bed costs and the portion of costs subject to reimbursement as a pass through cost for observation beds that are only in the general acute care routine area of the hospital. For title XIX, insert the amount calculated for title XVIII for the hospital, if applicable. To avoid duplication of reporting observation bed costs, do not transfer the title XIX amount to Worksheet C.

Line 87--*Transfer* the total observation bed days from Worksheet S-3, Part I, column 8, line 28. *NOTE: Observation days are only recognized and reported in the inpatient routine area of the hospital.*

Line 88--Calculate the result of general inpatient routine cost on line 27 divided by line 2.

Line 89--Multiply the number of days on line 87 by the cost per diem on line 88 and enter the result. Transfer this amount to Worksheet C, Parts I and II, column 1, line 92.

Lines 90 - 93--These lines compute the observation bed costs used to apportion the routine pass through costs and capital-related costs associated with observation beds for PPS and TEFRA providers. Lines 90 through 93 correspond to specific medical education programs reported on Worksheet D, Part III, columns 1, 2, and 3, respectively.

Column 1--*For line 90, transfer the amount from Worksheet D, Part I, column 1, line 30 for the hospital. For line 91 through 93, enter the cost from Worksheet D, Part III, columns 1, 2 and 3, line 30.*

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

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

Column 4--Enter the total observation cost from line 89. Enter the same amount on each line.

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

Transfer the amount in column 5:

From	To	To
Wkst. D-1, Part IV	Wkst. D, Part II	Wkst D, Part IV
Col. 5, line 90	Col. 1, line 92	
Col. 5, line 91		Col. 2, line 92
Col. 5, line 92		Col. 3, line 92
Col. 5, line 93		Col. 4, line 92

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

Outpatient

Column 3--Enter the total charges applicable to each outpatient service area. Obtain the total charges from Worksheet C, column 8, lines 88 through 93.

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

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

Titles V and XIX:

		Sum of	
Description	Enter in col. 5 for title V or col. 7 for title XIX	Worksheet D-3, col. 2	Worksheet D, Part V, sum of cols. 2 - 4 (& applicable subscripts)
RHC	line 21	line 88	line 88
FQHC	line 22	line 89	line 89
Clinic	line 23	line 90	line 90
Emergency	line 24	line 91	line 91
Observation Beds	line 25	line 92	line 92
Other Outpatient	line 26	line 93	line 93

Title XVIII:

		From			
Description	Enter in col. 6 for Title XVIII	Worksheet D-3, col. 2	Worksheet D, Part V cols. 2 - 4 (& applicable subscripts)		Less Part A Only Charges
RHC	line 21	line 88	plus	line 88 minus	
FQHC	line 22	line 89	plus	line 89 minus	From
Clinic	line 23	line 90	plus	line 90 minus	Provider
Emergency	line 24	line 91	plus	line 91 minus	Records
Observation Beds	line 25	line 92	plus	line 92 minus	
Other Outpatient	line 26	line 93	plus	line 93 minus	

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

If you have subproviders, the amounts entered in these columns are the sum of the hospital and subprovider Worksheets D-3 and D, Part V.

Columns 8, 9, and 10, lines 21-26--Compute program outpatient costs for titles V and XIX and title XVIII, Part B cost by multiplying the cost to charge ratio in column 4 by the program outpatient charges in columns 5, 6, and 7. Enter the resulting amounts in columns 8, 9, and 10, as appropriate, for each cost center.

Transfer program expenses.

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

Hospital: Sum of lines 9 and 27	TO	Worksheet E-3, Part VII, line 19
Subprovider: lines 10-12, as applicable	TO	Worksheet E-3, Part VII, line 19
Other Nursing Facility: line 14	TO	Worksheet E-3, Part VII, line 19

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

Hospital: Sum of lines 9 and 27	TO	Worksheet E, Part B, line 22
Subprovider: line 10-12, as applicable	TO	Worksheet E, Part B, line 22
Skilled Nursing Facility: line 13	TO	Worksheet E, Part B, line 22

4026.2 Part II - In An Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only)--This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicare beneficiaries who have Part B coverage and are not entitled to benefits under Part A. (See CMS Pub. 15-1, chapter 4, and §2120.) Do not complete this section unless you qualify for the new teaching hospital exception for graduate medical education payments in 42 CFR 413.77(e)(1).

Column 1--Enter the amounts allocated in the cost finding process to the indicated cost centers. Obtain these amounts from Worksheet B, Part I, sum of the amounts in columns 21 and 22, as adjusted for any post stepdown adjustments applicable to interns and residents in approved teaching programs.

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

Swing Inpatient Bed Amount	=	Interns and Residents Costs Allocated to Adults & Pediatrics	times	Total Swing Bed Days	divided by	Total Days
For line 30 (SNF)		Wkst. D-2, col. 1, line 29		Wkst. D-1, sum of lines 5 and 6		Wkst. D-1, line 1
For line 31 (NF)		Wkst. D-2, col. 1, line 29		Wkst. D-1, sum of lines 7 and 8		Wkst. D-1, line 1

The amount subtracted from line 29 must equal the sum of the amounts computed for lines 30 and 31.

If you have swing beds in your IPF subprovider, complete line 38 to adjust for swing bed costs. Compute the swing bed amounts as explained above except that the interns and residents costs allocated to adults and pediatrics (line 38) comes from Worksheet D-2, column 1, line 38. The amount subtracted from line 38 must equal the sum of subscripts of line 38, as applicable. If you have swing beds in your IRF subprovider, complete line 39 to adjust for swing bed costs. Compute the swing bed amounts as explained above except that the interns and residents costs allocated to adults and pediatrics (line 39) comes from Worksheet D-2, column 1, line 39. The amount subtracted from line 39 must equal the sum of subscripts of line 39, as applicable.

Column 3--Enter on lines 29 and 38 through 40, as applicable, the amounts in column 1 minus the amount in column 2. Enter on line 30 the amount from column 2. Enter on lines 32 through 36 and 41 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 30, 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 29, 30, 32 through 36, and 38 through 41, 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 30, or lines 38 through 40 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 37 the sum of the amounts on line 29 plus the sum of the amounts on lines 32 through 36.

Transfer the expenses on lines 37 through 41 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 37 through 41 to Worksheet E, Part B, line 22, as appropriate.

4026.3 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 413.77(e)(1). 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.

Description	From Column 6		
Hospital	Line 45	TO	Worksheet E, Part B, line 22
Subprovider	Line 46-48	TO	Worksheet E, Part B, line 22
SNF	Line 49	TO	Worksheet E, Part B, line 22

4027. WORKSHEET D-3 - INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

This worksheet provides for the apportionment of cost applicable to hospital inpatient services reimbursable under titles V, XVIII and XIX as indicated in 42 CFR 413.53. All hospital filing a full cost report, including CAHs (Worksheet S-2, line 105 is marked "Y") must complete this worksheet. Complete a separate copy of this worksheet for each sub-provider, distinct part SNF and NF, swing-bed SNF and NF, or any other component. Identify the health care program, provider component, and the payment system by checking the appropriate boxes at the top of the worksheet.

The cost centers *on this worksheet* 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.

Column 1--Enter the ratio of cost to charges developed for each cost center from Worksheet C, *lines 50 through 94 and 96 through 98*. The ratios in columns 10 and 11 of Worksheet C are used only for hospital or subprovider components for titles V, XVIII, and XIX inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) or PPS (see 42 CFR 412, Subpart N, O, or P), respectively. Use the ratios in column 9 in all other cases.

Column 2--*Enter from the PS&R or your records the inpatient program charges applicable to the provider component services only (not professional component) in the appropriate cost centers as detailed below. Also include charges for cost centers with a negative balance on Worksheet B Part I, column 26. Do not include program charges for swing bed services and Medicare charges identified as MSP/LCC*.

Lines 30 - 35--Enter the program charges from the PS&R or your records (hospital only).

Lines 40 - 42--Enter in column 2 the inpatient program charges for the subproviders' component only. For subprovider components do not complete lines 30-35 and 43. For a Hospital complex do not complete lines 40-42.

Line 43--Enter the charges for your nursery department for which you were reimbursed. Complete this for Medicaid services only.

Line 61--Enter the program charges for your clinical laboratory tests for which you reimburse the pathologist. See the instructions for Worksheet A (see §4013) for a more complete discussion on the use of this cost center.

> **NOTE:** Since the charges on line 61 are also included on line 60, laboratory, you must reduce total charges to prevent double counting. Make this adjustment on line 201.

Line 73--Enter only the program charges for drugs charged to patients that are not paid a predetermined amount.

Lines 88 - 90 and 93--Do not enter on these lines program charges related to any inpatient ancillary services (e.g., radiology- diagnostic, laboratory) provided in a clinic, RHC, or FQHC and billed as inpatient services. Instead, reclassify such program charges to the related ancillary cost centers.

Lines 92 and 92.01--Enter on these lines, as applicable, the program charges for observation bed services if the patient was subsequently admitted as an inpatient. However, these program charges can only be reported on the main hospital's (e.g., acute care hospital, freestanding psychiatric hospital, freestanding rehabilitation hospital) Worksheet D-3. (That is, program charges for observation bed services provided to patients subsequently admitted as inpatients to an acute hospital's excluded psychiatric or rehabilitation unit must be reported on Worksheet D-3 of the acute hospital.)

Lines 96 and 97--Do not enter program charges for oxygen rented or sold as the fee schedule applies for these services.

Line 200--Enter the total of the amounts in columns 2 and 3, lines 50 through 94 and 96 through 98.

Line 201--Enter in column 2 program charges for your clinical laboratory tests when the physician bills you for program patients only. Obtain this amount from line 61.

Line 202--Enter in column 2 the amount on line 200 less the amount on line 201.

Transfer the amount in column 2, line 202, as follows.

For title XVIII, Part A (other reimbursement), transfer the amount to Worksheet E-3, Part V, line 8. Do not transfer this amount if you are reimbursed under PPS or TEFRA. No transfers of swing bed charges are made to Worksheet E-2 since no LCC comparison is made. For titles V and XIX (if not a PPS provider), transfer the amount plus the amount from Worksheet D, Part V, sum of columns 3 and 4, line 202, to Worksheet E-3, Part VII, column 1, line 9.

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

Transfer column 3, line 200, as follows:

Type of Provider	TO
Hospital	Wkst. D-1, Part II, col. 1, line 48
Subprovider	Wkst. D-1, Part II, col. 1, line 48
SNF	Wkst. D-1, Part III, col. 1, line 84
NF	Wkst. D-1, Part III, col. 1, line 84
Swing Bed-SNF	Wkst. E-2, col. 1, line 3
Swing Bed-NF	Wkst. E-2, col. 1, line 3

4028.3 Part III - Summary of Costs and Charges--

Line 56--Enter in column 1 the sum of the costs in Part I, column 4, line 7 and column 3, line 41. Enter in column 3 the sum of the charges in Part I, column 1, line 7 and column 2, line 41.

Line 57--Enter in column 1 the cost of inpatient services of interns and residents not in an approved teaching program from Part II, column 3, line 48. Enter in column 3 your charges for the services for which the cost is entered in column 1. If you do not charge separately for the services of interns and residents, enter zero in column 3.

Line 58--Enter in column 1 the cost of outpatient services of interns and residents not in an approved teaching program from Part II, column 3, line *55*. Enter in column 3 the provider charges for the services for which the cost is entered in column 1. If you do not charge separately for the services of interns and residents, enter zero in column 3.

Line 59--Enter in column 1 the direct organ acquisition costs and allocated general service costs from Worksheet B, Part I, column 26, lines 105, 106, 107, 108, 109, 110, or 111, whichever is applicable.

These direct costs include, but are not limited to, the cost of services purchased under arrangements or billed directly to you for:

- Fees for physician services (preadmission donor and recipient tissue typing),
- Costs for organs acquired from other providers or organ procurement organizations,
- Transportation costs of organs,
- Organ recipient registration fees,
- Surgeon's fees for excising cadaveric organs, and
- Tissue typing services furnished by independent laboratories.

NOTE: Transportation costs to ship organs outside of the United States are not an allowable cost.

If you have a schedule of charges which represents the various direct organ acquisition costs included in column 1, enter in column 3 the total of the charges which are applicable to the costs in column 1. However, if you have no such schedule of charges, enter the amount from column 1 in column 3.

Line 60--If you have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter in columns 1 and 3 the amount from Worksheet(s) D-5, Part II, column 3, lines 24 through 31, as applicable.

Line 61--Enter in columns 1 and 3 the sum of lines 56 through 60. This amount must be equal to or greater than the amount reported on line 66 (revenues for organs sold).

Line 62--Enter the number of total usable organs (this includes all organs applicable to this worksheet except those that could not be transplanted). For islets since the number of islets cells injected into a recipient will vary depending on the patient, enter the number of patients who received islets injections. Each patient is allowed a maximum of two islet injections per inpatient stay.

Line 63-Enter total usable organs (line 62) less the sum of organs sent to military hospitals (without a reciprocal sharing agreement with the Organ Procurement Organization (OPO) in effect prior to March 3, 1988 and approved by the contractor), to veterans' hospitals, organs sent outside the United States, and organs transplanted into non-Medicare beneficiaries. Include organs that had partial payments by a primary insurance payer in addition to Medicare. Do not include organs that were totally paid by primary insurance other than Medicare, as they are non-Medicare. Do not include organs procured from a non-certified OPO.

Line 64--Enter line 63 divided by line 62.

Line 65--Enter in column 1 the amount in column 2, line 64 multiplied by the amount in column 1, line 61. Enter in column 3 the amount in column 2, line 64 multiplied by the amount in column 3, line 61.

Line 66--Enter in columns 1 and 3 the total revenue applicable to:

o Organs (included on line 63) furnished to other providers and organs sent to procurement organizations and others;

o Organs sent to OPOs, military hospitals with a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988, and approved by the contractor, and organs sent to transplant centers; and

o Organs that were partially reimbursed by another primary insurer other than Medicare and were included on line 63

> **NOTE:** When the primary payer makes a single payment for the transplant and acquisition, it is necessary to prorate the amount received between the transplant and the acquisition based on the charges submitted to the payer. Report the primary payer amounts applicable to organ transplants on Worksheet E, Part A, line 60. Report the primary payer amounts applicable to organ acquisition on this line.

Line 67--Enter the amount entered on line 65 minus the amount on line 66.

Line 68--Enter in all columns the total amount of organ acquisition charges billed to Medicare under Part B. This occurs when organs are transplanted into Medicare beneficiaries who, on the day of transplantation, are not entitled to Part A benefits. This computation reflects an adjustment between Medicare Part A and Part B costs and charges so that the amount added under Part B is the same amount subtracted under Part A.

Line 69--For columns 1 and 3 subtract line 68 from line 67. For columns 2 and 4 transfer that amount from line 68.

4030. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E, Parts A and B, calculate title XVIII settlement for inpatient hospital services under inpatient PPS (IPPS) and title XVIII (Part B) settlement for medical and other health services. Worksheet E-3 computes title XVIII, Part A settlement for non-IPPS hospitals, settlements under titles V and XIX, and settlements for title XVIII SNFs reimbursed under a prospective payment system. Worksheet E-4 computes total direct graduate medical education costs.

Worksheet E consists of the following two parts:

Part A - Inpatient Hospital Services Under PPS
Part B - Medical and Other Health Services

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

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

4030.1 Part A - Inpatient Hospital Services Under IPPS--

For SCH/MDH status change and/or geographical reclassification (see 42 CFR 412.102/103) subscript column 1 for lines 1-3, 22, 28, 29, *33,* 34, 41, 45 47, and 48. If you responded "1" and "2" or "2" and "1", respectively to Worksheet S-2, Part I, questions 26 and 27, which indicated your facility experienced a change in geographic classification status during the year, subscript column 1 and report the payments before the reclassification in column 1 and on or after the reclassification in column 1.01.

Enter on lines 1 through 3 in column 1 the applicable payment data for the period applicable to SCH status. Enter on lines 1 through 3 in column 1.01 the payment data for the period in which the provider did not retain SCH status. The data for lines 1 through 3 must be obtained from the provider's records or the PS&R.

Line Descriptions

Line 1--The amount entered on this line is computed as the sum of the Federal operating portion (DRG payment) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period.

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.

Line 2.01--For inpatient PPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line 92.

Line 3--Hospitals receive payments for indirect medical education for managed care patients based on the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture in conjunction with the PPS PRICER the simulated payments. Enter the total managed care "simulated payments" from the PS&R.

Line 4--Enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 3, line 14) 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 swing bed days (Worksheet S-3, Part I, column 8, sum of lines 5 and 6), and the number of observation days (Worksheet S-3, Part I, column 8, line 28).

Indirect Medical Educational Adjustment Calculation for Hospitals--Calculate the IME adjustment only if you answered "yes" to line 56 on Worksheet S-2 and complete lines 5 to 29 as applicable. (See 42 CFR 412.105.) Hospitals that incur indirect costs for graduate medical education programs are eligible for an additional payment as defined in 42 CFR 412.105(d). This section calculates the additional payment by applying the applicable multiplier of the adjustment factor for such hospitals.

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

Line 5--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).) Adjust this count for the 30 percent increase for qualified rural hospitals and also 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.) 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. (Effective 10/1/2001, see 42 CFR 413.79(h)(3)(ii)).

Line 6--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 is effective in the fourth program year of each of those new programs (see 66 FR, August 1, 2001, page 39881). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 5. 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 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 16.

Line 7--Enter the section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1).

Line 7.01--Enter the section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If this cost report straddles July 1, 2011, calculate the prorated section 5503 reduction amount off the cost report and enter the result on this line. (Prorate the cap reduction amount by multiplying it by the ratio of the number of days from July 1, 2011 to the end of the cost reporting period to the total number of days in the cost reporting period.) Otherwise enter the full cap reduction amount.

Line 8--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, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.

Line 8.01--Enter*, as applicable, all of or a portion of the amount of* the FTE cap slots *the hospital was awarded under* section 5503 of the ACA*. The amount of the section 5503 award that is reported on this line is the amount of the section 5503 award that is being "used" in this cost reporting period. In the 5-year evaluation period following implementation of section 5503 (that is, July 1, 2011 through June 30, 2016), at least 75 percent of the slots are to be "used" for additional primary care and/or general surgery residents, while 25 percent of the amount that is reported may be (but need not be) "used" for other purposes. During the 5-year evaluation period, failure to meet the requirements at 42 CFR section 413.79(n)(2) of the regulations means loss of a hospital's section*

5503 slots. Therefore, do not automatically report the full amount of the section 5503 award; only enter the amount of the section 5503 award that equates to at least 75 percent of the FTEs being "used" for additional primary care and/or general surgery FTEs, and no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting period. If this cost report straddles July 1, 2011, calculate the applicable prorated section 5503 amount of increase to the cap "off the cost report" and enter the result on this line. (The prorated cap increase amount is to be calculated by multiplying the number of FTE cap slots that would be reported for the entire cost reporting period in accordance with the preceding instructions by the ratio of the number of days from July 1, 2011 to the end of the cost reporting period to the total number of days in the cost reporting period).

Line 8.02--Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. Further subscript this line (lines 8.03 through 8.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to determine the effective date of the cap increase. *If the section 5506 award is phased in over more than one effective date, only report the portions of the section 5506 award as they become effective.* If the effective date of the cap increase is not the same as your fiscal year begin date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period).

Line 9--Adjusted IME FTE Resident Cap--Enter the result of line 5 plus line 6 minus line 7 minus line 7.01 plus or minus line 8 plus line 8.01 plus line 8.02 plus applicable subscripts. However, if the resulting IME cap is less than zero (0), enter zero (0) on this line.

Calculation of the allowable current year FTEs:

Line 10--Enter the FTE count for allopathic and osteopathic programs in the current year from your records. Do not include residents in the initial years of the new program, which means that the program has not yet completed one cycle of the program (i.e., "period of years," or the minimum accredited length of the program). (42 CFR 412.105(f)(1)(iv) and/or (f)(1)(v).) Contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. Exclude FTE residents displaced by hospital or program closure that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 412.105(f)(1)(v)).

Line 11--Enter the FTE count for residents in dental and podiatric programs.

Line 12--Enter the result of the lesser of line 9, or line 10 added to line 11.

Line 13--Enter the total allowable FTE count for the prior year, either from Form 2552-96 line 3.14 or from Form 2552-10 line 12, as applicable. Do not include residents in the initial years of the program that are exempt from the rolling average under 42 CFR 412.105(f)(1)(v). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 412.105(f)(1)(v)), enter on this line the allowable FTE count from line 12 plus the count of previously new FTE residents in that specific program that were added to line 16 of the prior year's cost report (line 3.17 if the prior year cost report was the 2552-96). If you were not training any residents in approved teaching programs in the prior year, make no entry.

Line 14--Enter the total allowable FTE count for the penultimate year, either from Form 2552-96 line 3.14, or Form 2552-10 line 12, as applicable. If you were not training any residents in approved

programs in the penultimate year, make no entry. Do not include residents in the initial years of the program that are exempt from the rolling average under 42 CFR 412.105(f)(1)(v). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 412.105(f)(1)(v)), enter on this line the allowable FTE count from line 12 plus the count of previously new FTE residents in that specific program that were added to line 16 of the penultimate year's cost report. (Line 3.17 if the prior year cost report was the 2552-96).

Line 15--Enter in the sum of lines 12 through 14 divided by three.

Line 16--Enter the number of FTE residents in the initial years of the program that meet the rolling average exception. (See 42 CFR 412.105(f)(1)(v))

Line 17--Enter the additional FTEs for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment (See 42 CFR 412.105(f)(1)(v)).

Line 18-Enter the sum of lines 15, 16 and 17.

Line 19--Enter the current year resident to bed ratio. Line 18 divided by line 4.

Line 20--In general, enter from the prior year cost report the intern and resident to bed ratio by dividing line 12 by line 4 (divide line 3.14 by line 3 if the prior year cost report was the 2552-96). However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e), add to the numerator of the prior year intern and resident to bed ratio the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program (i.e., the period of years is the minimum accredited length of the program). If the provider is participating in a Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap and current year FTE count due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator and the prior year numerator, and b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior year's numerator (see FR Vol. 66, No. 148 dated August 1, 2001, page 39880). Effective for cost reporting periods beginning on or after 10/1/02, if the hospital is training FTE residents in the current year that were displaced by the closure of another hospital or program, 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)). The amount added to the prior year's numerator is the displaced resident FTE amount that you would not be able to count without a temporary cap adjustment. This is the same amount of displaced resident FTEs entered on line 17.

Line 21--Enter the lesser of lines 19 or 20.

Line 22--Calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 21) to the .405 power) - 1} times {the sum of line 1 + line 3}.

IME Adjustment Calculation for the Add-on--Computation of IME payments for additional allopathic and osteopathic resident cap slots received under 42 CFR §412.105(f)(1)(iv)(C)--Complete lines 23 through 28 only where the amount on line 23 is greater than zero (0).

Line 23--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), section 422 of the MMA.

Line 24--IME FTE Resident Count Over the Cap--Subtract line 9 from line 10 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 23 through 28.

Line 25--Section 422 Allowable IME FTE Resident Count--If the count on line 24 is greater than zero, enter the lower of line 23 or line 24.

Line 26--Resident to Bed Ratio for Section 422--Divide line 25 by line 4.

Line 27--IME Adjustment Factor for Section 422 IME Residents--Enter the result of the following: .66 times [({1 + line 26} to the .405 power) - 1].

Line 28--IME Add On Adjustment--Enter the sum of lines 1 and 3, multiplied by the factor on line 27.

Line 29--Total IME Payment--Enter the sum of lines 22 and 28.

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 30 through 34. Complete this portion only if you are an IPPS hospital and answered yes to line 22, column 1 of Worksheet S-2, Part I.

Line 30--Enter the percentage of SSI recipient patient days to Medicare Part A patient days. (Obtain the percentage from your contractor.)

Line 31--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-2, Part I, columns 1 through 6, line 24) to total days reported on Worksheet S-3, Part I, column 8, line 14, plus column 8, line 32, minus the sum of lines 5 and 6, plus employee discount days reported on *W*orksheet S-3, Part I, column 8, line 30.

Line 32--Add lines 30 and 31 to equal the hospital's DSH patient percentage.

Line 33--Compare the percentage on line 32 with the criteria described in 42 CFR 412.106(c) and (d). Enter the payment adjustment factor calculated in accordance with 42 CFR 412.106(d). Hospitals qualifying for DSH in accordance with 42 CFR 412.106(c)(2) (Pickle Amendment hospitals), if Worksheet S-2, Part I, line 22, column 2 is "Y" for yes, enter 35.00 percent on line 33.

In addition, for MDH providers the rural 12 percent DSH payment cap is no longer applicable.

Line 34--Multiply line 33 by line 1.

Lines 35 - 39--Reserved for future use.

Additional Payment for High Percentage of ESRD Beneficiary Discharges--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104. When the average weekly cost per dialysis treatment changes within a cost reporting period, create an additional column (column *1.01*) for lines 41 and 45.

Line 40--Enter total Medicare discharges reported on Worksheet S-3, Part I, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages and 48520 and 48447).

Line 41--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see Vol. 69, FR 154, dated August 11, 2004, page 49087) excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48520 and 48447).

Line 42--Divide line 41, sum of columns 1 and *1.01* by line 40. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

Line 43--Enter the total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684, and 685, as applicable.

Line 44--Enter the average length of stay expressed as a ratio to 7 days. Divide line 43 by line 41, sum of columns 1 and *1.01*, and divide that result by 7 days.

Line 45--Enter the average weekly cost per dialysis treatment of $405.45 ($135.15 times the average weekly number of treatments (3)). See CR 6679, Transmittal 113, dated October 30, 2009. This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.

Line 46--Enter the ESRD payment adjustment (line 44, column 1 times line 45, column 1 times line 41, column 1 plus, if applicable, line 44, column 1 times line 45, column *1.01* times line 41, column *1.01*).

Line 47--Enter the sum of lines 1, 2, *2.01,* 29, 34, and 46.

Line 48--Sole community hospitals are paid the highest 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 75 percent of the amount of the excess over the Federal rate of the highest rate for the 1982, 1987, 2002, or 2006 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 contractor. 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 hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, or 1996.

Additionally, for sole community hospitals only (effective for cost reporting periods beginning on or after January 1, 2009), use the hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, 1996, or 2006. (See 42 CFR 412.78.)

For MDH discharges occurring on or after October 1, 2006, and before October 1, 2012, an MDH can use a FY 2002 hospital specific rate.

Line 49--For SCHs, enter the greater of line 47 or 48. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2012, if line 47 is greater than line 48, enter the amount on line 47. Where line 48 is greater than line 47, enter the amount on line 47, plus 75 percent of the amount that line 48 exceeds line 47. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 47.

For hospitals subscripting column 1 of line 47 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.

Line 50--Enter the payment for inpatient program capital costs from Worksheet L, Part I, line 12; or Part II, line 5, as applicable.

Line 51--Enter the special exceptions payment for inpatient program capital, if applicable pursuant to 42 CFR 412.348(g) by entering the result of Worksheet L, Part III, line 13 less Worksheet L, Part III, line 17. If this amount is negative, enter zero on this line.

Line 52--Enter the amount from Worksheet E-4, line 49. Complete this line only for the hospital component.

Obtain the payment amounts for lines 53 and 54 from your contractor.

Line 53--Enter the amount of Nursing and Allied Health Managed Care payments if applicable.

Line 54--Enter the special add-on payment for new technologies (PM A-02-124, change request 2301, dated December 13, 2002).

Line 55--Enter the net organ acquisition cost from Worksheet(s) D-4, Part III, column 1, line 69.

Line 56--Enter the cost of teaching physicians from Worksheet D-5, Part II, column 3, line 20.

Line 57--Enter on the appropriate Worksheet E, Part A, the routine service other pass through costs from Worksheet D, Part III, column 9, lines 30 through 35 for the hospital and lines 40 through 42 as applicable for the subproviders.

Line 58--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 59--Enter the sum of lines 49 through 58.

Line 60--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:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- 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 60. 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 60 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 60.

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-4, Part III, line 66.

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 60 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 61--Enter the result of line 59 minus line 60.

Line 62--Enter from the PS&R or your records the deductibles billed to program patients.

Line 63--Enter from the PS&R or your records the coinsurance billed to program patients.

Line 64--Enter the program allowable bad debts, reduced by the bad debt recoveries. If recoveries exceed the current year's bad debts, line 64 and 65 will be negative.

Line 65--Enter the result of line 64 (including negative amounts) times 70 percent.

Line 66--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 64.

Line 67--Enter the sum of lines 61 and 65 minus the sum of lines 62 and 63.

Line 68--Enter the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in Change Request 5860, transmittal 1509, dated May 9, 2008.

Line 69--Enter *the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses* by entering the sum of lines *93, 95 and 96*.

For SCHs, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.

Line 70--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

Enter on line 70.95 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Transmittal 1 indicated the use of line 70.96 for the additional payment in accordance with the Health Care and Education Reconciliation Act (HCERA) of 2010, section 1109 which established an additional payment effective for cost reporting periods which end during Federal fiscal years 2011 and 2012 (one payment for each year) for qualifying providers under section 1886(d) of the Act and also indicated the use of Worksheet E-1, Part I, for the corresponding interim payment. Such instructions are hereby rescinded and eliminated, as section 1109 payments will be funded by a separate appropriation unrelated to Part A of the Medicare trust fund and are accordingly excluded from the Medicare cost report.

Effective for discharges occurring during Federal fiscal years 2011 and 2012 (October 1, 2010, through September 30, 2011, and October 1, 2011, through September 30, 2012, respectively), temporary improved/changed payments are mandated by §§3125 and 10314 ACA of 2010, as addressed in 42 CFR 412.101 for discharges occurring during Federal fiscal years 2011 and 2012. For cost reporting periods which overlap October 1 for years 2010, 2011, and 2012, enter on lines 70.96 (*Low Volume Adjustment for FFY 2011)* (and if necessary, line 70.97 (*Low Volume Adjustment for FFY 2012))* the Medicare inpatient payment adjustment for low volume hospitals as applicable in accordance with *Exhibit 4 (low volume adjustment calculation schedule and corresponding instructions)*. The low volume adjustment payment must also be recorded on Worksheet E-1 as an interim payment.

Line 71--Enter the amount due you (i.e., the sum of the amounts on line 67 plus or minus lines 69 and 70 minus line 68).

Line 72--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For contractor final settlements, enter the amount reported on Worksheet E-1, column 2, line 5.99 on line 73. Include in interim payment the amount received as the estimated nursing and allied health managed care payments.

Line 74--Enter line 71 minus the sum of lines 72 and 73. Transfer to Worksheet S, Part III.

Line 75--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a 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 76 through 89 were intentionally skipped to accommodate future revisions to this worksheet.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART A. LINES 90 THROUGH 96 ARE FOR CONTRACTOR USE ONLY.

Line 90--Enter the original operating outlier amount from line 2 sum of all columns of this *Worksheet E, Part A prior to the inclusion of lines 92, 93, 95, and 96 of Worksheet E, Part A.*

Line 91--Enter the original capital outlier amount from Worksheet L, part I, line 2.

Line 92--Enter the operating outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, Chapter 3, §20.1.2.5 - §20.1.2.7.

Line 93--Enter the capital outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, Chapter 3, §20.1.2.5 - §20.1.2.7.

Line 94--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 95--Enter the operating time value of money for operating related expenses.

Line 96--Enter the capital time value of money for capital related expenses.

NOTE: If a cost report is reopened more than one time, subscript lines 90 through 96, respectively, one time for each time the cost report is reopened.

Instructions For Completing Exhibit 4--

Low Volume Adjustment Calculation Schedule:

Sections 3125 and 10314 of ACA 2010 amended the low-volume hospital adjustment in section 1886(d)(12) of the Social Security Act by revising, for FYs 2011 and 2012, the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. CMS implemented these changes to the low-volume payment adjustment in the regulations at section 412.101 in the FY 2011 IPPS final rule (75 FR 50238 through 50275).

Under the ACA, sections 3125 and 10314 provide for a temporary change in the low-volume adjustment for qualifying hospitals for FYs 2011 and 2012 as follows:

- *Those hospitals with 200 or fewer Medicare discharges will receive an adjustment of an additional 25 percent for each discharge; and*
- *Those with more than 200 and fewer than 1,600 Medicare discharges will receive an adjustment of an additional percentage for each discharge. This adjustment is calculated using the formula [(4/14) - (Medicare discharges/5600)].*

To qualify as a low-volume hospital, the hospital must meet both of the following criteria:

- *Be more than 15 road miles from the nearest subsection (d) hospital; and*
- *Have fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data.*

CMS provided a table listing the IPPS hospitals with fewer than 1,600 Medicare discharges and their low-volume percentage add-on if applicable, for FYs 2011 and 2012. However, this list is not a list of all hospitals that qualify for the low-volume adjustment since it does not reflect whether or not the hospital meets the mileage criteria. Hospitals were required to request low-volume status in writing to their FI/MAC and provide documentation that they met the mileage criteria. In order to receive the applicable low-volume add-on payment, FIs/MACs will verify that the hospital meets both the discharge and mileage criteria.

The low-volume payment adjustment for eligible hospitals is based on their total per discharge payments made under section 1886 of the Act, including capital IPPS payments, DSH payments, IME payments, and outlier payments. For SCHs and MDHs, the low-volume payment adjustment for eligible hospitals is based on either the Federal rate or the hospital-specific payment (HSP) rate, whichever results in a greater operating IPPS payment. The low-volume payment amount calculated by the IPPS Pricer is an interim payment amount and is subject to adjustment during year end cost report settlement if any of the payment amounts upon which the low-volume payment amount is based are also recalculated at cost report settlement (for example, payments for DSH and IME or Federal rate versus HSP rate payments for SCHs and MDHs).

***Note:** Because a hospital's eligibility for the low-volume payment adjustment and/or a hospital's applicable low-volume adjustment percentage can change during its cost reporting period (for example, a hospital with a cost report that spans the start of the Federal Fiscal Year (FFY)), it is necessary to determine the low-volume payment amount using the applicable low-volume adjustment percentage for the FFY and payment amounts listed above for a hospital's discharges that occur during the FFY for each FFY included by the hospitals' cost reporting period.*

After the cost report is calculated for settlement the low-volume payment adjustment must be calculated. The low-volume payment amount must be calculated by FFY. Therefore, if the cost report overlaps a FFY the information computed on Worksheet E, Part A must be recomputed by FFY accordingly. The amounts may not be prorated but must be calculated using the appropriate information. The following payment amounts are multiplied by the low-volume payment adjustment percentage by FFY:

- *Operating Federal IPPS payments;*
- *Operating HSR payments;*
- *Operating Outlier payments including any Operating Outlier Reconciliation amounts;*
- *Operating IME payments;*
- *Operating IME payments for Medicare Advantage patients;*
- *Operating DSH payments;*
- *ESRD Adjustment payments;*
- *Total Capital IPPS payment*
- *New Technology payments; and*
- *Capital Outlier Reconciliation amounts (if applicable, see instructions)*

Complete Exhibit 4 to compute the low-volume adjustment applicable to this cost reporting period. ***The following Exhibit 4 is designed to simulate the Medicare cost report and must be completed after the cost report is calculated for settlement.***

Column 0--Line references are comparable to the actual line references on Worksheet E, Part A and Worksheet L, Part I.

Column 1--Enter from Worksheet E, Part A and Worksheet L, Part I, the amounts reported on the corresponding lines of the Medicare cost report.

Column 2--Enter amounts related to discharges occurring in the cost reporting period either pre-entitlement (discharges occurring in the cost reporting period prior to October 1, 2010) or post-entitlement (discharges occurring in the cost reporting period after September 30, 2012). Discharges occurring in these periods are not eligible for the low-volume adjustment.

In addition, if there are discharges occurring during either FFY 2011 or 2012 and the provider was not eligible for the low-volume adjustment for the entire eligibility period, report the information relative to those discharges in this column, for example, where a provider has a cost reporting period ending June 30, 2011. The low-volume adjustment for discharges occurring in this cost reporting period is effective for discharges on or after October, 1, 2010; however, the provider did not request the low-volume adjustment until November 15, 2010 and the low-volume adjustment was implemented within 30 days of the request. The period of time from October 1, 2010 until the MAC notified the provider of eligibility, which should be no later than December 15, 2010, is considered a period of ineligibility.

Column 3--Enter amounts related to discharges occurring on or after October 1, 2010 through September 30, 2011 in column 3. Do not include information for discharges occurring during the period of ineligibility.

Column 4--Enter amounts related to discharges occurring during the period of October 1, 2011 through September 30, 2012 in column 4. Do not include information for discharges occurring during the period of ineligibility.

Column 5--Subtotal columns 2 through 4. Column 5 must agree with column 1 and any resulting rounding difference should be applied to the highest value in columns 2-4.

Line Descriptions

Line 1--The amount entered on this line is computed as the sum of the Federal operating portion (DRG payment) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement.

Line 2--Enter the amount of outlier payments made for PPS discharges occurring during the cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement.

Line 3 (Corresponds to Worksheet E, Part A, Line 2.01)--For inpatient PPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line Worksheet E, Part A, line 92 for each respective period. The lump sum utility produces a claim by claim output. If the provider has two different low-volume hospital adjustment percentages during its cost reporting period, the MAC must report the operating and capital outlier reconciliation adjustment amounts for the discharges occurring in each of the federal fiscal years spanned by the cost report separately. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 2.01.

Line 4 (Corresponds to Worksheet E, Part A, Line 3)--Enter the indirect medical education for managed care patients based on the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture, in conjunction with the PPS PRICER, the simulated payments. Enter the total managed care "simulated payments" from the PS&R. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement.

Line 5 (Corresponds to Worksheet E, Part A, Line 21)--Enter the ratio calculated from Worksheet E, Part A, line 21, in columns 2 through 4.

Line 6 (Corresponds to Worksheet E, Part A, Line 22--Calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times {the sum of line 1 + line 4}. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 22.

Line 7 (Corresponds to Worksheet E, Part A, Line 27)-- Enter the ratio calculated from Worksheet E, Part A, line 27, in columns 2 through 4.

Line 8 (Corresponds to Worksheet E, Part A, Line 28)--IME Add On Adjustment--Enter the sum of lines 1 and 4, multiplied by the factor on line 7.

Line 9 (Corresponds to Worksheet E, Part A, Line 29)--Total IME Payment--Enter the sum of lines 6 and 8. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 29.

Line 10 (Corresponds to Worksheet E, Part A, Line 33)--Enter the DSH percentage calculated from Worksheet E, Part A, line 33, in columns 2 through 4.

Line 11 (Corresponds to Worksheet E, Part A, Line 34)--Multiply line 10 by line 1. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 34.

Line 12 (Corresponds to Worksheet E, Part A, Line 46)--Prorate in columns 2 through 4 the amount reported on Worksheet E, Part A, line 46, based on the ratio of days in each applicable period to total days in the cost reporting period. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 46.

Line 13 (Corresponds to Worksheet E, Part A, Line 47)--Enter the sum of lines 1, 2, 3, 9, 11 and 12.

Line 14 (Corresponds to Worksheet E, Part A, Line 48)--For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments. The sum of columns 2 through 4 must equal the amount reported on Worksheet E Part A, line 48. If Worksheet E, Part A, line 47 is greater than Worksheet E, Part A, line 48, do not complete this line.

Line 15 (Corresponds to Worksheet E, Part A, Line 49)--Enter in column 1, the amount from Worksheet E, Part A, line 49. For SCHs, if line 13, column 1 is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, for each applicable column. If line 14, column 1 is greater than line 13, column 1, enter in columns 2 through 4, the amount reported on line 14, for each applicable column. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2012, if line 13, column 1 is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 through 4, the amount on line 13, for each applicable column, plus or minus 75 percent of the difference between line 14 minus line 13 for each applicable column. Hospitals not qualifying as SCH or MDH providers will enter in columns 2 through 4, the amount from line 13, for each applicable column. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 49.

Line 16 (Corresponds to Worksheet E, Part A, Line 50)--Enter in columns 2 through 4, the amounts computed from line 26, columns 2 through 4. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 50.

Line 17 (Corresponds to Worksheet E, Part A, Line 54)--Enter the special add-on payment for new technologies. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement.

Line 18 (Corresponds to Worksheet E, Part A, Line 93)--Enter the capital outlier reconciliation adjustment amount in columns 2 through 4 accordingly. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 93.

Line 19 Subtotal--Enter in columns 2 through 4, the sum of amounts on lines 15, 16, 17 and 18. For SCH, if the hospital specific payment amount on line 14, column 1, is greater than the federal specific payment amount on line 13, column 1, enter in columns 2 through 4, the sum of the amounts on lines 15, 16 and 17.

Line 20 (Corresponds to Worksheet L, Part I, Line 1)--Enter the amount of the federal rate portion of the capital DRG payments for other than outlier during this cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 1.

Line 21 (Corresponds to Worksheet L, Part I, Line 2)--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during this cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 2.

Line 22 (Corresponds to Worksheet L, Part I, Line 5)-- Enter the ratio calculated from Worksheet L, Part I, line 5 in all applicable columns.

Line 23 (Corresponds to Worksheet L, Part I, Line 6)--Multiply line 22 by line 20. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 6.

Line 24 (Corresponds to Worksheet L, Part I, Line 10)--Enter the percentage calculated from Worksheet L, Part I, line 10 in all applicable columns.

Line 25 (Corresponds to Worksheet L, Part I, Line 11)--Multiply line 24 by line 20 and enter the result. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 11.

Line 26 (Corresponds to Worksheet L, Part I, Line 12)--Enter the sum of lines 20, 21, 23 and 25. Transfer this amount to line 16. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 12.

Low-volume adjustment--Effective for discharges occurring during FFYs 2011 and 2012, compute the amount of the low-volume adjustment as follows:

Line 27--Low-volume adjustment factor--Enter the appropriate adjustment factor in columns 3 and 4.

Line 28 (Corresponds to Worksheet E, Part A, Line 70.96)--Multiply line 19 by line 27. Transfer this amount to the cost report calculated for settlement, Worksheet E, Part A, line 70.96.

Line 29 (Corresponds to Worksheet E, Part A, Line 70.97)--Multiply line 19 by line 27. Transfer this amount to the cost report calculated for settlement, Worksheet E, Part A, line 70.97.

EXHIBIT 4

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE

LOW VOLUME CALCULATION EXHIBIT 4	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	

		W/S E, Part A line	(Amounts from E pt A)	(prior to 10/1/10 or after 9/30/12 Pre/Post Entitlement	10/01/2010 thru 09/30/2011	10/01/2011 thru 09/30/2012	(col. 2 through 4) Total	
		(0)	(1)	(2)	(3)	(4)	(5)	
1	DRG Amounts Other than Outlier Payments	1						1
2	Outlier payments for discharges. (see instructions)	2						2
3	Operating outlier reconciliation	2.01						3
4	Managed Care Simulated Payments	3						4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E, Part A, line 21 (see instructions)	21						5
6	IME payment adjustment (see instructions)	22						6
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	Amount from Worksheet E Part A, line 27 (see instructions)	27						7
8	IME Adjustment (see instructions)	28						8
9	Total IME payment (sum of lines 6 and 8)	29						9
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage (see instructions)	33						10
11	Disproportionate share adjustment (see instructions)	34						11
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment (see instructions)	46						12
13	Subtotal (see instructions)	47						13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48						14
15	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49						15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50						16
17	Special add-on payments for new technologies	54						17
18	Capital outlier reconciliation adjustment amount (see instructions)	33						18
19	**SUBTOTAL**							19
		W/S L, line	(Amounts from L)					
		(0)	(1)	(2)	(3)	(4)	(5)	
20	Capital DRG other than outlier	1						20
21	Capital DRG outlier payments	2						21
22	Indirect medical education percentage (see instructions)	5						22
23	Indirect medical education adjustment (line 1 times line 5)	6						23
24	Allowable disproportionate share percentage (see instructions)	10						24
25	Disproportionate share adjustment (line 10 times line 1)	11						25
26	Total prospective capital payments (sum of lines 1-2, 6 and 11)	12						26
		W/S E, Part A line	(Amounts to E pt A)					
		(0)	(1)	(2)	(3)	(4)	(5)	
27	Low volume adjustment factor							27
28	Low volume adjustment (transfer amount to Worksheet E part A) (FY 2011)							28
29	Low volume adjustment (transfer amount to Worksheet E part A) (FY 2012)							29

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4030.2 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. For purposes of prospective payment for outpatient services *when the PCR transition date (applicable to cancer hospitals) (see the following paragraph), transitional outpatient payment calculation date, or geographic reclassification date (urban to rural only) (42 CFR 412.103 and 412.230) occurs at other than the cost report period beginning date*, complete subscripted column 1.01 *in addition to column 1* for lines 2 through 8 only. Order the subscripted columns chronologically as the transition dates or geographic reclassification corresponds to your fiscal year. The dates should also agree with the format on Worksheet D, Part V, columns 2, 2.01, 2.02 and 2.03, etcetera, if applicable.

In accordance with ACA 2010, section 3138, cancer hospitals (as defined in 42 CFR 412.23(f)) must utilize a predetermined PCR to calculate the corresponding transitional outpatient payment effective for services rendered beginning January 1, 2012. Where the cost reporting period overlaps a PCR revision date, subscript column 1 as indicated in the preceding paragraph to correspond to each unique PCR. For calendar year 2012 the PCR for cancer hospitals is 0.91, but is subject to change every calendar year. Enter the applicable PCR(s) on line 5, column 1 and applicable subscripts. See Federal Register, vol. 76, November 30, 2011, page 74206.

NOTE: If you are not a cancer or children's hospital or covered by ACA section 3121, do not complete lines 2 and 5 through 8.

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 202, columns 6 and 7, for hospitals and enter in column 1. For SNFs transfer the amount from Worksheet D, Part V, columns 6 and 7.

The following providers are temporarily eligible for hold harmless payments and must use columns 1 and 1.01 to correspond to the respective portion of the cost reporting period for lines 2 through 8. *Rural hospitals with 100 or fewer beds whose reporting period overlaps December 31, 2012 are eligible through December 31, 2012; SCHs and EACHs regardless of bed size whose reporting period overlaps February 29, 2012 are eligible through February 29, 2012; and SCHs and EACHs with 100 or fewer beds whose reporting period overlaps December 31, 2012 are eligible through December 31, 2012*, (Worksheet S-2, Part I, line 120, column 1 *or 2* is "Y" for yes).

CAHs are not subject to transitional corridor payments, therefore lines 2 through 9 do not apply to CAHs. Transfer Worksheet D, Part V, columns 6 and 7, line 202.

Line 2--Enter the cost of medical and other health services reimbursed under OPPS from Worksheet D, Part V, column 5 and applicable subscripts, line 202. Subtract from this amount outpatient pass through costs reported on Worksheet D, Part IV, line 200, column 13.

Line 3--Enter the gross PPS payments received including payment for drugs and device pass through payments.

Line 4--Enter the amount of outlier payments made for outpatient PPS services rendered during the cost reporting period.

Contractors only, add or subtract as applicable to the gross PPS payments the total outlier reconciliation amount from line 94.

Line 5--Enter the hospital specific payment to cost ratio provided by your contractor. 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)

For cancer hospitals enter a PCR of 0.91 for services rendered during calendar year 2012. Obtain subsequent cancer hospital PCR updates from your contractor or applicable CMS publications.

Line 6--Enter the result of line 2 times line 5.

If the sum of lines 3 and 4 is < line 6 complete lines 7 and 8, otherwise do not complete lines 7 and 8.

Line 7--Enter the result of the sum of lines 3 and 4 divided by line 6.

Line 8--Enter the transitional corridor payment amount calculated based on the following:

a. If the sum of lines 3 and 4 is < line 6 and Worksheet S-2, Part I, line 3, column 4 response is 3 or 7 (cancer or children's hospital), enter the result of line 6 minus the sum of lines 3 and 4.

In accordance with ACA 2010, section 3121, and MMEA of 2010, section 108, *as amended by the Temporary Payroll Tax Cut Continuation Act of 2011, section 308, and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002,* the outpatient hold harmless provision is effective for services *rendered* from January 1, 2010 through *February 29, 2012 to all SCHs and EACHs regardless of bed size; and from March 1, 2012 through December 31, 2012 to all SCHs and EACHs with 100 or fewer beds; and from* January 1, 2010 through December 31, *2012 for* rural hospitals with 100 or fewer beds.

a. For services rendered January 1, 2010 through December 31, *2012*, if Worksheet S-2, Part I, line 120, columns 1 or 2 is "Y", enter 85 percent of the result of line 6 minus the sum of lines 3 and 4.

Line 9--Enter the outpatient ancillary pass through amount from *W*orksheet D, Part IV, column 13, line 200.

Line 10--If you are an approved CTC, enter the cost of organ acquisition from Worksheet D-4, Part III, column 2, line 69 when Worksheet E is completed for the hospital or the hospital component of a health care complex. Make no entry on line 10 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 11--Enter the sum of lines 1 and 10.

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 or customary charges as defined in 42 CFR 413.13(a).

NOTE: CAHs are not subject to the computation of the lesser of reasonable costs or customary charges. If the component is an CAH, do not complete lines 12 through 20. Instead, enter on line 21 the amount computed on line 11.

Line Descriptions

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see 42 CFR 413.13(c)), also enter the total reasonable cost from line 11 directly on line 21. Still complete lines 6 through 16 to insure that you meet one of the criteria for this exemption.

Lines 12 - 20--These lines provide for the accumulation of charges which relate to the reasonable cost on line 11.

Do not include on these lines: (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, §2104.3) and (2) charges to beneficiaries for excess costs. (See CMS Pub. 15-1, §§2570-2577.)

Line 12--For total charges for medical and other services, enter the sum of Worksheet D, Part V, columns 3 and 4, line 202.

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Line 13--If you are an approved CTC, enter the organ acquisition charges from Worksheet D-4, Part III, column 4, line 69 when Worksheet E is completed for the hospital or the hospital component of a health care complex.

Line 14--Enter the sum of lines 12 and 13.

Lines 15 - 18--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the 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 17 is greater than zero, multiply line 14 by line 17, and enter the result on line 18. 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 15 through 17. Enter on line 18 the amount from line 14. In no instance may the customary charges on line 18 exceed the actual charges on line 14. (See 42 CFR 413.13(e).)

Line 19--Enter the excess of the customary charges over the reasonable cost. If line 18 exceeds line 11, enter the difference.

Line 20--Enter the excess of reasonable cost over the customary charges. If line 11, exceeds line 18, enter the difference.

Line 21--Enter the amount from line 11, less any amount reported on line 20 for hospital/services subject to LCC.

For hospital/services that are not subject to LCC in accordance with 42 CFR 413.13 (e.g., CAHs or nominal charge public or private hospitals identified on Worksheet S-2, Part I, lines 155-161), enter the reasonable costs from line 11.

For CAHs enter on this line 101 percent of line 11.

Line 22--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

Provider/Component	Title XVIII Hospital	Title XVIII Subprovider	Title XVIII Skilled Nursing Facility
Hospital	Part I, col. 9, line 9 plus line 27; or Part II, col. 7, line 37; or Part III, col. 6, line 45	Part I, col. 9, lines 10, 11 or 12; or Part II, col. 7, col. lines 38, 39 or 40 or Part III, col. 6, line 46, 47 or 48	Part I, col. 9, line 13; or Part II, 7, line 41; or Part III, col. 6, line 49

Line 23--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost (see 42 CFR 415.160 and CMS Pub. 15-1, §2148), enter the amount from Worksheet D-5, Part II, column 3, line 21.

Line 24--Enter the sum of lines 3, 4, 8, and 9, all columns.

Computation of reimbursement Settlement

Line 25--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 26--Enter the deductible and coinsurance relating to the amounts reported on line 24.

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, Part I, lines 155-161 columns 1-5, as applicable), enter the Part B deductibles billed to program beneficiaries only. Do not enter any Part B coinsurance. For CAHs enter the deductibles on line 25 and the coinsurance on line 26.

Line 27--Subtract lines 25 and 26 from lines 21 and 24 respectively. Add to that result the sum of lines 22 and 23.

NOTE: If these services are exempt from LCC, line 21 minus line 25 times 80 percent plus lines 22 and 23. Add to that result line 24 minus line 26.

For critical access hospitals (CAHs), enter the lesser of (line 21 minus the sum of lines 25 and 26) or 80 percent times the result of (line 21 minus line 25 minus 101% of lab cost (Worksheet D, Part V, column 6, lines 60, 61, and subscripts) minus 101% of *costs not subject to deductible and coinsurance* (Worksheet D, Part V, column 7, line *200*). Add back the aforementioned *101% of* lab *cost* and *101% of cost not subject to deductibles and coinsurance*. Add to that result the sum of lines 22 and 23.

Line 28--Enter in column 1 the amount from Worksheet E-4, line 50. Complete this line for the hospital component only.

Line 29--Enter in column 1 the amount from Worksheet E-4, line 36. Complete this line for the hospital component only.

Line 30--Enter in column 1 the sum of columns 1 and 1.01, lines 27 through 29.

Line 31--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:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- 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 31. 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 31 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 31.

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 and pass through payments. 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:

Reimbursement Method	From Column	Transfer To
Part B Payments	4	Wkst. E, Part B, line 41
Part A Payments		
IPPS	2	Wkst. E, Part A, line 72
TEFRA	2	Wkst. E-3, Part I, line 19
IPF PPS	2	Wkst. E-3, Part II, line 32
IRF PPS	2	Wkst. E-3, Part III, line 33
LTC PPS	2	Wkst. E-3, Part IV, line 23
Cost	2	Wkst. E-3, Part V, line 31
SNF PPS Title XVIII	2	Wkst. E-3, Part VI, line 16

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.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 8 ARE FOR CONTRACTOR 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:

Worksheet E-1, Column as Indicated	From Settlement Worksheet
2	Wkst. E, Part A, line 74
4	Wkst. E, Part B, line 43
2	Wkst. E-3, Part I, line 21
2	Wkst. E-3, Part II, line 34
2	Wkst. E-3, Part III, line 35
2	Wkst. E-3, Part IV, line 25
2	Wkst. E-3, Part V, line 33
2	Wkst. E-3, Part VI, line 18

For swing bed-SNF services, column 2 must equal Worksheet E-2, column 1, line 22. Column 4 must equal Worksheet E-2, column 2, line 22.

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. These amounts must agree with amount due provider reported on Worksheet E, Part A, line 71; Worksheet E, Part B, line 40; Worksheet E-2, line 19; Worksheet E-3, Part I, line 18; Worksheet E-3, Part II, line 31; Worksheet E-3, Part III, line 32; Worksheet E-3, Part IV, line 22; Worksheet E-3, Part V, line 30; and Worksheet E-3, Part VI, line 15.

Line 8--Enter the contractor name, the contractor number *and NPR date* in columns *0*, 1 and 2, respectively.

4031.2 Part II - Calculation of Reimbursement Settlement for Health Information Technology--

THIS PART IS COMPLETED BY THE CONTRACTOR FOR STANDARD COST REPORTING PERIODS AND BY THE CONTRACTOR FOR NONSTANDARD COST REPORTING PERIODS.

In accordance with the American Recovery and Reinvestment Act (ARRA) of 2009, section 4102, inpatient acute care services under IPPS (providers subject to section 1886(d) of the Act) and CAHs are eligible for health information technology (HIT) payments.

This *part* captures relevant data *used to compute the* HIT payment and records *the single HIT initial payment* paid by the contractor to the provider and *any* corresponding adjustments *to this initial payment*.

Data Collection Required for the Health Information Technology Calculation--

NOTE: Lines 1 through 7 must transfer data as indicated below for reporting periods which cover exactly 12 months (referred to as standard cost reporting periods *and covers a range of 360 through 371 days*). For cost reporting periods which cover other than exactly 12 months (less than or greater than 12 months (referred to as nonstandard cost reporting periods *and covers a range of less than 360 days or greater than 371 days)* lines 1 through 8 must be directly input *by the contractor***.**

NOTE: For standard cost reporting periods, the provider will complete lines 30 and 31 in the "as filed" cost report and the amount computed on line 32 will be transferred to Worksheet S, Part III, column 4. For non-standard cost reporting periods, the "as filed" cost report will display zeros on all lines and a zero will be transferred from line 32 to Worksheet S, Part III, column 4. The contractor must complete this worksheet for nonstandard cost reporting periods.

Line 1--As defined in ARRA, section 4102, transfer the total hospital discharges from Worksheet S-3, Part I, column 15, line 14.

Line 2--Transfer the Medicare days from Worksheet S-3, Part I, column 6, sum of lines 1 and 8 through 12.

Line 3--Transfer the Medicare HMO days from Worksheet S-3, Part I, column 6, line 2.

Line 4--Transfer the total inpatient *days* from Worksheet S-3, Part I, column 8, sum of lines 1 and 8 through 12.

Line 5--Transfer the hospital charges from Worksheet C, Part I, column 8, line 200.

Line 6--Transfer the hospital charity care charges from Worksheet S-10, column 3, line 20.

Line 7--CAHs only, transfer the reasonable costs to purchase certified HIT technology from Worksheet S-2, Part I, line 168.

Line 8--Calculate and enter the HIT payment in accordance with ARRA, section 4102 as indicated below. This line can be overridden by the contractor in instances where the provider's circumstances require a customized HIT calculation.

For CAHs, if Worksheet S-2, lines 105 and 167 are both "Y" for yes, enter the result of {(H1)/(line 4 x H2)} + .20 times the amount on Worksheet S-2, Part I, **line 168**. (Note: the result of {(H1)/(line 4 x H2)} + .20 cannot exceed 100 percent.) The resulting amount must be fully expensed in the current reporting period. H1 = Line 2 plus line 3. H2 = Total charges from Worksheet C, Part I, column 8, line 200 minus charity care charges from Worksheet S-10, column 3, line 20 divided by Worksheet C, Part I, column 8, line 200.

OR

For acute care IPPS hospitals (§1886(d) of the Act), if Worksheet S-2, line 105 is "N" for no and line 167 is "Y" for yes, enter the result of {($2,000,000.00 + H1) x {(H2)/(line 4 x H3)} x H4}. If line 1 is less than 1,150 discharges then H1 equals 0 (zero). If line 1 equals 1,150 through 23,000 discharges, then H1 equals the result of line 1 minus 1,149 times $200. If line 1 is greater than or equal to 23,000 discharges then H1 = $4,370,200 [that is: 23,000 minus 1,149 times $200]. H2 = Line 2 plus line 3. H3 = Total charges from Worksheet C, Part I, column 8, line 200 minus charity care charges from Worksheet S-10, column 3, line 20 divided by Worksheet C, Part I, column 8, line 200. H4 = The transition factor from Worksheet S-2, Part I, line 169.

Lines 9 - 29--Reserved for future use.

Inpatient Hospital Services Under IPPS & CAH--

Line 30--Enter the initial (*first*) payment *received* for HIT assets *for this cost reporting period*. This *initial* payment is *a single* payment *for the cost reporting period rather than a* series of *periodic interim* payments *during the period*. *This line must be completed by the providers for standard cost reporting periods and by the contractors for nonstandard cost reporting periods.*

Line 31--Enter *the sum of all additional initial payment adjustments, as applicable for this cost reporting period*. *Enter a positive amount on this line if the sum of the initial payment adjustments represents an increase to the initial payment. Enter a negative amount on this line if the sum of the initial payment adjustments represents a decrease to the initial payment.*

Line 32--Balance Due Provider/(Program)--Calculate and enter the result of line 8 minus *the sum of* line*s* 30 *and* 31. Transfer this amount to Worksheet S, Part III, column 4, line 1.

4032. WORKSHEET E-2 - CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

This worksheet provides for the reimbursement calculation for swing bed services rendered to program patients under titles V, XVIII, and XIX. It provides for an accumulation of reimbursable costs determined on various worksheets within the cost report package. It also provides (under Part B) for the computation of the lesser of 80 percent of reasonable cost after deductibles or reasonable cost minus coinsurance and deductibles. These worksheets have been designed so that components must prepare a separate worksheet for swing bed-SNF title XVIII, Parts A and B, and separate worksheets for swing bed-NF for title V and title XIX. Use column 1 only on the worksheets for title V and title XIX. Indicate the use of each worksheet by checking the appropriate boxes.

Lines 1 - 9--Enter in the appropriate column on lines 1 through 7 the indicated costs for each component of the health care complex.

Line 1--Enter the cost of swing bed-SNF inpatient routine services transferred from Worksheet D-1, Part II, line 66 (title XVIII only). Since swing beds are paid on the basis of SNF PPS, enter the total PPS payments in column 1 or 2, as applicable, from the provider's books and records or the PS&R. (See Vol. 67 FR 147 dated July 31, 2002 and PM A-02-016, change request 1666) CAHs transfer 101 percent of the amount from *W*orksheet D-1, part II, line 66.

Do not use lines 2 and 3 for swing bed SNF PPS providers.

Line 2--Enter the cost of swing bed-NF inpatient routine services transferred from Worksheet D-1, Part II, line 69 (titles V and XIX only). Make no entry on line 2 when Worksheet E-2 is used for swing bed-SNF.

Line 3--Enter the amount of ancillary services. CAHs transfer for Title XVIII services 101 percent of the amounts from the applicable worksheets):

Title V	from	Worksheet D-3, col. 3, line 200
Title XVIII, Part A	from	Worksheet D-3, col. 3, line 200
Title XVIII, Part B	from	The sum of Worksheet D, Part V, cols. 6 and 7, line 202
Title XIX	from	Worksheet D-3, col. 3, line 200

Enter title XVIII, Part B amounts only in column 2. Enter all other amounts in column 1.

Line 4--Enter (in column 1 for titles V and XIX and in column 2 for title XVIII) the per diem cost for interns and residents not in an approved teaching program transferred from Worksheet D-2, Part I, column 4, line 2.

Line 5--For title XVIII, enter in column 1 the total number of days in which program swing bed-SNF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 10 and 11. For titles V or XIX, enter in column 1 the total number of days in which program swing bed-NF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 12 and 13. For title XVIII, enter in column 2 the total number of days in which Medicare swing bed beneficiaries were inpatients and had Medicare Part B coverage. Determine such days without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days.

4033. 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
Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS
Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS
Part IV - Calculation of Medicare Reimbursement Settlement Under LTCH PPS
Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement (CAHs)
Part VI - Calculation of Reimbursement Settlement - All Other Health Services for Part A Services for Title XVIII PPS SNFs
Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services

4033.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA--Use Worksheet E-3, Part I to calculate Medicare reimbursement settlement under TEFRA (includes cancer and children's hospitals) 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

Line 1--Enter (for TEFRA hospitals and subproviders) the amount from Worksheet D-1, Part II, line 63.

Line 2--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-4, Part III, column 1, line 69 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-5, Part II, column 3, line 20.

Line 4--Enter the sum of lines 1, 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:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- 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 allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 11 and 12 will be negative.

Line 12--Multiply the amount (including negative amounts) from line 11 by 70 percent.

Line 13--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 11.

Line 14--Enter the sum of lines 10 and 12.

Line 15--Enter the amount from Worksheet E-4, line 49 for the hospital component only.

Line 16--*DO NOT USE THIS LINE.*

Line 17--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. 15-1, §2146.4.) Specify the adjustment in the space provided.

Enter on line 17.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 18--Enter the sum of lines 14, 15, and 16 plus or minus line 17.

Line 19--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 20 the amount on line 5.99.

Line 21--Enter line 18 minus the sum of lines 19 and 20. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 22--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a 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.

4033.2 Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS--Use Worksheet E-3, Part II to calculate Medicare reimbursement settlement under IPF PPS for hospitals and subproviders. (See 42 CFR 412, subpart N.)

Use a separate copy of Worksheet E-3, Part II for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part II 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

Line 1--Enter the net Federal IPF PPS payment. This amount excludes payments for outliers, electroconvulsive therapy (ECT), and the teaching adjustment. Obtain this information from the PS&R and/or your records.

Line 2--Enter the net IPF outlier payment. Obtain this from the PS&R and/or your accounting books records.

Line 3--Enter the net IPF payments for ECT. Obtain this from the PS&R and/or your accounting books and records.

NOTE: Complete only line 4 or line 5, but not both.

Line 4--For providers that trained residents in the most recent **cost reporting period filed on or before November 15, 2004** (response on Worksheet S-2, Part I, line 71, 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 FR, volume 69, No. 219, dated November 4, 2004, page 66922 for a detailed explanation.

Line 4.01--Effective for cost reporting periods beginning on or after July 1, 2011 for IPFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, that you would not be able to count without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2). Further subscript this line (lines 4.02 through 4.20) as necessary if the IPF receives temporary FTE cap adjustments under §412.424(d)(1)(iii)(F)(1) or (2) on more than one occasion for FTEs displaced by more than one closed program or closed hospital. If the effective date of the cap increase is not the same as your fiscal year beginning date, prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period.)

Line 5--For providers that did not train residents in the most recent cost report filed before November 15, 2004, but qualify to receive a cap adjustment under §412.424(d)(1)(iii) for training residents in a newly accredited program(s) after that cost reporting period, enter the unweighted cap adjustment (response to Worksheet S-2, Part I, line 71, 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 6--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 4th program year of the first new program, then prorate the count accordingly.

Line 7--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 4th program year of the first new program, then prorate the count accordingly.

Line 8--For providers that completed line 4, enter the lower of the FTE count on line 6 or the *sum of the* cap amounts on line*s* 4 *and 4.01 (and applicable subscripts 4.02 through 4.20).*

For providers that qualify to receive a cap adjustment under §412.424(d)(1)(iii) during the first 3 program years of the first new program's existence, enter the FTE count from line 7.

Beginning with the 4th program year of the first new program's existence, enter the lower of the FTE count on line 6 or the FTE count on line 5. Add to this count the FTEs on line 7 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 4th program year of the first new program.

Line 9--Enter the total IPF patient days divided by the number of days in the cost reporting period (Worksheet S-3, Part I, column 8, line 1 (independent/freestanding) or 16 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 10--Enter the medical education adjustment factor by adding 1 to the ratio of line 8 to line 9. 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 + (line 8 / line 9)) to the .5150 power - 1}.

Line 11--Enter the medical education adjustment by multiplying line 1 by line 10.

Line 12--Enter the adjusted net IPF PPS payments by entering the sum of lines 1, 2, 3, and 11.

Line 13--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-IPPS hospital that does not complete Worksheet E, Part A.

Line 14--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-4, Part III, column 1, line 69 when Worksheet E-3, Part II, is completed for the freestanding/independent IPF (or the hospital based IPF/unit of a health care complex). Make no entry on line 14 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 15--For IPFs or IPF subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter the amount from Worksheet D-5, Part II, column 3, line 20.

Line 16--Enter the sum of lines 12, 13, 14 and 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:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- 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 17. 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 17 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 17 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 18--Enter line 16 minus line 17.

Line 19--Enter the Part A deductibles.

Line 20--Enter line 18 minus line 19.

Line 21--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 22--Enter the result of subtracting line 21 from line 20.

Line 23--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 23 and 24 will be negative.

Line 24--Multiply the amount (including negative amounts) from Line 23 by 70 percent.

Line 25--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 23.

Line 26--Enter the sum of lines 22 and 24.

Line 27--Enter the amount from Worksheet E-4, line 49 for the hospital component (*freestanding IPF)* only. *Do not complete this line for an IPF unit.*

Line 28--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility or line 40 for the IPF subprovider. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 29--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 30--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. 15-1, §2146.4.) Specify the adjustment in the space provided.

Enter on line 30.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 31--Enter the sum of lines 26, *27* and 28 plus or minus lines 29 and 30.

Line 32--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 33 the amount on line 5.99.

Line 34--Enter line 31 minus the sum of lines 32 and 33. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 35--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a 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.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-3, PART II. LINES 50 THROUGH 53 ARE FOR CONTRACTOR USE ONLY.

Line 50--Enter the original outlier amount from *W*orksheet E-3, Part II, line 2.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, Chapter 3, §190.7.2.3 - §190.7.2.5.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-4, Chapter 3, §190.7.2.3 - §190.7.2.5.)

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.

4033.3 Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS--Use Worksheet E-3, Part III to calculate Medicare reimbursement settlement under IRF PPS for hospitals and subproviders. (See 42 CFR 412, subpart P.)

Use a separate copy of Worksheet E-3, Part III for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part III 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

Line 1--Enter the net Federal IRF PPS payment. 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.

Line 2--Enter the Medicare SSI ratio from your contractor as applicable for a freestanding IRF (IRF hospital or facility) or a hospital based IRF (subprovider or subunit).

Line 3--IRF LIP payment, enter the result of {(1 + (line 2) +(L1/L2)) to the .4613 power - 1} times (line 1). L1 = IRF Medicaid Days from Worksheet S-2, Part I, columns 1 through 6, line 25. L2 = IRF total days from Worksheet S-3, Part I, column 8, lines 1 or 17 and subscripts as applicable plus employee discount days (S-3, Part I, column 8, line 30 (line 31 for IRF subproviders)).

Line 4--Enter the IRF outlier payment. Obtain this from the PS&R and/or your records.

NOTE: Complete only line 5 or line 6, but not both.

Line 5--For providers that trained residents in the most recent **cost reporting period ending on or before November 15, 2004** (response to Worksheet S-2, Part I, line 76, 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.

Line 5.01--Effective for cost reporting periods beginning on or after October 1, 2011 for IRFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, that you would not be able to count without a temporary cap adjustment in accordance with FR, volume 76, No. 151, dated August 5, 2011, page 47846. Further subscript this line (lines 5.02 through 5.20) as necessary if the IRF receives temporary FTE cap adjustments on more than one occasion for FTEs displaced by more than one closed program or closed hospital in accordance with the FR. If the effective date of the cap increase is not the same as your fiscal year beginning date, prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period.)

Line 6--For providers that did not train residents in the most recent cost reporting period ending on or before November 15, 2004, that qualify to receive a cap adjustment (see FR Vol. 70, No. 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 Worksheet S-2, Part I, line 76, 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 7--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 4th program year of the first new program, then prorate the count accordingly.

Line 8--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 4th program year of the first new program, then prorate the count accordingly.

Line 9--For providers that completed line 5, enter the lower of the FTE count on line 7 or the *sum of the* cap amount*s* on line*s* 5 *and 5.01 (and applicable subscripts 5.02 through 5.20).*

For providers that qualify to receive a cap adjustment (see FR Vol. 70, No. 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 8.

Beginning with the 4th program year of the first new program's existence, enter the lower of the FTE count on line 7 or the FTE count on line 6. Add to this count the FTEs on line 8 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 4th program year of the first new program.

Line 10--Enter the total IRF patient days divided by the number of days in the cost reporting period (Worksheet S-3, column 8, line 1 (independent/freestanding) or 17 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 11--Enter the medical education adjustment factor by adding 1 to the ratio of line 9 to line 10. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as {(1 + (line 9 / line 10)) to the .6876 power - 1}.

Line 12--Enter the medical education adjustment by multiplying line 1 by line 11. Add this amount to line 13.

Line 13--Enter the sum of lines 1, 3, 4 and 12.

Line 14--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-IPPS hospital that does not complete Worksheet E, Part A.

Line 15--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-4, Part III, column 1, line 69 when Worksheet E-3, Part III, is completed for the freestanding/independent IRF (or the hospital based IRF/unit of a health care complex). Make no entry on line 15 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 16--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-5, Part II, column 3, line 20.

Line 17--Enter the sum of lines 13, 14, 15 and 16.

Line 18--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:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,

- Disability provisions, and
- 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 18. 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 18 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 18 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 19--Enter line 17 minus line 18.

Line 20--Enter the Part A deductibles.

Line 21--Enter line 19 less line 20.

Line 22--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 23--Enter the result of subtracting line 22 from line 21.

Line 24--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 24 and 25 will be negative.

Line 25--Multiply the amount (including negative amounts) from line 24 by 70 percent.

Line 26--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 24.

Line 27--Enter the sum of lines 23 and 25.

Line 28-- Enter the amount from Worksheet E-4, line 49 for the hospital component (*freestanding IRF)* only. *Do not complete this line for an IRF unit.*

Line 29--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility or line 41 for IRF the subproviders. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

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 8 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 8 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 9--Enter line 7 minus line 8.

Line 10--Enter the Part A deductibles.

Line 11--Enter line 9 less line 10.

Line 12--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 13--Enter the result of subtracting line 12 from line 11.

Line 14--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 14 and 15 will be negative.

Line 15--Multiply the amount (including negative amounts) from line 14 by 70 percent.

Line 16--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 14.

Line 17--Enter the sum of lines 13 and 15.

Line 18-- Enter the amount from Worksheet E-4, line 49 for the hospital component (*freestanding LTCH)* only.

Line 19--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 20--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 21--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. 15-1, §2146.4.) Specify the adjustment in the space provided.

Enter on line 21.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 22--Enter the sum of lines 17, 18, and 19 plus or minus lines 20 and 21.

Line 23--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 24 the amount on line 5.99.

Line 25--Enter line 22 minus the sum of lines 23 and 24. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 26--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a 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.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-3, PART IV. LINES 50 THROUGH 53 ARE FOR CONTRACTOR USE ONLY.

Line 50--Enter the original outlier amount from *W*orksheet E-3, Part IV, line 2.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, Chapter 3, §150.26 - §150.28.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-4, Chapter 3, §150.26 - §150.28)

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.

4033.5 Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement (CAHs)--Use Worksheet E-3, Part V, to calculate reimbursement settlement for Medicare Part A services furnished by critical access hospitals under cost reimbursement (i.e., neither PPS nor TEFRA).

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs:

Hospital (CAH) - Worksheet D-1, Part II, line 49

Line 2--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable. Only complete this line if your facility is a CAH that does not complete Worksheet E, Part A.

Line 3--If you are approved as a CTC, enter the cost of organ acquisition from Worksheet D-4, Part III, column 1, line 69 when this worksheet 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--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:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- 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--CAHs enter on this line 101 percent of *the amount on* line 4, minus line 5.

Computation of Lesser of Reasonable Cost or Customary Charges--**CAHs are not subject to this provision for inpatient services.**

Line Descriptions

NOTE: Do not complete lines 7 through 16.

Lines 7 - 16--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. 15-1, §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-1, §§2570-2577.

Line 7--Enter the program inpatient routine service charges from your records for the applicable component. Include charges for both routine and special care units. The amounts entered include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 8--Enter the total charges for inpatient ancillary services from Worksheet D-3, column 2, sum of lines 50 through 98.

Line 9--If you are an approved CTC, enter the organ acquisition charges from Worksheet D-4, Part III, column 3, line 69 when Worksheet E-3, Part V is completed for the hospital or the hospital component of a health care complex.

Line 10--Enter the sum of lines 7 through 9.

Lines 11 - 14--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or when you fail to make reasonable efforts to collect such charges from those patients. If line 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 on line 14 over the reasonable cost on line 6.

Line 16--Enter the excess of reasonable cost on line 6 over the customary charges on line 14. Transfer line 16 to line 21.

Line 17--For hospitals that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter amounts from Worksheet D-5, Part II, column 3, line 20.

Computation of Reimbursement Settlement

Line 18--CAHs do not complete this line.

Line 19--Enter the sum of lines 6 *and 17*.

Line 20--Enter the Part A deductibles billed to Medicare beneficiaries.

Line 21--Enter the amount, if any, recorded on line 16. If you are a nominal charge provider, enter zero. *Do not complete this line.*

Line 22--Enter line 19 *minus line* 20.

Line 23--Enter from PS&R or your records the coinsurance billed to Medicare beneficiaries.

Line 24--Enter line 22 minus line 23.

Line 25--Enter from your records program allowable bad debts net of recoveries. If recoveries exceed the current year's bad debts, lines 25 and 26 will be negative.

Line 26--*No reduction is required for critical access hospitals*.

Line 27--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 25.

Line 28--Enter the sum of lines 24 and 25, or *line* 26.

Line 29--Enter any other adjustments. For example, if you change the recording of vacation pay from cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

Enter on line 29.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 30--Enter line 28, plus or minus line 29.

Line 31--Enter interim payments from Worksheet E-1, column 2, line 4. For contractor final settlement, report on line 32 the amount from line 5.99.

Line 33--Enter line 30 minus the sum of lines 31 and 32. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 34--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a 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.

4033.6 Part VI - Calculation of Reimbursement Settlement - All Other Health Services for Title XVIII Part A PPS SNF Services-- For title XVIII SNFs reimbursed under PPS, complete this part for settlement of Part A services. For Part B services, all SNFs complete Worksheet E, Part B.

When this part is completed for a component, show both the hospital and component numbers.

Computation of Net Costs of Covered Services

Line Descriptions

Prospective Payment Amount

Line 1--Compute the sum of the following amounts obtained your books and records or from the PS&R:

- The Resource Utilization Group (RUG) payments made for PPS discharges during the cost reporting period, and
- The RUG payments made for PPS transfers during the cost reporting period.

Line 2--Enter the amount from Worksheet D, Part III, column 9, line 44.

Line 3--Enter the amount from Worksheet D, Part IV, column 11, line 200.

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

Line 5--*Do not use this line as vaccine costs are included on line 1 of Worksheet E, Part B. Line 5 is shaded on Worksheet E-3, Part VI.*

Line 6--Enter any deductible amounts imposed.

Line 7--Enter any coinsurance amounts.

Line 8--Enter from your records program allowable bad debts for deductibles and coinsurance net of bad debt recoveries. If recoveries exceed the current year's bad debts, lines 8 and 9 will be negative.

Line 9--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 8.

Line 10--DRA 2005 SNF Bad Debt--Calculate this line as follows: [((line 8 - line 9) *.7) + line 9]. This is the adjusted SNF reimbursable bad debt in accordance with DRA 2005, section 5004.

Line 11--Enter the title XVIII reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include on this line the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, Part III, line 85.

Line 12--Enter the result of line 4 plus line 5 minus the sum of lines 6 and 7 plus lines 10 and 11.

Line 13--Enter the amounts paid or payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer for inpatient services. Enter only the primary payer amounts applicable to Part A routine and ancillary services.

Line 14--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. 15-1, §2146.4.) Specify the adjustment in the space provided.

Enter on line 14.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 15--Enter the result of line 12, plus or minus 14, minus line 13.

Line 16--For title XVIII, enter the total interim payments from Worksheet E-1, column 2, line 4. For contractor final settlement, report on line 17 the amount from line 5.99.

Line 18--Enter line 15 minus the sum of the amounts on lines 16 and 17. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 19--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying *a* 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.

4033.7 Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services--Worksheet E-3 calculates reimbursement for titles V or XIX services for hospitals, subproviders, other nursing facilities and ICF/MRs.

Use a separate copy of this part for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of this part to indicate the component and program for which it is used. When this part is completed for a component, show both the hospital and component numbers. Enter check marks in the appropriate spaces to indicate the applicable reimbursement method for inpatient services (e.g., TEFRA, OTHER).

Computation of Net Costs of Covered Services

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs.

Cost Reimbursement

Hospital/CAH or Subprovider - Worksheet D-1, Part II, line 49
Skilled Nursing Facility, Other Nursing Facility, ICF/MR - Worksheet D-1, Part III, line 86. If Worksheet S-2, line 92 is answered "yes", and multiple Worksheets D-1 are prepared, add the multiple Worksheets D-1 and enter the result.

TEFRA

Hospital or Subprovider - Worksheet D-1, Part II, line 63

NOTE: If you are a new provider reimbursed under TEFRA, use Worksheet D-1, Part II, line 49.

Line 2--Enter the cost of outpatient services for titles V or XIX which is the sum of Worksheet D, Part V, columns 6 and 7 and subscripts where applicable.

Line 3--For titles V and XIX, enter *in column 1* the amount paid or payable by the State program for organ acquisition.

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

Line 5--Enter *in column 1* the amounts paid or payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer for inpatient services *for titles V and XIX.*

Line 6--Enter *in column 2* the primary payer amounts applicable to outpatient services for titles V and XIX.

Line 7--Enter line 4 minus the sum of lines 5 and 6.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or your customary charges for the same services. This part provides for the computation of the lesser of reasonable cost or customary charges as defined in 42 CFR 413.13(a).

Line Descriptions

Lines 8 - 11--These lines provide for the accumulation of charges which relate to the reasonable cost on line *4*.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-1, §§2570-2577.

Line 8--Enter *in column 1* the program inpatient routine service charges from your records for the applicable component for titles V and XIX. This includes charges for both routine and special care units.

The amounts entered on line 8 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 9--For titles V and XIX, enter the sum of the appropriate program ancillary charges from Worksheet D, Part V, columns 3 and/or 4 plus subscripts as applicable, line 202 *in column 2. Enter charges from* Worksheet D-3, column 2, line 202 *in column 1*.

Line 10--Enter *in column 1* for titles V and XIX the organ acquisition charges from line 3.

Line 11--Enter *in column 1* for titles V and XIX the amount of the incentive resulting from the target amount computation on Worksheet D-1, Part II, line 58, if applicable.

Line 12--Enter the sum of the amounts recorded on lines 8 through 11.

Lines 13 - 16--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the 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 15 is greater than zero, multiply line 12 by line 15, and enter the result on line 16. 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 13 through 15. Enter on line 16 the amount from line 12. In no instance may the customary charges on line 16 exceed the actual charges on line 12.

Line 17--Enter the excess of the customary charges over the reasonable cost. If the amount on line 16 is greater than the amount on line *4*, enter the excess.

Line 18--Enter the excess of total reasonable cost over the total customary charges. If the amount on line *4* exceeds the amount on line 16, enter the excess.

Line 19--Enter for titles V or XIX*, columns 1 and 2,* the cost of services rendered by interns and residents as follows from Worksheet D-2:

	Col. 1 Title V	*Col. 2* *Title V*	*Col. 1* Title XIX	*Col. 2* *Title XIX*
Hospital	Part I, col. 8, line 9	*Part I, col. 8, line 27*	Part I, col. 10, line 9	*Part I, col. 10, line 27*
Subprovider	Part I, col. 8, lines 10-12 as applicable		Part I, col. 10, lines 10-12 as applicable	
Nursing Facility, ICF/MR	Part I, col. 8, line 14		Part I, col. 10, line 14	

Line 20--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter the amounts from Worksheet D-5, Part II, column 3.

Col. 1	*Col. 2*	*Col. 1*	*Col. 2*
Title V	*Title V*	Title XIX	*Title XIX*
Line 18	*Line 19*	Line 22	*Line 23*

Line 21--Enter the *lesser of line 4 or line 16*. *If this is a CAH or otherwise exempt from lower of cost or charges, transfer the amount from line 4.*

Prospective Payment Amount

NOTE: Lines 22 through 26 must only be completed for PPS providers.

Line 22--Input the total *I*PPS payments for titles V and/or XIX, as applicable, *in column 1*. *Enter the total OPPS payments for titles V and/or XIX, as applicable, in column 2.* Obtain this from your books and records.

Line 23--Enter the amount of outlier payments made for *I*PPS discharges during the period*, in column 1*. *Enter the outlier payment for OPPS in column 2.*

Line 24--Enter *in column 1* the payment for inpatient program capital costs from Worksheet L, Part I, line 12; or Part II, line 5, as applicable.

Line 25--Enter *in column 1* the result of Worksheet L, Part III, line 13 less Worksheet L, Part III, line 17. If this amount is negative, enter zero on this line.

Line 26--Enter the routine and ancillary service other pass through costs, respectively, from Worksheet D, Part III, column 9, line 200 and from Worksheet D, Part IV, column 11, line 200*, in column 1. Enter the amount from Worksheet D, Part IV, column 13, line 200, in column 2*.

Line 27--Enter the sum of lines 22 through 26*, in columns 1 and 2 respectively*.

Line 28--For titles V and XIX only, enter the customary charges for *I*PPS *in column 1 and OPPS in column 2*.

Line 29--For titles V and XIX, enter the *sum of lines 21 and 27, in columns 1 and 2, respectively*.

Computation of Reimbursement Settlement

Line 30--Enter the amount, if any, from line 18*, in columns 1 and 2, respectively*.

Line 31--Enter the sum of lines 19 *and 20 plus* line 29 *minus lines 5 and 6, in columns 1 and 2 respectively*.

Line 32--Enter any deductible amounts imposed *in columns 1 and 2 respectively*.

Line 33--Enter any coinsurance amounts imposed *in columns 1 and 2 respectively*.

Line 34--Enter from your records reimbursable bad debts for deductibles and coinsurance net of bad debt recoveries *in columns 1 and 2 respectively*.

Line 35--Enter *in column 1* the 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, Part III, line 85.

Line 36--Enter the sum of lines 31, 34, and 35 minus the sum of lines 32 and 33 *in columns 1 and 2, respectively*.

Line 37--Enter any other adjustments *in columns 1 and 2, respectively*. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

Line 38--Enter the result of line 36 plus or minus line 37 *in columns 1 and 2, respectively*.

Line 39--Enter the amount from Worksheet E-4, line 31 *in column 1*.

Line 40--Enter the sum of lines 38 and 39 *in columns 1 and 2, respectively*.

Line 41--For titles V and XIX, obtain interim payments from your records *and enter in columns 1 and 2, respectively*.

Line 42--Enter the result of line 40 minus line 41*, in columns 1 and 2, respectively*. Transfer *the sum of columns 1 and 2 to* Worksheet S, Part III, *column 1 (Title V) or column 5 (Title XIX),* line as appropriate.

Line 43--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a 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.

4034. WORKSHEET E-4 - DIRECT GRADUATE MEDICAL EDUCATION (GME) 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 413.75 through 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 56 of Worksheet S-2, Part I is yes. 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 graduate 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. This worksheet will also calculate payment for direct GME as determined under 42 CFR 413.79(c)(3) and (4) and IME as determined under 42 CFR 412.105(f)(1)(iv)(B) and (C) 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.

NOTE: Do not complete this worksheet for a cost reporting period prior to the base period used for calculating the per resident amount (PRA) in situations where the hospital did not train residents in approved residency training programs or did not participate in the Medicare program during the base period but either condition changed in a cost reporting period beginning on or after July 1, 1985. 42 CFR 413.77(e)(1) specified that in this situation, any GME costs for the cost reporting period prior to the base period are reimbursed on a reasonable cost basis.

Also, do not complete this worksheet for residents training in the general acute care part of a CAH since the associated costs are reimbursed on a reasonable cost basis. However, complete this worksheet for residents training in an IPF or an IRF unit of a CAH.

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 413.77(e)(1).)

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

Line 1--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 contractor. (42 CFR 413.79(c)(2)) Also include here the 30 percent increase to the count for qualified rural hospitals (42 CFR 413.79(c)(2)(i)), and the increase due to primary care residents that were on approved leaves of absence (42 CFR 413.79(i)). Temporarily reduce the cap of a hospital that closed a program(s), if the regulations at 42 CFR 413.79(h)(3)(ii) are applicable. (Effective 10/1/2001.)

Line 2--Enter the unweighted resident FTE count for allopathic and osteopathic programs that 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 FTEs that were already included in the cap on line 1. 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(k). 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 15.

Line 3--Enter the section 422 reduction amount to the direct GME cap as specified under 42 CFR §413.79(c)(3).

Line 3.01--Enter the section 5503 reduction amount to the direct GME cap as specified under 42 CFR §413.79(m). If this cost report straddles July 1, 2011, then calculate the prorated section 5503 reduction amount off the cost report and enter the result on this line. (Prorate the cap reduction amount by multiplying it by the ratio of the number of days from July 1, 2011, to the end of the cost reporting period to the total number of days in the cost reporting period). Otherwise enter the full cap reduction amount.

Line 4--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(f), and (63 FR 26 336 May 12, 1998)), and (67 FR 50069 August 1, 2002).

Line 4.01--Enter*, as applicable, all or a portion of the amount of the* FTE cap slots *the hospital was awarded under* section 5503 of ACA*. The amount of the section 5503 award that is reported on this line is the amount of the section 5503 award that is being "used" in this cost reporting period. In the 5-year evaluation period following implementation of section 5503 (that is, July 1, 2011 through June 30, 2016), at least 75 percent of the slots are to be "used" for additional primary care and/or general surgery residents, while 25 percent of the amount that is reported may be (but need not be) "used" for other purposes. During the 5-year evaluation period, failure to meet the requirements at 42 CFR section 413.79(n)(2) of the regulations means loss of a hospital's section 5503 slots. Therefore, do not automatically report the full amount of the section 5503 slots; only enter the amount of the section 5503 award that equates to at least 75 percent of the FTEs being "used" for additional primary care and/or general surgery FTEs, and no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting period. If this cost report straddles July 1, 2011, then calculate the applicable prorated section 5503 amount of increase to the cap off the cost report and enter the result on this line. (The prorated cap increase amount is to be calculated by multiplying the number of FTE cap slots that would be reported for the entire cost reporting period in accordance with the preceding instructions by the ratio of the number of days from July 1, 2011 to the end of the cost reporting period to the total number of days in the cost reporting period).*

Line 4.02--Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. Further subscript this line (lines 4.03 through 4.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to determine the effective date of the cap increase. *If the section 5506 award is phased in over more than one effective date, only report the portions of the section 5506 award as they become effective.* If the effective date of the cap increase is not the same as your fiscal year begin date, then prorate the cap

increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period.)

Line 5--Enter the result of line 1 plus line 2 minus line 3 minus line 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus subscripts as applicable. However, if the resulting cap is less than zero, enter zero on this line.

Line 6--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 , i.e., the program has not yet completed one cycle of the program (the "period of years" or the minimum accredited length of the program. The residents in programs within the "period of years" are exempt from the rolling average rules. (42 CFR 413.79(d)(5) and (e).) Contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or greater than 3 years. Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)).

Line 7--Enter the lesser of lines 5 or 6.

Line 8--Enter in column 1, 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 period of years of the program that meet the criteria for an exception to the rolling average rules. Enter in column 2, 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. (42 CFR 413.79(d)(5) and (e)). Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)).

Line 9--If line 6 is less than or equal to line 5, enter the amounts from line 8, columns 1 and 2, in columns 1 and 2 of this line. Otherwise, multiply the amount in each column of line 8 by (line 5/line 6). Enter in column 3 the sum of columns 1 and 2. (42 CFR 413.79(c)(2)(iii).)

Line 10--Enter in column 2 the weighted dental and podiatric resident FTE count for the current year.

Line 11--Enter in column 1, the amount from column 1, line 9. Enter in column 2, the sum of the amounts in column 2, lines 9 and 10.

Line 12--Enter in column 1, the weighted FTE count for primary care residents for the prior year, 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 has expired (see 42 CFR 413.79(d)(5), also enter on this line the count of FTE residents in that specific primary care program included in Form 2552-96, line 3.22 or Form 2552-10, sum of lines 15 and 16 of the prior year's cost report. If subject to the cap in the prior year Form 2552-96 cost report, report the result of line 3.07 times (line 3.04/line 3.05). If subject to the cap in the prior year Form 2552-10 cost report, report the result of column 1, line 8 times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the prior year, 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 has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific nonprimary care program included in Form 2552-96, line 3.16 or Form 2552-10, sum of lines 15 and 16 of the prior year's cost report. If subject to the cap in the prior year Form 2552-96 cost report, report the result of line 3.08 times (line 3.04/line 3.05) plus line 3.11. If subject to the cap in the prior year Form 2552-10 cost report, report the result of column 2, line 8 times (line 5/line 6) plus line 10.

Line 13--Enter in column 1, the weighted FTE count for primary care residents for the cost reporting year before last, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(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 has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific primary care program included in Form 2552-96, line 3.22 or for 2552-10, sum of lines 15 and 16 of that year's cost report. If subject to the cap in the year before last Form 2552-96 cost report, report the result of line 3.07 times (line 3.04/line 3.05). If subject to the cap in that year Form 2552-10 cost report, report the result of column 1, line 8 times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the cost reporting year before last, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(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 has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific nonprimary care program included in Form 2552-96, line 3.16 or Form 2552-10, sum of lines 15 and 16 of that year's cost report. If subject to the cap in the cost reporting year before last, Form 2552-96 cost report, report the result of line 3.08 times (line 3.04/line 3.05) plus line 3.11. If subject to the cap in that year Form 2552-10 cost report, report the result of column 2, line 8 times (line 5/line 6) plus line 10.

Line 14--Enter the rolling average FTE count in each column, by adding lines 11 through 13 and dividing by 3.

Line 15--Enter the weighted number of FTE residents in the initial years of a program that meets the exception to the rolling average rules in column 1 for primary care and in column 2 for nonprimary care FTEs.

Line 16--Enter the temporary weighted FTE residents that were displaced by program or a hospital closure in column 1 for primary care and in column 2 for nonprimary care FTEs, which you would not be able to count without a temporary cap adjustment. (42 CFR 413.79(h).)

Line 17--Enter the sum of lines 14 through 16.

Line 18-- Enter in column 1, the primary care and OB/GYN per resident amount. Enter in column 2, the nonprimary care per resident amount.

Line 19--Enter the result of multiplying lines 17 times line 18. Enter in column 3, the sum of columns 1 and 2.

Line 20--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 21--Direct GME FTE Resident *Unweighted* Count Over/Under the Cap--Subtract line 7 from line 6 and enter the result here. If the result is zero or negative, the hospital does not need to use the direct GME section 422 additional cap and lines 22 through 24 will not be completed.

Line 22--Section 422 Allowable Direct GME FTE Resident Count--If the count on line 21 is less than or equal to the count on line 20, then divide line 8 by line 6, and multiply *the resulting ratio* by *the amount on* line 21. If the count on line 21 is greater than the count on line 20, then divide line 8 by line 6, and multiply *the resulting ratio* by *the amount on* line 20.

Line 23--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 24--Enter the product of lines 22 and 23. This is the allowable section 422 GME cost.

Line 25--Enter the sum of lines 19 and 24. This is the total Part A direct GME cost.

Computation of Program Patient Load--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 26--Enter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 8 through 12, and 16 through 18, and subscripts, as applicable. For titles V or XIX, enter the amounts from columns 5 or 7, respectively, sum of lines 1, 8 through 12, and 16 through 18, and subscripts, as applicable. *For title XVIII, e*nter in column 2, Medicare managed care days from Worksheet S-3, Part I, column 6, lines 2, 3 and 4. *For title XIX, enter in column 2, Medicaid managed care days from Worksheet S-3, Part I, column 7, lines 2, 3 and 4*.

Line 27--*Transfer to* column*s* 1 *and 2, respectively,* the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, and 16 through 18 and subscripts as applicable.

Line 28--In each column, divide line 26 by line 27 and enter the result (expressed as a decimal). Column 1 is the Title XVIII Part A inpatient utilization and column 2 is the Medicare managed care inpatient utilization.

Line 29--Multiply the amount on line 25, column 1, by the amount reported in each column of line 28.

Line 30--In column 2, enter the amount on line 29, column 2 multiplied by the reduction factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. *This is the reduction for direct GME payments for Medicare managed care (Medicare+Choice).*

Line 31--Enter the sum of columns 1 and 2, line 29, less the amount in column 2, line 30.

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 32--Enter the amount from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94.

Line 33--Enter the amount from Worksheet C, Part I, column 8, sum of lines 74 and 94. This amount represents the total charges for renal and home dialysis.

Line 34--Divide line 32 by line 33, and enter the result. This amount represents the ratio of ESRD direct medical education costs to total ESRD charges.

Line 35--Enter from your records the Medicare outpatient ESRD charges.

Line 36--Enter the result of multiplying line 34 by line 35. This represents the Medicare outpatient ESRD costs. Transfer this amount to Worksheet E, Part B, line 29.

Lines 37 - 41--Deduct (specify)-- Identify on these lines deductions from operating expenses not accounted for included in line 29.

Line 42--Total Deductions--Enter on line 42, column 2, the sum of lines 37 to 41, column 1.

Line 43--Total Operating Expenses--Enter on line 43, column 2, the result of line 29, column 2 plus line 36, column 2, less line 42, column 2.

4040.4 Worksheet G-3 - Statement of Revenues and Expenses--
This worksheet requires the reporting of total revenues for the entire facility and total operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statements, submit a reconciliation report with the cost report submission.

Line 1--Total Patient Revenue--Transfer from Worksheet G-2, Part I, line *28*, column 3.

Line 2--Less: Allowance and Discounts on Patient's Accounts--Enter on this line total patient revenues not received. This includes:

Provision for Bad Debts,
Contractual Adjustments,
Charity Discounts,
Teaching Allowances,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Line 3--Net Patient Revenues--Subtract line 2 from line 1.

Line 4--Less: Total Operating Expenses--Transfer from Worksheet G-2, Part II, line *43*.

Line 5--Net Income from Service to Patients--Subtract line 4 from line 3.

Lines 6 - 23--Enter on the appropriate line 6 through 23 all other revenue not reported on line 1. Obtain these amounts from your accounting books and/or records.

Line 24--Other (Specify)--Enter from hospital books. Enter all other revenue not reported on lines 6 through 23. Obtain this from your accounting books and/or records. Subscript this line as necessary.

Line 25--Total Other Income--Enter the sum of lines 6 through 24.

Line 26--Total--Enter the sum of lines 5 and 25.

Line 27--Other Expenses (Specify)--Enter all other expenses not reported on lines 6 through 24. Subscript this line as necessary.

Line 28--Total Other Expenses--Enter the sum of line 27 and subscripts.

Line 29--Net Income (or Loss) for the Period--Enter the result of line 26 minus line 28.

4041. WORKSHEET H - ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

This worksheet provides for the recording of direct HHA costs such as salaries, fringe benefits, transportation, and contracted services as well as other costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. The direct costs reported in columns 1, 2 and 4 are obtained from your accounting books and records. All of the cost centers listed do not apply to all agencies**.**

The HHA must maintain the records necessary to determine the split in salary (and employee-related benefits) between two or more cost centers and must adequately substantiate the method used to split the salary and employee-related benefits. These records must be available for audit by your contractor. Your contractor can accept or reject the method used to determine the split in salary. Any deviation or change in methodology to determine splits in salary and employee benefits must be requested in writing and approved by your contractor before any change is effectuated. Where approval of a method has been requested in writing and this approval has been received (prior to the beginning of the cost reporting period), the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until your contractor determines that the method is no longer valid due to changes in your operations.

Column 1--Enter all salaries and wages (a salary is the gross amount paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses) for the HHA in this column for the actual work performed within the specific area or cost center. For example, if the administrator spends 100 percent of his/her time in the HHA and performs skilled nursing care which accounts for 25 percent of that person's time, then 75 percent of the administrator's salary is entered on line 5 (administrative and general-HHA) and 25 percent of the administrator's salary is entered on line 6 (skilled nursing care). Enter the sum of column 1, lines 1 through 23 on line 24.

Column 2--Enter all payroll-related employee benefits for the HHA in the appropriate cost center in this column. See CMS Pub. 15-1, §§2144 - 2145 for a definition of fringe benefits. Entries are made using the same basis as that used for reporting salaries and wages in column 1. Therefore, using the same example as given for column 1, 75 percent of the administrator's payroll-related fringe benefits is entered on line 5 (administrative and general - HHA) and 25 percent of the administrator's payroll-related fringe benefits is entered on line 6 (skilled nursing care). Enter the sum of column 2, lines 1 through 23 on line 24.

Report payroll-related employee benefits in the cost center where the applicable employee's compensation is reported. This assignment is performed on an actual basis or upon the following basis:

- FICA based on actual expense by cost center;
- Pension and retirement and health insurance (non union) based on gross salaries of participating individuals by cost centers;
- Union health and welfare based on gross salaries of participating union members by cost center; and
- All other payroll-related benefits based on gross salaries by cost center.

NOTE: The sum of visits reported in columns 6 and 7 must equal the corresponding amounts on Worksheet S-4, column 5, lines 21, 23, 25, 27, 29 and 31, respectively. These visits are reported for episodes completed during the fiscal year.

Columns 8 and 11--Do not use these columns.

Column 12--Enter the total program cost for each discipline (sum of columns 9 and 10). Add the amounts on lines 1 through 6, and enter this total on line 7.

Visits by CBSA--Lines 8 through 14--HHAs are paid for home health services under Title XVIII on the basis of the geographic location at which the service is furnished. Enter for each discipline the CBSA code of the location where the home health service was furnished. Subscript each discipline line to accommodate multiple CBSAs serviced by your home health agency.

Column Descriptions

Column 1--Enter the CBSA code in which the corresponding HHA visits were rendered for each discipline on lines 8 through 13.

Columns 2 and 3--Enter the visit count for each of the corresponding disciplines for each CBSA.

Column 4, lines 8 through 14--These lines are shaded to prevent data input.

Line 14--Enter the total program visits for each discipline by adding lines 8 through 13 and subscripts, and enter this total on line 14.

Supplies and Drugs Cost Computation.--Certain services covered by the program and furnished by a home health agency are not included in the cost per visit for apportionment purposes. Since an average cost per visit and HHA PPS do not apply to these items, develop and apply the ratio of total cost to total charges to program charges to arrive at the program cost for these services.

Column 1--Enter the facility costs in column 1, lines 15 and 16, from Worksheet H-2, Part I, column 28, lines 8 and 9, respectively.

Column 2--Enter the shared ancillary costs from Worksheet H-3, Part II, column 3, lines 4 and 5, respectively.

Columns 3 through 5--In column 3, enter the sum total of columns 1 and 2 on lines 15 and 16, respectively. Enter in column 4, lines 15 and 16, respectively, the total charges for such services in accordance with the instructions in §4041, lines 12 and 13. 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 subject to cost reimbursement. The actual vaccine/drug cost for pneumococcal, influenza, hepatitis B and osteoporosis are cost reimbursed.

Do not enter charges for drugs and medical supplies subject to reimbursement on the basis of a fee schedule.

Line Descriptions for Columns 6 through 8

Line 15--*Columns 6 through 11 are shaded to prevent the input of medical supplies charged to patients as* all medical supplies are covered under the HHA PPS benefit.

Line 16--This line represents pneumococcal, influenza, and hepatitis B vaccine costs and injectable osteoporosis drugs, but not the administration of these medications. Enter the program covered charges for drugs charged to patients for items not reimbursed on the basis of a fee schedule or OPPS. Enter in column 7 the program charges for pneumococcal vaccine and influenza vaccine exclusive of their respective administration costs. Enter in column 8 the program charges for hepatitis B vaccine and injectable osteoporosis drugs exclusive of their respective administration costs.

Columns 6 and 9--To determine the Medicare cost, multiply the program charges (column 6) by the ratio (column 5) for each line. Enter the product in column 9.

Columns 7 and 10--To determine the Medicare Part B cost, multiply the Medicare charges (column 7) by the ratio (column 5) for each line. Enter the product in column 10.

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.

4044.2 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 lines 1 through 5 of* this *part of the* worksheet, and the*se* 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-3, Part I as indicated. If lines 1-5 are subscripted, transfer the aggregate of each line.

4046. WORKSHEET H-5 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.)

The column headings designate two categories of payments: Part A and Part B.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor. Do not include on this worksheet any payments made for DME or medical supplies charged to patients that are paid on the basis of a fee schedule.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA for cost and HHA PPS reimbursed services. The amount entered reflects payments for all episodes concluded in this fiscal year. **Do not include any payments received for fee scheduled services.** 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 your interim payments due to an offset against overpayments 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. 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 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, and 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--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to the appropriate column on Worksheet H-4, Part II, line 32.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET H-5. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR CONTRACTOR.

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 *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. Enter in column 2 the amount on Worksheet H-4, Part II, column 1, line 34. Enter in column 4 the amount on Worksheet H-4, Part II, column 2, line 34.

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 you agree to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the total of the amounts on lines 4, 5.99, and 6. Enter in column 2 the amount on Worksheet H-4, Part II, column 1, line 31. Enter in column 4 the amount on Worksheet H-4, Part II, column 2, line 31.

Line 8--Enter the contractor name, the contractor number *and NPR date* in columns *0*, 1 and 2, respectively.

4047. ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

This worksheet provides for the analysis of the direct and indirect expenses related to the renal dialysis cost centers, allocation of cost between inpatient and outpatient renal dialysis services where separate cost centers are not maintained, and the allocation of the cost to the various modes of outpatient dialysis treatment. The ancillary renal dialysis cost center is serviced by the general cost centers and includes all reimbursable cost centers within the provider organization which provide services to the renal dialysis department. The cost used in the analysis for the renal dialysis department is obtained, in part, from Worksheets A; B, Part I; and C. Complete a separate Worksheet I series for lines 74 and 94 of Worksheet A. In other words, complete one Worksheet I series for line 74 and one for line 94, if appropriate.

4048. WORKSHEET I-1 - ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

This part provides for recording the direct salaries and other direct expenses applicable to the total inpatient and outpatient renal dialysis cost center or outpatient renal dialysis cost center where you maintain a separate and distinct outpatient renal dialysis cost center. If you have more than one renal dialysis department, and/or more than one home dialysis department, submit one Worksheet I series combining the renal dialysis departments and a separate Worksheet I series combining the home dialysis departments. You must also have on file, as supporting documentation, a Worksheet I series for each renal dialysis department and for each home dialysis department along with the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-1, §2720. Do not combine the cost of the renal dialysis with home program dialysis reported separately on Worksheet A, lines 74 and 94.

This worksheet also provides for recording the indirect expenses applicable to the total renal or outpatient renal dialysis department obtained from Worksheet B, Part I, columns 1 through 23, line 74 as adjusted for post stepdown adjustments, if any. When completing a separate Worksheet I for home program dialysis, transfer the direct expenses from Worksheet B, Part I, columns 1 through 23, line 94. Do not combine the cost of the renal department with home program dialysis. These costs are listed separately on Worksheet A, lines 74 and 94, respectively.

Column Descriptions

Column 1--Enter on lines 1 through 8 the amounts included from Worksheet A, column 7 for salaries only. Enter on lines 10 through 16 and 18 through 26 the amounts from Worksheet B, Part I, all columns for lines 74 and 94. The subtotal on Worksheet I-1, line 27 agrees with the sum of Worksheet B, Part I, column 26, line 74 or line 94 if a home dialysis cost center was established and used on Worksheet A.

Column 2--This column lists the statistical bases for allocating costs on Worksheet I-3.

Column 3--Enter paid hours per type of staff listed on lines 1 through 6.

Column 4--Enter full time equivalents by dividing column 3 by 2080 hours.

Line Descriptions

Lines 1 - 6--Enter on these lines the direct patients care salaries after adjustments and reclassification that you reported in column 7 of Worksheet A. Direct patient care salary includes only the salary of staff providing direct patient care services. Also include fee paid to non-employees providing direct patient care services. Time spent furnishing administrative or management services by direct patient care personnel is reported on line 8, non-patient care salary.

Column 4--Enter on the appropriate lines the number of treatments billed to the Medicare program directly. Obtain this information from your records and/or the PS&R.

Column 5--Determine the amounts entered on the appropriate lines by multiplying the number of treatments entered on each line in column 4 by the average cost per treatment entered on the corresponding line in column 3. Transfer the total expenses from this column, line 11 to Worksheet I-5, line 1. If you complete a Worksheet I-4 for renal dialysis and a Worksheet I-4 for home dialysis, add the sum of the cost from this column, line 11, and transfer the total to Worksheet I-5, line 1.

Column 6--Total Program Payment--Enter the total program payment by the type of treatment for the reporting period. Since this amount is calculated on a patient basis and is case mix adjusted, the total program payment will be provider specific for each modality.

The ESRD composite payment rate is an average payment calculated based on the total Medicare payments by type of treatment divided by the total ESRD treatments.

Column 7--Average Payment Rate--Enter the total average payment rate by the type of treatment for the reporting period. Determine the amounts entered on the appropriate lines by dividing the total payments on each corresponding line in column 6 by the number of treatments entered on each line in column 4.

Line 11--Enter in columns 1 and 4 the sum total of lines 1 through 8. Enter in columns 2, 5, and 6 the sum total of lines 1 through 10.

Transfer the total payment from column 6, line 11 to Worksheet I-5, line 2.

4052. WORKSHEET I-5 - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

This worksheet provides for the calculation of reimbursable Part B bad debts relating to outpatient renal dialysis treatments. If you have completed more than one Worksheet I-2 (i.e., one for renal dialysis department and one for home program dialysis), make a consolidated bad debt computation.

Line 1--Enter the amount from Worksheet I-4, column 5, line 11.

Line 2--Enter the amount from Worksheet I-4, column 6, line 11 (net of deductibles).

Line 3--Enter the amount shown in your records for deductibles billed to Medicare (Part B) for dialysis treatments.

Line 4--Enter the amount shown in your records for coinsurance billed to Medicare (Part B) for dialysis treatments.

The amounts on lines 3 and 4 must exclude coinsurance and deductible amounts for services other than dialysis treatments (e.g., Epoetin and Aranesp).

Line 5--Enter the uncollectible portion of the amounts entered on lines 3 and 4 reduced by any amount recovered during the cost reporting period.

Line 6--Reserved for future use.

Line 7--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be included in the amount on line 5.

Line 8--Enter the sum of lines 3 and 4, less line 5.

Line 9--Subtract line 3 from line 2, and enter 80 percent of the difference.

Line 10--*Enter the result of line 1 minus* the sum of lines 8 and 9. If the result is negative, enter zero and do not complete line 11.

Line 11--Enter the lesser of line 5 or line 10. Transfer this amount to Worksheet E, Part B, line 33.

Line 19--Enter the actual coinsurance billed to program patients (from your records).

Line 20--For title XVIII, enter the difference of line 17 minus line 19. For titles V and XIX, enter the difference of line 18 minus line 19.

Line 21--Enter allowable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records). If recoveries exceed the current year's bad debts, line 21 will be negative.

Line 22--This line is reserved for future use.

Line 23--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 21.

Line 24--CMHCs enter the result of line 20 plus line 21.

Line 25--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see CMS Pub. 15-1 §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 26--Enter the result of line 24 plus or minus line 25.

Line 27--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4.

Line 28--For contractor final settlement, report on this line the amount from Worksheet J-4, line 5.99.

Line 29--Enter the balance due provider/program (line 26 minus lines 27 and 28), and transfer this amount to Worksheet S, Part III, columns as appropriate, lines as appropriate.

Line 30--Enter the program reimbursement effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with §115.2. Attach a schedule showing the supporting details and computation.

4056. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based CMHC, 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 contractor.

Line Descriptions

Line 1--Enter the total program interim payments paid to the CMHC. 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 CONTRACTOR 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 *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.

Line 8--Enter the contractor name, the contractor number *and NPR date* in columns *0*, 1 and 2, respectively.

Allocate all expenses to the cost centers on the basis of square footage of the space occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

Column 2--Allocate all expenses (e.g., interest, and personal property tax) for movable equipment to the appropriate cost centers on the basis of dollar value.

Column 4--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet K, column 3, is included in this cost center. Allocate this expense to the cost centers to which it applies on the basis of miles applicable to each cost center.

This basis of allocation is not mandatory and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs, which are not directly assigned. However, a hospice must request the use of the alternative method in accordance with CMS Pub. 15-1, §2313. The hospice must maintain adequate records to substantiate the use of this allocation.

Column 6--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments.

Therefore, obtain the amounts to be entered on Worksheet K-4, Part II, column 6, from Worksheet K-4, Part I, columns 0 through 5.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet K-4, Part I, column 0) for purposes of determining the basis of allocation (Worksheet K-4, Part II, column 5) of the A&G costs. This procedure may be followed when the hospice contracts for services to be performed for the hospice and the contract identifies the A&G costs applicable to the purchased services

The contracted A&G costs must be added back to the applicable cost center after allocation of the hospice A&G cost before the reimbursable costs are transferred to Worksheet K-5. A separate worksheet must be included to display the breakout of the contracted A&G costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Contractor approval does not have to be secured in order to use the above described method of cost finding for A&G.

Worksheet K-4, Part II, Column 6A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet K-4, Part I, column 5A, line 39 and the accumulated cost reported on Worksheet K-4, Part II, column 6, line 6. Enter any amounts reported on Worksheet K-4, Part I, column 5A for (1) any service provided under arrangements to program patients only that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead.

In addition, report on line 6 the administrative and general costs reported on Worksheet K-4, Part I, column 6, line 6 since these costs are not included on Worksheet K-4, Part II, column 6 as an accumulated cost statistic.

The accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 6 (A&G), the reconciliation column designation must be 6A.

Worksheet K-4, Part II, Column 6--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, enter the amount from Worksheet K-4, Part I, column 5A.

4062. WORKSHEET K-5 - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

This worksheet distributes the hospital's overhead to the specific cost centers of the hospice.

4062.1 Part I - Allocation of General Service Costs to Hospice Cost Centers.--Worksheet K-5, Part I, provides for the allocation of the expenses of each general service cost center of the hospital to those cost centers which receive the services.

Obtain the direct total expenses (column 0, lines 2 through 33) from *W*orksheet K-4 Part I, lines 7 through 38. The amounts on columns 0 through 23 and column 25, line 34 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 23 and column 25, line 116.

Complete the amounts entered on lines 1 through 33, columns 1 through 23 and column 25 in accordance with the instructions in §4062.2.

NOTE: Worksheet B, Part I established the method used to reimburse direct graduate medical education cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 25, excluded the costs of interns and residents, column 25 on this worksheet must also exclude these costs.

In column *24*, enter the total of columns 4A through 23.

In column 27, for lines 2 through 33, multiply the amount in column 26 by the unit cost multiplier on line 35, and enter the result in this column. *The total of the amounts on lines 2 through 33 must equal the amount in column 26, line 1.*

In column 28, enter on lines 2 through 33 the sum of columns 26 and 27. The total on line 34 equals the total in column 26, line 34.

4062.2 Part II - Allocation of General Service Costs to Hospice Cost Centers - Statistical Basis.--Worksheet K-5, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the hospital's general service cost centers on Worksheet K-5, Part I. To facilitate the allocation process, the general format of Worksheet K-5, Parts I and II, is identical.

The statistical basis shown at the top of each column on Worksheet K-5, Part II, is the recommended basis of allocation of the cost center indicated and must be consistent with the statistical basis utilized on Worksheet B, Part I.

Lines 1 - 33--On Worksheet K-5, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 34--Enter the total of lines 1 through 33 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 116.

4064. WORKSHEET L - CALCULATION OF CAPITAL PAYMENT

Worksheet L, Parts I through III, 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 IPPS complete this worksheet.

Worksheet L consists of the following three parts:

Part I - Fully Prospective Method
Part II - Payment Under Reasonable Cost
Part III - Computation of Exception Payments

COMPLETE EITHER PART I OR PART II, OR PARTS I AND III.

At the top of the worksheet, indicate by checking the applicable boxes the health care program, provider component, and the IPPS capital payment method for which the worksheet is prepared.

4064.1 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 IPPS capital settlement when the hospital's base year hospital-specific rate is below the adjusted Federal rate and for IPPS hospitals with cost reporting periods beginning after the capital PPS transition.

Line Descriptions

Line 1--Enter the amount of the Federal rate portion of the capital DRG payments for other than outlier during the period.

Line 2--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).)

Indirect Medical Education Adjustment

Lines 3 - 6

Line 3--Enter the result of dividing the sum of total patient days (Worksheet S-3, Part I, column 8, lines 14 and 30) 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 8, line 13), and swing bed days (Worksheet S-3, Part I, column 8, lines 5 and 6).

Line 4--Obtain the intern and resident amount from Worksheet E, Part A, line 18 plus line 25.

Line 5--Enter the result of the following calculation: $\{e^{.2822 \times \text{line 4/line 3}}\}-1$ 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 divided by line 3 cannot exceed 1.5.

Line 6--Multiply line 5 by line 1.

Capital Disproportionate Share Adjustment

Lines 7 - 11

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 45 on Worksheet S-2, Part I. (See 42 CFR 412.312(b)(3).) For hospitals qualifying for disproportionate share in accordance with 42 CFR 412.106(c)(2) (Pickle amendment hospitals), do not complete lines 7 through 9, and enter 11.89 percent on line 10.

Line 7--Enter the percentage of SSI recipient patient days (from your contractor or your records) to Medicare Part A patient days. This amount agrees with the amount reported on Worksheet E, Part A, line 30.

Line 8--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-2, Part I, columns 1 through 6, line 24*)* to total days reported on Worksheet S-3, Part I, column 8, line 14*,* plus column 8*, line 32* minus the sum of lines 5 and 6*, plus* employee discount days reported on *W*orksheet S-3, Part I, column 8, line 30. This amount *must* agree with the amount reported on Worksheet E, Part A, line 31.

Line 9--Add lines 7 and 8, and enter the result.

Line 10--Enter the percentage that results from the following calculation: $(e^{.2025 \times \text{line } 9})-1$ where e equals 2.71828. *If Worksheet S-2, Part I, line 22, column 2 is "Y" (Pickle amendment hospital), enter 11.89 percent.*

Line 11--Multiply line 10 by line 1 and enter the result.

Line 12--Enter the sum of lines 1, 2, 6 and 11. For title XVIII, transfer this amount to Worksheet E, Part A, line 50.

4064.2 Part II - Payment Under Reasonable Cost.--This part computes capital settlement under reasonable cost principles subject to the reduction pursuant to 42 CFR 412.324(b). Use the reasonable cost method for capital settlement determinations for new providers under 42 CFR 412.324(b) for the first two years or for titles V or XIX determinations, if applicable. This part may also be completed for cost reporting periods beginning on or after October 1, 2002, for the first two years for new providers under 42 CFR 412.304(c)(2)(i) (response to Worksheet S-2, Part I, line 47, column 1 is "Y" and column 2 is "N").

Line Descriptions

Line 1--Enter the amount of program inpatient routine service capital costs. This amount is the sum of the program inpatient routine capital costs from the appropriate Worksheet D, Part I, column 7, sum of the amounts on lines 30 through 35 and 43 for the hospital (lines 40 through 42 as applicable for the subprovider).

Line 2--Enter the amount of program inpatient ancillary capital costs. This amount is the sum of the amounts of program inpatient ancillary capital costs from the appropriate Worksheet D, Part II, column 5, line 200.

Line 3--Enter the sum of lines 1 and 2.

Line 4--Enter a reduction factor of 85 percent.

Line 5--Multiply line 3 by line 4. For title XVIII, transfer the amount to Worksheet E, Part A, line 50.

4064.3 Part III - Computation of Exception Payments.--This part computes minimum payment levels by class of provider *eligible for* additional exception payment for *extraordinary circumstances* pursuant to 42 CFR 412.*312(e)*. Complete this part only if the provider component completed Part I of this worksheet. Complete this part only if the provider qualifies for the *exception payment for extraordinary circumstances* pursuant to 42 CFR 412.348*(f)* (the facility indicates "Y" to question 46 on *W*orksheet S-2, Part I).

Line 1--Enter the amount of program inpatient routine service and ancillary service capital costs. This amount is the sum of the program inpatient routine service capital costs from the appropriate Worksheet D, Part I, column 7, sum of lines 30 through 35 and 43 for the hospital, lines 40 through 42, as applicable for the subprovider, and program inpatient ancillary service capital costs from Worksheet D, Part II, column 5, line 200.

Line 2--Enter program inpatient capital costs for extraordinary circumstances as provided by 42 CFR 412.348*(f)*, if applicable, from Worksheet L-1, sum of Part II, column 7, sum of lines 30 through 35 and 43 for the hospital; lines 40 through 42, as applicable for the subproviders; and Part III, column 5, line 200.

Line 3--Enter line 1 less line 2.

Line 4--Enter the appropriate minimum payment level percentage: The minimum payment levels for portions of cost reporting periods beginning on or after October 1, 2001 are:

- SCHs (located in either an urban or a rural area) - 90 percent;
- Urban hospitals with at least 100 beds and a disproportionate patient percentage of at least 20.2 percent - 80 percent; and
- All other hospitals - 70 percent.

For providers that qualify for *an* exception payment *for extraordinary circumstances* pursuant to 42 CFR 412.348*(f) in conjunction with 412.312(e)* the appropriate minimum payment level is 70 percent.

The minimum payment *levels will* be revised, if necessary, to keep total payments under the exceptions process at no more than 10 percent of capital prospective payments.

If you were an SCH during a portion of the cost reporting period, compute the minimum payment level percentage by dividing the number of days in your cost reporting period for which you were not an SCH (70 percent factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 70 percent. Divide the number of days in your cost reporting period for which you were an SCH (90 percent factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 90 percent. Add the amounts from steps 1 and 2 to compute the capital cost minimum payment level percentage. Display exception percentage in decimal format, e.g., 70 percent is displayed as .70 or 0.70.

Line 5--Enter the product of line 3 multiplied by line 4.

Line 6--Hospitals that did not qualify as sole community providers during the cost reporting period enter a reduction factor of 85 percent. SCHs enter 100 percent. If you were a sole community hospital during a portion of the cost reporting period, compute the capital cost reduction percentage by dividing the number of days in your cost reporting period for which you were not a sole community hospital (reduction factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 15 percent and subtract the amount from 100. Enter the resulting extraordinary circumstance percentage adjustment in decimal format, e.g., 85 percent is displayed as .85 or 0.85.

Line 7--Enter the product of line 2 multiplied by line 6.

Line 8--Enter the sum of lines 5 and 7.

Line 9--Enter the amount from Part I, line 12, if applicable.

Line 10--Enter line 8 less line 9.

Lines 11 - 14--A hospital is entitled to an additional payment if its capital payments for the cost reporting period is less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive. This additional payment amount is reduced for any amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels. The offsetting amounts will be determined based on the amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels in the lesser of the preceding 10-year period or the period of time under which the hospital is subject to the prospective payment system for capital related costs.

A positive amount on line 10 represents the amount of capital payments under the minimum payment level in the current year. This amount must be offset for the amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels in prior years, as reported on line 11. If the net amount on line 12 remains a positive amount, this amount represents the current year's additional payment for capital payments under the minimum payment level. Report this amount on line 13. If the net amount on line 12 is a negative amount, this amount represents the reduced amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. In this case, no additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the following cost reporting period.

A negative amount on line 10 represents the amount of capital payments over the minimum payment level in the current year. Add any carry forward of prior years' amounts of the hospital's cumulative payments in excess of cumulative minimum payment levels, as reported on line 11, to the current year excess on line 12. The net amount on line 12 represents the total amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. No additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the subsequent cost reporting period.

Line 11--The offsetting amounts will be determined based on the amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels in the lesser of the preceding 10-year period or the period of time under which the hospital is subject to the prospective payment system for capital related costs. Enter the appropriate offset amount as computed pursuant to 42 CFR 412.312(e)(3).

Line 12--Enter the sum of lines 10 and 11.

Line 13--If the amount on line 12 is positive, enter the amount on this line.

Line 14--If the amount on line 12 is negative, enter the amount on this line.

Complete lines 15 through 17 only when line 12 is a positive amount.

Line 15--Enter the current years allowable operating and capital payments calculated from Worksheet E, Part A, line 47, plus the capital payments reported on line 9 above, minus 75 percent of the current year's operating disproportionate share payment amount reported on Worksheet E, Part A, line 34.

Line 16--Current years operating and capital costs from *W*orksheet D-1, line 49 minus the sum of D, Part III, lines 30 through 35, column 9 (PPS subproviders use lines 40 through 42, as applicable, column 9), and D, Part IV, column 11, line 200.

Line 17--Enter on this line the current year's exception offset amount. This is computed as line 15 minus line 16. If this amount is negative, enter zero on this line. If the amount on line 13 is greater than line 17, transfer the amount on line 13, less any reported amount on line 17, to Worksheet E, Part A, line 51.

4065. WORKSHEET L-1 - ALLOCATION OF ALLOWABLE *CAPITAL* COSTS FOR EXTRAORDINARY CIRCUMSTANCES

This worksheet provides for the determination of direct and indirect capital-related costs associated with capital expenditures for extraordinary circumstances, allocated to inpatient operating costs. Only complete this worksheet for providers that qualify for an additional payment for extraordinary circumstances under 42 CFR 412.348*(f)* (the facility indicates "Y" to question 46 on worksheet S-2, Part I).

4065.1 Part I - Allocation of Allowable Capital Costs for Extraordinary Circumstances.--Use this part in conjunction with Worksheet B-l. The format and allocation process employed is similar to that used on Worksheets B, Part I and B-1. Any cost center subscripted lines and/or columns added to Worksheet B, Part I, are also added to this worksheet in the same sequence.

Column 0--Assign capital expenditures relating to extraordinary costs to specific cost centers on this worksheet, column 0. Enter on the appropriate lines those capital-related expenditure amounts relating to extraordinary costs which were directly assigned on Worksheet B, Part II. Enter on lines 3 and 4, as applicable, the remaining capital expenditure amounts relating to extraordinary costs which have not been directly assigned.

Columns 1 through 23--Transfer amounts on the top lines of columns 1 and 2 from column 0, line as applicable. For example, transfer line 1, column 0 to line 1, column 1. For all other columns, the top line represents the cross total amount.

For each column, enter on line 203 of this worksheet, Part I, the total statistics of the cost center being allocated. Obtain the individual statistics from Worksheet B-1 from the same column and line number used to allocate cost on this worksheet. (For example, obtain the amount of capital-related costs - buildings and fixtures from Worksheet B-1, column 1, line 1.)

Divide the amount entered on line 203 by the total capital expenses entered in the same column on the first line. Enter the resulting unit cost multiplier on line 204. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. The applicable cost center statistics are reported on Worksheet B-1. Enter the result of each computation on this worksheet in the corresponding column and line. (See §4000.1 for rounding standards.)

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 197) of all the cost centers receiving the allocation on this worksheet must equal the amount entered on the first line. Perform the preceding procedures for each general service cost center. Complete the column for one cost center before proceeding to the column for the next cost center.

After the capital-related costs of all the general service cost centers have been allocated, enter in column 24 the sum of columns 2A through 23 for lines 30 through 196. (See §4020 for exception regarding negative cost centers.)

When an adjustment is required to capital costs for extraordinary circumstances after cost allocation, show the amount applicable to each cost center in column 25. Submit a supporting schedule showing the computation of the adjustment.

Transfer From Worksheet: L-1, Part I, Column 26	To Worksheet L-1, Part II
Line 30 - Adults and Pediatrics	Column l, line 30 for the hospital
Lines 31 through 35 - Intensive Care Type Inpatient Hospital Units	Column 1, lines 31 through 35
Lines 40 through 42, as applicable - Subprovider	Column l, lines 40 through 42, as applicable
Line 43 - Nursery	Column 1, line 43 for titles V and XIX
	To Worksheet L-1, Part III
Lines 50 through 76 - Ancillary Services	Column l, lines 50 through 76
Lines 88 through 91 and 93 - Outpatient Service Cost	Column l, lines 88 through 91 and 93
Subscripts of line 92 - Distinct Part Observation Bed Units	Column 1, subscripts of line 92
Lines 88, 89, 94, 97, and 98	Column l, lines 88, 89, 94, 97, and 98

4065.2 Part II - Computation of Program Inpatient Routine Service Capital Costs for Extraordinary Circumstances.--This part computes the amount of capital costs for extraordinary circumstances applicable to hospital inpatient routine service costs. Complete only one Worksheet L-1, Part II for each title. Report hospital and subprovider information on the same worksheet, lines as appropriate.

Column 1--Enter on each line the capital costs for extraordinary circumstances as appropriate. Obtain this amount from Worksheet L-1, Part I, column 26.

Column 2--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 amount in column 1 by the ratio of the amount entered on Worksheet D-1, line 26 to the amount entered on Worksheet D-1, line 21.

Column 3--Enter column 1 minus column 2.

Column 4--Enter on each line the total patient days, excluding swing bed days, by cost center from the corresponding lines of Worksheet D, Part I, column 4.

physician services furnished in other locations by physicians who are not on your full time staff are paid to you only if your agreement with the physician provides for compensation for such services.

Determination of Total Allowable Cost Applicable To RHC/FQHC Services.--Lines 10 through 18 determine the amount of the overhead costs incurred by both the parent provider and the facility which apply to RHC or FQHC services.

Line 10--Enter the cost of health care services from Worksheet M-1, column 7, line 22.

Line 11--Enter the total nonreimbursable costs from Worksheet M-1, column 7, line 28.

Line 12--Enter the sum of lines 10 and 11 for the cost of all services (excluding overhead).

Line 13--Enter the percentage of RHC or FQHC services. This percentage is determined by dividing the amount on line 10 (the cost of health care services) by the amount on line 12 (the cost of all services, excluding overhead).

Line 14--Enter the total facility overhead costs incurred from Worksheet M-1, column 7, line 31.

Line 15--Enter the overhead costs incurred by the parent provider allocated to the RHC/FQHC. This amount is the difference between the total costs after cost allocation on Worksheet B, Part I, column 26 and Worksheet B, Part I, column 0. If GME costs are claimed on line 20 of Worksheet M-1, do not include the GME costs allocated to the RHC/FQHC in columns 21 and 22 of Worksheet B, Part I.

Line 16--Enter the sum of lines 14 and 15 to determine the total overhead costs related to the RHC/FQHC.

Line 17--If you are claiming allowable GME cost (line 20 of *W*orksheet M-1 completed), divide the total *intern and resident* visits reported on *Worksheet S-8, line 15, column 5* by the total visits for the facility (sum of lines 8 and 9, column 5 above), multiply the result by line 16 above, and enter that amount. If you are not claiming GME enter -0-.

Line 18--Subtract the amount on line 17 from line 16 and enter the result.

Line 19--Enter the overhead amount applicable to RHC/FQHC services. It is determined by multiplying the amount on line 13 (the ratio of RHC/FQHC services to total services) by the amount on line 18 (total overhead costs).

Line 20--Enter the total allowable cost of RHC/FQHC services. It is the sum of line 10 (cost of RHC/FQHC health care services) and line 19 (overhead costs applicable to RHC/FQHC services).

4068. WORKSHEET M-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet applies to title XVIII only and provides for the reimbursement calculation. Use this worksheet to determine the interim all inclusive rate of payment and the total program payment due you for the reporting period for each RHC or FQHC being reported.

Determination of Rate For RHC/FQHC Services.--Worksheet M-3 calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line descriptions

Line 1--Enter the total allowable cost from Worksheet M-2, line 20.

Line 2--Report vaccine costs on this line from Worksheet M-4.

Line 3--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4--Enter the greater of the minimum or actual visits by the health care staff from Worksheet M-2, column 5, line 8.

Line 5--Enter the visits made by physicians under agreement from Worksheet M-2, column 5, line 9.

Line 6--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

For services rendered from January 1, 2010, through December 31, 2013, the maximum rate per visit entered on line 8 and the outpatient mental health treatment service limitation applied on line 14 both correspond to the same time period (partial calendar year). Consequently, both are entered in the same column and no further subscripting of the columns is necessary.

Lines 8 and 9--The limits are updated every January 1. However, the possibility exists that limits may also be updated other than on January 1. Complete columns 1, 2 and 3, if applicable (add a column 3 for lines 8-14 if the cost reporting overlaps 3 limit update periods) of lines 8 and 9 to identify costs and visits affected by different payment limits for a cost reporting period that overlaps January 1. If only one payment limit is applicable during the cost reporting period (calendar year reporting period), complete column 2 only.

Line 8--Enter the per visit payment limit. Obtain this amount from CMS Pub. 27, §505 or from your contractor.

NOTE: If you are based in a small rural hospital with less than 50 beds (the bed count is based on the same calculation used on Worksheet E, Part A, line 4), in accordance with 42 CFR §412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2.

NOTE: RHCs that are based in a small urban hospital with less than 50 beds (as calculated above) will also be exempt from the per visit limit.

For RHCs based in small urban hospitals transfer the adjusted cost per visit (line 7) to line 9, column 1 and/or 2.

Line 9--Enter the lesser of the amount on line 7 or line 8.

Calculation of Settlement.--Complete lines 10 through 29 to determine the total program payment due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period. Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

Line descriptions

Line 10--Enter the number of program covered visits excluding visits subject to the outpatient mental health services limitation from your contractor records.

Line 11--Enter the subtotal of program cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered program beneficiary visits for RHC/FQHC services during the reporting period).

Line 12--Enter the number of program covered visits subject to the outpatient mental health services limitation from your contractor records.

Line 13--Enter the program covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14--Enter the limit adjustment. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: For services rendered through December 31, 2009, the limitation is 62.50 percent; services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; services from January 1, 2013 through December 31, 2013, the limitation is 81.25 percent; and services on or after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health treatment service limit percentage. This limit applies only to therapeutic services, not initial diagnostic services.

NOTE: *Section 4104 of ACA eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. RHCs and FQHCs must provide detailed HCPCS coding for preventive services to ensure coinsurance and deductible are not applied. Providers must maintain this documentation to apply the appropriate reductions on lines 16.03 and 16.04.*

Line 15--Enter the amount of GME pass through costs determined by dividing the program intern and resident visits reported on Worksheet S-8, line 15 by the total visits reported on Worksheet *S-8, line 15,* column 5. Multiply that result by the allowable GME costs equal to the sum of Worksheet M-1, column 7, line 20 and Worksheet M-2, line 17. *For cost reporting periods that overlap January 1, 2011 prorate the result using a ratio of days prior to and on or after January 1, 2011 for each column. For cost reporting periods beginning on or after January 1, 2011, do not use column 1 and enter the result in column 2.*

Line 16--*For cost reporting periods that overlap January 1, 2011, enter in column 1 the sum of lines 11, 14, and 15, column 1 and in column 2, the sum of lines 11, 14, and 15, column 2. For cost reporting periods beginning on or after January 1, 2011, do not use column 1 and e*nter the total program cost in column 2. This is equal to the sum of the amounts in columns 1 and 2, respectively (and 3 if applicable), lines 11, 14, and 15.

Line 16.01--Enter the total program charges from the contractor's records *(PS&R)*. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in *column 2*.

Line 16.02--Enter the total program preventive charges from the provider's records. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program preventive charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in *column 2*.

Line 16.03--Enter the total program preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16, *column 2*.

Line 16.04.--Enter the total program non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program non- preventive costs ((line 16 minus line*s* 16.03 *and 18*) times .80) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program non-

preventive costs ((line 16, *column 2,* minus line*s* 16.03 *and 18, column 2*) times .80) in *column 2*.

Line 16.05--Enter the total program costs. For cost reporting periods that overlap January 1, 2011, enter total program costs (line *16* times .80) *for services rendered prior to January 1, 2011* in column 1, and enter the sum of lines 16.03 and 16.04, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the sum of lines 16.03 and 16.04, in *column 2*.

Line 17--Enter the primary payer amounts from your records.

Line 18--Enter the amount credited to the RHC's program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the contractor from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the contractor. FQHCs enter zero on this line as deductibles do not apply.

Line 19--Enter the coinsurance amount applicable to the RHC or FQHC for program patient visits on lines 10 and 12 as recorded by the contractor from clinic bills processed during the reporting period. *This line captures data for informational and statistical purposes only. This line does not impact the settlement calculation.*

Line 20--Enter the net program costs, excluding vaccines. *For cost reporting periods that overlap January 1, 2011, enter* the result of subtracting the *amount* on *line 17* from the amount on line 16.05, columns 1 and 2. *For cost reporting beginning on or after January 1, 2011, enter the result of subtracting the amount on line 17 from the amount on line 16.05, column 2.*

Line 21--Enter the amount from Worksheet M-4, line 16.

Line 22--Enter the total allowable Medicare cost, sum of the amounts on lines 20 and 21.

Line 23--Enter your total allowable bad debts, net of recoveries, from your records. If recoveries exceed the current year's bad debts, line 23 will be negative.

Line 24--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 23.

Line 25--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see Pub. 15-1, §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 26--This is the sum of lines 22 and 23 plus or minus line 25.

Line 27--Enter the total interim payments from Worksheet M-5 made to you for covered services furnished to program beneficiaries during the reporting period (from contractor records).

Line 28--For final settlement, report on line 28 the amount on line 5.99 of Worksheet M-5.

Line 29--Enter the total amount due to/from the program (line 26 minus line 27 and 28). Transfer this amount to Worksheet S, Part III, column 3, line 10 and/or 11 as applicable.

Line 30--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal costfinding process. (See *CMS* Pub. 15-*2*, §115.2.) A schedule showing the supporting details and computations must be attached.

Transfer this amount to Worksheet M-3, line 2.

Line 16--Enter the Medicare cost of pneumococcal and influenza vaccines and their administration costs. This is equal to the sum of the amount in column 1, line 14 plus column 2 (and applicable subscripts), line 14.

Transfer the result to Worksheet M-3, line 21.

4070. WORKSHEET M-5 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based RHC/FQHC, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor.

Line Descriptions

Line 1--Enter the total program interim payments paid to the RHC/FQHC. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable.

Line 2--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period. It does not include payments reported on line 1.

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

Line 4--Transfer the total interim payments to the title XVIII Worksheet M-3, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET M-5. LINES 5 THROUGH 7 ARE FOR CONTRACTOR 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 *NPR* has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due from the provider to the program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet M-3, line 26.

Line 8--Enter the contractor name, the contractor number *and NPR date* in columns *0*, 1 and 2, respectively.