

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-20 One-Time Notification</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 1171</b>	<b>Date: January 31, 2013</b>
	<b>Change Request 7746</b>

**SUBJECT: Instructions to Contractors for Implementing Section 5506 of the Affordable Care Act (ACA)-Preservation of Resident Cap Positions from Closed Teaching Hospitals - Round 1 and Round 2 Only**

**I. SUMMARY OF CHANGES:** This Change Request (CR) provides contractors with instructions for incorporating section 5506 resident cap increases that are effective retroactively on applicable hospitals' cost reports that have already been filed, and for recalculating the hospital's direct GME and IME payments accordingly on those filed cost reports. This CR applies to Round 1 and Round 2 of section 5506.

**EFFECTIVE DATE: March 4, 2013**

**IMPLEMENTATION DATE: March 4, 2013, as part of the normal settlement process.**

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

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

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

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
N/A	

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**One Time Notification**

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

# Attachment – One-Time Notification

Pub. 100-20

Transmittal: 1171

Date: January 31, 2013

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**SUBJECT: Instructions to Contractors for Implementing Section 5506 of the Affordable Care Act (ACA) - Preservation of Resident Cap Positions from Closed Teaching Hospitals – Round 1 and Round 2 Only**

**Effective Date: March 4, 2013**

**Implementation Date: March 4, 2013, as part of the normal settlement process.**

## **I. GENERAL INFORMATION**

**A. Background:** Section 5506 of the ACA directed CMS to develop a process to preserve the FTE (full-time equivalent) resident caps from teaching hospitals that close. CMS finalized its policy for implementing section 5506, which included establishment of an application process and procedures for redistributing the FTE resident cap slots associated with the closed hospital's direct GME and IME caps, in the November 24, 2010 Federal Register (75 FR 72212). Hospitals that wished to apply for the FTE resident cap slots of the 14 teaching hospitals that closed between March 23, 2008 and August 3, 2010 submitted their applications to CMS by April 1, 2011. For ease of reference, we are referring to this first round of section 5506 applications as Round 1. Hospitals that applied for the FTE resident cap slots of the 1 New York City teaching hospital that closed on October 31, 2010 (St. Vincent's Medical Center, SVMC), submitted their applications to CMS by December 1, 2011. For ease of reference, we are referring to this second round of section 5506 application as Round 2.

On February 28, 2012, CMS mailed award letters to hospitals and posted on the CMS website the awards for hospitals that received slots from hospitals closed under Round 1. To see the awardees, the awards, and the effective dates, go to <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html>, and in the Downloads section of the page, click on [Section 5506 Cap Increases Related to Applications Due April 1, 2011](#).

On November 30, 2012, CMS posted on our website the awards from Round 2 for hospitals that received slots due to the closure of SVMC. On December 6, 2012, CMS mailed award letters to hospitals. To see the awardees, the awards, and the effective dates, go to <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html>, and click on the "Section 5506 Cap Increases Round 2 – Applications due Dec 1, 2011" link in the Downloads section of the page.

Based on the policy established in the November 24, 2010 Federal Register (75 FR 72225-6), and further clarified in the August 31, 2012 Federal Register (77 FR 53437-53443), the additional cap slots that a hospital receives under section 5506 may have different effective dates. That is, of the total cap slots that a qualifying hospital receives, some slots may increase the FTE resident cap retroactively, while other slots may increase the hospital's FTE resident cap prospectively. CMS is not requiring hospitals to file amended cost reports to incorporate section 5506 cap increases that are effective retroactively and affect cost reports that have already been filed. Instead, the contractors will revise the applicable hospitals' cost reports. The purpose of this CR is to provide instructions to the contractors for incorporating the section 5506 cap increases *that are effective retroactively* on applicable hospitals' cost reports *that have already been filed*, and for recalculating the hospital's direct GME and IME payments accordingly on those already filed cost reports. This CR also provides hospitals with instructions for incorporating Round 1 and Round 2 section 5506 cap increases into cost reports that have not yet been filed. *This CR does NOT apply to future rounds of section 5506 after Round 1 and Round 2.*

**B. Policy:** In the November 24, 2010 Federal Register, CMS established seven Ranking Criteria under which hospitals' applications for slots from closed hospitals are ranked. CMS clarified the effective dates of the Ranking Criteria applicable to Round 1 and Round 2 in the August 31, 2012 IPPS Federal Register [77

FR 53437-53443 August 31, 2012]. Slots are redistributed to applying hospitals based, in part, on these seven Ranking Criteria, with a higher-ranked application receiving slots before a lower-ranked application. For hospitals receiving slots under Ranking Criteria 1 or 3, the permanent cap increase would be effective beginning with the cost reporting period *following* the one in which the hospital closure occurred (see 75 FR 72225 November 24, 2010). For hospitals receiving slots under Ranking Criterion 2, the permanent cap increase is effective on the day of the particular hospital's closure (77 FR 53437-8 August 31, 2012). Since the first section 5506 hospital closure occurred on May 31, 2008, these cost reporting periods are all in the past, dating as far back as calendar year 2008. For hospitals receiving slots under Ranking Criteria 4, 5, 6, or 7, the permanent cap increases are effective as of a July 1, either in the past or in the future, or on January 30, 2012, the date of the award announcement under Round 1, and November 30, 2012, the date of the award announcement under Round 2. Following are instructions for contractors on how to amend hospitals' applicable submitted cost reports to reflect the change in direct GME and IME payment due to the FTE resident cap increases received under section 5506, and instructions for providers on how to report the FTE counts of cost reports that have not yet been submitted.

Note that contractors may be amending several cost reports for each applicable hospital; that is, the hospital's FYs 2008, 2009, 2010 2011, and possibly 2012 cost report, depending on the hospital's fiscal year end.

Also note that separate instructions are provided below for amending cost reports filed on the CMS Form 2552-96 and on the CMS Form 2552-10. This is because worksheet E, Part A and worksheet E-3, Part IV on the CMS Form 2552-96 were not revised, and will not be revised, to incorporate lines to report the section 5506 FTE resident cap increases. However, worksheet E, Part A and worksheet E-4 of the CMS Form 2552-10 were amended to accommodate the section 5506 FTE resident cap increases. Therefore, the instructions for amending a cost report and reporting the section 5506 FTE resident cap increase will differ depending on whether the applicable cost report is filed on the CMS Form 2552-96 or the CMS Form 2552-10.

Contractors and hospitals shall use the excel spreadsheet called CR 7746 Section 5506 Temp Adj Calc.xlsx that is provided with this CR to determine the proper FTE counts and section 5506 adjustments to be reported on each applicable cost report in which there were displaced residents and/or a section 5506 cap increase. The 3<sup>rd</sup> and 4<sup>th</sup> tabs of that spreadsheet may be used to record and track all of a hospital's section 5506 cap adjustments and their effective dates (even for subsequent section 5506 rounds).

- I. Steps to Recalculate the IME and Direct GME Payment Due to a Section 5506 FTE Resident Cap Increase
  1. Refer to the CMS website (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html>) or the hospital's section 5506 award letter to identify any cap increases that are effective during cost reports that have already been filed. Contractors shall complete Tab3 and Tab4 of the CR 7746 Section 5506 Temp Adj Calc.xlsx. (Instructions for completing these tabs are on the tabs, and in the EXAMPLE provided below).
  2. Determine if the cost report was filed on CMS Form 2552-96 or CMS Form 2552-10. If it was filed on CMS Form 2552-96, then proceed to step 3. If it was filed on CMS Form 2552-10, then skip to step 4.
  3. If the Form 2552-96 cost report has been settled as of the implementation date of this CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount. Proceed to step 3.a.

If the Form 2552-96 cost report has NOT been settled, and the desk review/audit has not been completed as of the date of this CR, when the contractor performs the desk review/audit for this cost report, the contractor shall proceed to step 3.a. and incorporate the applicable steps in this CR into the desk review.

If the Form 2552-96 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall proceed to step 3.a. and complete the applicable steps in this CR before settling the cost report.

For Form 2552-96 Cost Reports:

- a. Report the amount of the section 5506 cap increase for IME and/or direct GME respectively that *is effective during the cost report that you are amending* on worksheet S-3, Part I, line 17. Use column 7 for the IME cap increase and column 8 for the direct GME cap increase. (Normally line 17 is for “Other Long Term Care Facilities,” but we are adopting this line and its columns for special reporting of the section 5506 cap increases on the Form 2552-96 cost reports, and it will serve as an indicator as to whether the hospital received a section 5506 cap increase in this cost reporting period). If you complete Tab3 and Tab4 of the CR 7746 Section 5506 Temp Adj Calc.xlsx, then the chart called Cost Report Entries at the bottom of Tab4 will automatically calculate the amounts to be entered on worksheet S-3, Part I, line 17. Proceed to step 3.b.
- b. IME: On worksheet E, Part A, line 3.06, enter the amount of the section 5506 cap increase applicable to this cost reporting period. (Normally line 3.06 is used to report an adjustment to the cap due to Medicare GME affiliation agreements, but we are adopting it for purposes of recalculating the hospital’s allowable FTE count and IME payment under section 5506. However, if a hospital is also a member of a Medicare GME affiliation group during this cost reporting period, the positive or negative adjustment due to that Medicare GME affiliation agreement would still be reported on line 3.06, as usual, so that the section 5506 cap and the affiliations adjustment would be added together). If the effective date of the cap increase is not the same as the 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). Complete Tab3 and Tab4 of the CR 7746 Section 5506 Temp Adj Calc.xlsx, and the chart called Cost Report Entries at the bottom of Tab4 will automatically calculate the amount to be entered on worksheet E, Part A, line 3.06. (Note that this calculated amount for line 3.06 does *not* include any adjustments for affiliation agreements).

Proceed through lines 3.07 through 3.24 on worksheet E, Part A, to recalculate the hospital’s IME payment on that cost report. For providers that have received temporary adjustments under 42 CFR 413.79(h) for displaced residents *and* that received section 5506 cap awards, complete Tab1 and Tab2 of the CR 7746 Section 5506 Temp Adj Cal.xlsx, and the chart called Cost Report Entries at the bottom of Tab1 will automatically calculate the amounts to be entered on worksheet E, Part A. Refer to section II. below for detailed instructions on completing CR 7746 Section 5506 Temp Adj Calc.xlsx and worksheet E, Part A.

- c. Direct GME: On worksheet E-3, Part IV, line 3.03, enter the amount of the section 5506 cap increase applicable to this cost reporting period. (Normally line 3.03 is used to report an adjustment to the cap due to Medicare GME affiliation agreements, but we are adopting it for purposes of recalculating the hospital’s allowable FTE count and direct GME payment under section 5506. However, if a hospital is also a member of a Medicare GME affiliation group during this cost reporting period, the positive or negative adjustment due to that Medicare GME affiliation agreement would still be reported on line 3.03, as usual, so that the section 5506 cap and the affiliations adjustment would be added together). If the effective date of the cap increase is not the same as the 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.) Complete Tab3 and Tab4 of the CR 7746 Section 5506 Temp Adj Calc.xlsx, and the chart called Cost Report Entries at the bottom of Tab4 will automatically calculate the amount to be entered on worksheet E-3, Part IV, line 3.03. (Note that this calculated amount for line 3.03 does *not* include any adjustments for affiliation agreements).

Proceed through lines 3.04 through 6.08 on worksheet E-3, Part IV, to recalculate the hospital's direct GME payment on that cost report. For providers that have received temporary adjustments under 42 CFR 413.79(h) for displaced residents *and* that received section 5506 cap awards, complete Tab1 and Tab2 of CR 7746 Section 5506 Temp Adj Calc.xlsx, and the chart called Cost Report Entries at the bottom of Tab1 will automatically calculate the amounts to be entered on worksheet E-3, Part IV. Refer to section II. below for detailed instructions on completing on completing CR 7746 Section 5506 Temp Adj Calc.xlsx and worksheet E-3, Part IV on the CMS Form 2552-96 and the worksheet E-4 on the CMS Form 2552-10.

4. If the Form 2552-10 cost report has been settled as of the date of the CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount. Proceed to step 4.a.

If the Form 2552-10 cost report has NOT been settled and the desk review/audit has NOT been completed as of the date of the CR, when the contractor performs the desk review/audit for this cost report, the contractor shall proceed to step 4.a. and incorporate the applicable steps in this CR into the desk review.

If the Form 2552-10 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall proceed to step 4.a. and complete the applicable steps in this CR before settling the cost report.

For Form 2552-10 Cost Reports:

- a. IME: Report the amount of the section 5506 cap increase for IME on worksheet E, Part A, line 8.02 *applicable to this cost reporting period*, and proceed through the rest of Worksheet E, Part A, making revisions as necessary.

The instructions for IME on worksheet E, Part A, line 8.02 state, "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 . . .*" The phrase "if the hospital receives FTE cap slot awards on more than one occasion under section 5506" means that a hospital could receive slots from more than one round of section 5506 applications; that is, from Round 1 or Round 2 and/or from future teaching hospital closures. Upon the completion of each round of section 5506 application processes, CMS will post the awards on its website and issue an award letter to each hospital receiving section 5506 slots under that round. The number of times line 8.02 and its subscripts are filled out shall equal the number of times the hospital receives awards on the web file and the number of award letters the hospital receives for each respective round. Line 8.02 shall only be subscripted to report slots awarded from *different* rounds of section 5506; that is, from different CMS application processes. Eventually, as the multiple effective dates become effective over multiple cost reporting periods, line 8.02 will reflect the *total* IME section 5506 cap increase the hospital received the first time that it received section 5506 slots, but not necessarily from Round 1. Similarly, line 8.03 will reflect the *total* IME section 5506 cap increase the hospital received under a subsequent round of section 5506. (In other words, if a hospital did not receive slots under Round 1, but did receive slots under Round 2, then line 8.02 would reflect the awards from Round 2, and so forth. Each subscript of line 8.02 will eventually reflect the total IME section 5506 cap increase received for each respective round).

Refer to section II. below for detailed instructions on completing worksheet E, Part A.

- b. Direct GME: Report the amount of the section 5506 cap increase for direct GME on worksheet E-4, line 4.02 *applicable to this cost reporting period*, and proceed through the rest of Worksheet E-4, making revisions as necessary.

The instructions for direct GME on worksheet E-4, line 4.02 state, “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 . . .*” The phrase “if the hospital receives FTE cap slot awards on more than one occasion under section 5506” means that a hospital could receive slots from more than one round of section 5506 applications; that is, from future teaching hospital closures. Upon the completion of each round of section 5506 application processes, CMS will post the awards on its website and issue an award letter to each hospital receiving section 5506 slots under that round. The number of times line 4.02 and its subscripts are filled out shall equal the number of times the hospital receives awards on the web file and the number of award letters the hospital receives for each respective round. Line 4.02 shall only be subscripted to report slots awarded from *different* rounds of section 5506; that is, from different CMS application processes. Eventually, as the multiple effective dates become effective, line 4.02 will reflect the *total* direct GME section 5506 cap increase the hospital received the first time that it received section 5506 slots, but not necessarily from Round 1. Similarly, line 4.03 will reflect the *total* direct GME section 5506 cap increase the hospital received under a subsequent round of section 5506. (In other words, if a hospital did not receive slots under Round 1, but did receive slots under Round 2, then line 4.02 would reflect the awards from Round 2, and so forth. Each subscript of line 4.02 will eventually reflect the total direct GME section 5506 cap increase received for each respective round).

Refer to section II. below for detailed instructions on completing worksheet E-4.

## II. Interaction of the 3-Year Rolling Average and Slots Awarded Under Section 5506 (Applicable to CMS Form 2552-96 and CMS Form 2552-10):

As a hospital’s FTE resident cap increases as a result of section 5506 awarded slots, the hospital is able to count more FTE residents for IME and direct GME payment purposes on a cost report. The higher allowable current year FTE count also means that a larger FTE count would be incorporated into the rolling average calculation and into the IME intern and resident-to-bed (IRB) ratio cap. If a hospital received a section 5506 award, but did not also receive a temporary cap adjustment for displaced residents under section 413.79(h), then the additional FTEs counted are immediately subject to the rolling average and the IRB ratio cap. For a hospital that did receive a temporary FTE cap adjustment and an attending exemption from the rolling average under section 413.79(h) for training residents displaced from a closed hospital, the following describes when and how section 5506 slots would replace the temporary cap adjustments of displaced FTE residents, resulting in the inclusion of the displaced FTEs in the rolling average and subsection to the IME IRB ratio cap:

### *Separation of Awards from Round 1 and Round 2:*

Slots awarded under Round 1 may only replace temporary FTE cap adjustments associated with residents displaced from Round 1. If in a cost reporting period, a hospital is awarded slots from Round 1 and is training FTEs displaced both by the closed hospitals associated with Round 1 and with the closed hospital associated with Round 2, the slots awarded under Round 1 would not remove Round 2 SVMC displaced FTEs from exemption from the rolling average. Only slots awarded from Round 2 may remove SVMC FTEs from being reported after the rolling average. Similarly, slots awarded under Round 2 would not remove Round 1 displaced FTEs from exemption from the rolling average. Furthermore, no slots awarded under Round 1 or Round 2 may replace residents displaced by the closure of other programs or hospitals that were not part of Round 1 or Round 2 (such as the closure in New York of Brookdale University Hospital Medical Center’s anesthesiology program or the closure of Peninsula Hospital Center). If a hospital received a temporary cap adjustment under section 413.79(h) for residents displaced from another closed

program or hospital not associated with Round 1 or Round 2, those displaced FTEs would continue to be exempt from the rolling average and the IRB ratio cap, so long as the hospital qualifies for a temporary cap adjustment (i.e., the hospital's total allopathic and osteopathic FTE count including FTEs from all program or hospital closures is greater than the hospital's FTE resident cap *with* the usual adjustments (including section 5503 or section 5506 adjustments)).

Use the attached spreadsheet CR 7746 Section 5506 Temp Adj Calc.xlsx that is provided with this CR to determine the amount of temporary cap adjustment, if any, a hospital qualifies for in a cost reporting period, and how to report the section 5506 cap adjustments and FTE counts on the cost report. Complete Tab1 for a hospital if the hospital was training displaced residents from closed hospitals in the particular cost reporting period you are working on, AND also received a section 5506 award(s) applicable in that cost reporting period. (Note that Tab1 may also be completed for the purpose of determining if a hospital is eligible for a temporary cap adjustment under 42 CFR 413.79(h) for displaced FTEs, even in the absence of section 5506 awards). Complete Tab2 if the hospital was training displaced residents from closed hospitals in this cost reporting period, AND a portion of the displaced residents were from closed hospitals that had caps slots redistributed under Round 1 or Round 2 of section 5506, AND the hospital received a section 5506 award(s) under Round 1 or Round 2 applicable during this cost reporting period. Complete Tabs3 and 4 for all hospitals that received a section 5506 cap award(s), even if the hospital did not train displaced residents in this cost reporting period. Be sure to enter into Tab3, cells B1, B2, B3, and B4, the provider's name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. When completing Tab1 and/or Tab2, be sure to enter into cells B1, B2, B3, and B4, the provider's name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. Contractors shall ask a hospital to provide any FTE information for IME and for direct GME respectively (including unweighted, weighted, and displaced FTE information) that the contractor requires in order to implement this CR.

## **A. IME**

### **1. Section 5506 Cap Calculation**

a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of 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). Complete Tabs3 and 4 of CR 7746 Section 5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab2, cell L21.

b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of 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). Complete Tabs 3 and 4 of CR 7746 Section 5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab2, cell L22.

### **2. Identification of the Displaced FTE Residents**

a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L24).

b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input Tab 2, cell L25).

c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period from Round 1 and Round 2 and also from program or hospital closures *not* associated with Round 1 or Round 2 (first you have to manually enter the amount into Tab 1, cell I19, and then it will automatically input into Tab 2, cell L27. Note: Tab 2, cell L27 and Tab 1, cell I19 must equal each other.)

d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L26).

### 3. Determination of FTE Caps and Counts

a. Determine the IME adjusted FTE cap, including the section 5506 cap increase(s). This amount is reported on worksheet E, Part A, line 3.07 of Form CMS 2552-96 and on worksheet E, Part A, line 9 of Form CMS 2552-10 (manual input into Tab 1, cell I14).

b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell I17).

c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell I21)

d. Of the total unweighted displaced FTEs from 2.c., determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. is greater than the adjusted cap from 3.a., then the hospital might be eligible for a temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell I24). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell I26 (automatic input) is the amount of displaced FTEs that are not over the cap. If this amount is greater than zero, then that is the portion of displaced FTEs that is covered by the FTE cap and *for this portion of displaced FTEs*, no temporary cap adjustment to or exemption from the rolling average is necessary. If this amount is less than or equal to zero, then all of the hospital's FTEs, including displaced FTEs, are in excess of the cap, and a temporary adjustment is necessary.

e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell I28 and automatic input into Tab 2, cell L28). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount.

### 4. Temporary Adjustment Calculation

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

a. Take the lesser of the potential for a temporary cap adjustment from 3.e. or the displaced FTE count of closures not associated with either Round 1 or Round 1 from 2.d. This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L30).

b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1. This step offsets the number of displaced FTEs associated with Round 1 (2.a.)

from the Round 1 section 5506 award effective in this cost reporting period (1.a.). If a hospital's cumulative section 5506 Round 1 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 1, then the Round 1 section 5506 award will "cancel" any temporary cap adjustment associated with Round 1 displaced FTEs. Only if the amount of Round 1 displaced FTEs exceeds the Round 1 section 5506 award will some amount of temporary cap adjustment be provided for the Round 1 displaced FTEs. Specifically, take the lower of (3.e. – 4.a.) or (2.a. – 1.a.) (NOT the absolute value). The result is the amount of temporary cap adjustment, if any, that will be provided in this cost reporting period for Round 1 displaced FTEs (automatic input into Tab 2, cell L31).

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. This step offsets the number of displaced FTEs associated with Round 2 (2.b.) from the Round 2 section 5506 award effective in this cost reporting period (1.b.). If a hospital's cumulative section 5506 Round 2 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 2, then the Round 2 section 5506 award will "cancel" any temporary cap adjustment associated with Round 2 displaced FTEs. Only if the amount of Round 2 displaced FTEs exceeds the Round 2 section 5506 award will some amount of temporary cap adjustment be provided for the Round 2 displaced FTEs. Specifically, take the lower of (3.e. - 4.a. - 4.b.) or (2.b. - 1.b.) (NOT the absolute value). The result is the amount of temporary adjustment, if any, that will be provided in this cost reporting period for Round 2 displaced FTEs (automatic input into Tab 2, cell L32).

d. Add 4.a., 4.b., and 4.c. This sum is the portion of the displaced FTEs that is added after the rolling average to the numerator of the current year IRB ratio (automatic input into Tab 2, cell L33, and Tab 1, cell I29). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E59).

To compute the prior year IRB ratio, complete cells I34 through I41 on Tab 1. See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. (Choosing either 2552-96 or 2552-10 will also change references to cost report lines in Tab 1, cells C15, H15, J34, and J40).

## **B. DIRECT GME**

### **1. Section 5506 Cap Calculation**

a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of 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). Complete Tabs 3 and 4 of CR 7746 Section 5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab2, cell L36.

b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of 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). Complete Tabs 3 and 4 of CR 7746 Section

5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab2, cell L37.

## 2. Identification of the Displaced FTE Residents

- a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L39).
- b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input Tab 2, cell L40).
- c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period from Round 1 and Round 2 and also from program or hospital closures *not* associated with Round 1 or Round 2 (first you have to manually enter the amount into Tab 1, cell D19, and then it will automatically input into Tab 2, cell L42. Note: Tab 2, cell L42 and Tab 1, cell D19 must equal each other.)
- d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L41).

## 3. Determination of FTE Caps and Counts

- a. Determine the direct GME adjusted FTE cap, including the section 5506 cap increase(s). This amount is reported on worksheet E-3, Part IV, line 3.04 of Form CMS 2552-96 and on worksheet E-4, line 5 of Form CMS 2552-10 (manual input into Tab 1, cell D14).
- b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell D17).
- c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell D21)
- d. Of the total unweighted displaced FTEs from 2.c., determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. is greater than the adjusted cap from 3.a., then the hospital might be eligible for a temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell D24). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell D26 (automatic input) is the amount of displaced FTEs that are not over the cap. If this amount is greater than zero, then that is the portion of displaced FTEs that is covered by the FTE cap and *for this portion of displaced FTEs*, no temporary cap adjustment to or exemption from the rolling average is necessary. If this amount is less than or equal to zero, then all of the hospital's FTEs, including displaced FTEs, are in excess of the cap, and a temporary adjustment is necessary.
- e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell D28 and automatic input into Tab 2, cell L43). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount.

## 4. Temporary Adjustment Calculation

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

a. Take the lesser of the potential for a temporary cap adjustment from 3.e. or the displaced FTE count of closures not associated with either Round 1 or Round 2 from 2.d. This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L45).

b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1. This step offsets the number of displaced FTEs associated with Round 1 (2.a.) from the Round 1 section 5506 award effective in this cost reporting period (1.a.). If a hospital's cumulative section 5506 Round 1 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 1, then the Round 1 section 5506 award will "cancel" any temporary cap adjustment associated with Round 1 displaced FTEs. Only if the amount of Round 1 displaced FTEs exceeds the Round 1 section 5506 award will some amount of temporary cap adjustment be provided for the Round 1 displaced FTEs. Specifically, take the lower of (3.e. – 4.a.) or (2.a. – 1.a.) (NOT absolute value). The result is the amount of temporary cap adjustment, if any, that will be provided in this cost reporting period for Round 1 displaced FTEs (automatic input into Tab 2, cell L46).

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. This step offsets the number of displaced FTEs associated with Round 2 (2.b.) from the Round 2 section 5506 award effective in this cost reporting period (1.b.). If a hospital's cumulative section 5506 Round 2 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 2, then the Round 2 section 5506 award will "cancel" any temporary cap adjustment associated with Round 2 displaced FTEs. Only if the amount of Round 2 displaced FTEs exceeds the Round 2 section 5506 award will some amount of temporary cap adjustment be provided for the Round 2 displaced FTEs. Specifically, take the lower of (3.e. - 4.a. - 4.b.) or (2.b. - 1.b.) (NOT absolute value). The result is the amount of temporary adjustment, if any, that will be provided in this cost reporting period for Round 2 displaced FTEs (automatic input into Tab 2, cell L47).

d. Add 4.a., 4.b., and 4.c. This sum is the *unweighted direct GME* portion of the displaced FTEs that is exempt from the rolling average (automatic input into Tab 2, cell L48, and Tab 1, cell D29). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E54).

## 5. Weighted FTE Count Calculation

Convert unweighted FTE counts to weighted FTE counts and determine a weighted portion to be added after the primary care & OB/GYN rolling average and the weighted portion to be added after non-primary care rolling average:

a. Determine the ratio of the unweighted temporary cap adjustment to the total displaced FTEs (automatic input into Tab 1, cell D30).

b. Determine the current year weighted primary care and OB/GYN displaced FTEs (manual input into Tab 1, cell D32).

c. Determine the current year weighted non-primary care displaced FTEs (manual input into Tab 1, cell D34).

d. Determine the weighted temporary cap adjustment/amount to be added to the primary care & OB/GYN rolling average (multiply the ratio in 5.a. by the weighted primary care & OB/GYN displaced FTEs in 5.b.) (automatic input into Tab 1, cell D36)

e. Determine the weighted temporary cap adjustment/amount to be added to nonprimary care rolling average (multiply the ratio in 5.a. by the weighted non-primary care displaced FTEs in 5.c.) (Tab 1, cell D38).

The remaining portion of the weighted displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count, and in the weighted primary care & OB/GYN and non-primary care FTE counts. Complete Tab 1, cells D41 and D44, entering the current year allopathic and osteopathic weighted primary care/OB/GYN and nonprimary care FTEs, respectively, including displaced FTEs. See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. (Choosing either 2552-96 or 2552-10 will also change references to cost report lines in Tab 1, cells C15, H15, J34, and J40).

### C. EXAMPLE

Following is an example illustrating how the amount of FTEs to be reported after the rolling average should be determined and reported on the cost report:

Hospital X has a 12/31 FYE and the Medicare contractor is working on amending the 12/31/11 cost report.

Hospital X has the following relevant FTE counts (you will need this information to complete the example):

- a. IME and direct GME unweighted allopathic and osteopathic displaced FTE resident count for residents relating to closed hospitals in Round 1 of section 5506 = 7.00
- b. IME and direct GME unweighted allopathic and osteopathic displaced FTE resident count for residents relating to closed hospitals in Round 2 of section 5506 = 6.00
- c. Remaining unweighted allopathic and osteopathic displaced FTE resident count (not associated with Round 1 or Round 2) = 2.00
- d. IME and direct GME total unweighted displaced FTE count = 7.00 + 6.00 + 2.00 = 15.00.
- e. IME and direct GME adjusted cap, including the section 5506 add-on in FYE 12/31/11 = 100.00.
- f. IME and direct GME unweighted allopathic and osteopathic FTE count *without* displaced FTE residents = 98.00.
- g. Direct GME weighted displaced FTEs in primary care and OB/GYN = 8.00.
- h. Direct GME weighted displaced FTEs in non-primary care = 2.00.
- i. Direct GME weighted primary care and OB/GYN audited FTE residents including displaced FTEs = 45.00.
- j. Direct GME weighted non-primary care audited FTE residents including displaced FTEs (excluding dental and podiatry) = 38.00.
- k. Prior year allowable IME FTEs = 100.00
- l. Prior year available beds = 300.00.

Hospital X received the following slots and effective dates under Round 1:

#### IME

Effective 7/1/08:	1.75
Effective date for cost reports beginning after 6/16/08:	1.07
Effective 7/1/09:	1.70
Effective 7/1/10:	21.12
Effective 7/10/10:	3.00
Effective date for cost reports beginning after 7/10/10:	0.43

Effective 7/1/11: 7.02

DGME

Effective 6/16/08: 7.00  
Effective 7/1/08: 1.75  
Effective date for cost reports beginning after 6/16/08: 2.60  
Effective 7/1/09: 1.55  
Effective 7/1/10: 17.02  
Effective 7/10/10: 3.00  
Effective date for cost reports beginning after 7/10/10: 1.14  
Effective 7/1/11: 5.43

Hospital X received the following slots and effective dates under Round 2:

IME

Effective date for cost reports beginning after 10/31/10: 1.00  
Effective 7/1/11: 1.99

DGME

Effective date for cost reports beginning after 10/31/10: 1.00  
Effective 7/1/11: 1.99

Enter into Tab 3, cells B1, B2, B3, and B4, the provider's name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. FYB is 01/01/11 and FYE is 12/31/11.

Enter into Tab 3, columns B through L, the effective dates and the corresponding amount of slots awarded. Round 1 effective dates and slots begin on row 22, and Round 2 effective dates and slots begin on row 63. For DGME, enter into Tab3, column B, the effective dates that say, "Effective date for cost reports beginning after m/dd/yy", and enter the corresponding slots into column C. If the effective date is just "Effective m/d/yy," then enter into Tab3, column E the effective date, and the corresponding slots in column F. For IME, enter into Tab3, column H, the effective dates that say, "Effective date for cost reports beginning after m/dd/yy," and enter the corresponding slots into column I. If the effective date is just, "Effective m/d/yy," then enter into Tab3, column K the effective date, and the corresponding slots into column L. For example, for IME Round 1, enter into Tab3 cell K22 "7/1/08," and enter into cell L22 "1.75." Then enter into cell H22 "6/16/08," and enter into cell I22 "1.07." Continue to enter the rest of the Round 1 and the Round 2 effective dates and slots in this manner.

Note that in columns N through R, the actual amount of each cap award that is effective during FYE 12/31/11 is automatically calculated, and prorating for slots effective 7/1/11 also occurs automatically. Also note that the total cumulative slots effective during FYE 12/31/11 are automatically calculated for DGME, Round 1, in cell O54 (should say 36.80), and Round 2, in cell O95 (should say 2.00), and for IME, Round 1, cell R55 (should say 32.61), and Round 2, in cell R96 (should say 2.00).

The detailed effective date and award information from Tab 3 must be manually transferred to Tab 4 in summary form. Tab 4 lists in chronological order the applicable round and the cumulative section 5506 cap award effective during prior and current cost reporting periods. Cells G14 and G31 on Tab4 should say "2" – the number of award rounds applicable to this cost reporting period. Follow the instructions on Tab 4.

For DGME, enter 1 into cell B19, and enter 36.80 into cell C19 (note that 36.80 comes from Tab 3, cell O54). Enter 2 into cell B20, and enter 2.00 into cell C20 (note that 2.00 comes from Tab 3, cell O95).

For IME, enter 1 into cell B36, and enter 32.61 into cell C36 (note that 32.61 comes from Tab 3, cell R55). Enter 2 into cell B37, and enter 2.00 into cell C37 (note that 2.00 comes from Tab 3, cell R96).

Cell H29 should say 38.80, the combined Round 1 and Round 2 DGME cap increase, and cell H46 should say 34.61, the combined Round 1 and Round 2 IME cap increase. At the bottom of Tab 4, there is a chart listing the lines on the cost report where the section 5506 cap awards are reported, and the amount reported on each line. Click on cell D49 to access the down arrow to toggle between cost report Form 2552-96 and Form 2552-10. Since the current cost report in this example is FYE 12/31/11, choose Form 2552-10.

Proceed to complete Tabs 1 and 2.

Enter into Tab 1, cells B1, B2, B3, and B4, the provider's name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. FYB is 01/01/11 and FYE is 12/31/11.

## **IME**

### **1. Section 5506 Cap Calculation**

a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab2, cell L21 = 32.61.

b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab2, cell L22 = 2.00.

### **2. Identification of the Displaced FTE Residents**

a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L24=7.00).

b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input Tab 2, cell L25 = 6.00).

c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period (First manual input into Tab 1, cell I19 = 15.00, and then automatic input into Tab 2, cell L27 = 15.00.)

d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L26=2.00).

### **3. Determination of FTE Caps and Counts**

a. Determine the IME adjusted FTE cap, including the section 5506 cap increase(s). This amount is reported on on worksheet E, Part A, line 9 of Form CMS 2552-10 (manual input into Tab 1, cell I14 = 100.00).

b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell I17 = 98.00).

c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell I21= 113.00)

d. Of the total unweighted displaced FTEs from 2.c., determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. (113.00) is greater than the adjusted cap from 3.a. (100.00), then the hospital might be eligible for a

temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell I24, should say 13.00). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell I26 (automatic input, should say 2.00) is the amount of displaced FTEs that are not over the cap. This means that of the 15 total displaced FTEs, 13.00 are over the cap, and potentially may be exempt from the rolling average. However, 2.00 displaced FTEs are covered by the FTE cap and *for this portion of FTEs*, no temporary cap adjustment to the rolling average is necessary.

e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell I28 and automatic input into Tab 2, cell L28; should say 13.00). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount of 13.00.

#### 4. Temporary Adjustment Calculation

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

a. Take the lesser of the potential for a temporary cap adjustment from 3.e. (13.00) or the displaced FTE count of closures not associated with either Round 1 or Round 1 from 2.d. (2.00). This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L30; should say 2.00).

b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1 ( $13.00 - 2.00 = 11.00$  remaining). This step offsets the number of displaced FTEs associated with Round 1 (2.a., 7.00 FTEs, Tab 2, cell L24) from the Round 1 section 5506 award effective in this cost reporting period (1.a., 32.61, Tab 2, cell L21 ). If a hospital's cumulative section 5506 Round 1 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 1, then the Round 1 section 5506 award will "cancel" any temporary cap adjustment associated with Round 1 displaced FTEs. Only if the amount of Round 1 displaced FTEs exceeds the Round 1 section 5506 award will some amount of temporary cap adjustment be provided for the Round 1 displaced FTEs. Specifically, take the lower of ( $13.00 - 2.00$ ) or ( $7.00 - 32.61$ ) (not absolute value). While there are 11 slots potentially available from which to provide a temporary cap adjustment under Round 1, since the Round 1 section 5506 award of 32.61 effective in this cost reporting period exceeds the 7.00 Round 1 displaced FTEs, the section 5506 award "cancels" any temporary cap adjustment for Round 1 displaced FTEs. Mathematically, since  $7.00 - 32.61$  equals a negative number, this means that there is no temporary cap adjustment provided in this cost reporting period for Round 1 displaced FTEs (automatic input into Tab 2, cell L31 = 0).

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. Since none of 11 available slots were assigned to Round 1, there are still 11 slots potentially available to be added after the rolling average for Round 2 displaced FTEs. This step offsets the number of displaced FTEs associated with Round 2 (2.b., 6.00 FTEs, Tab 2, cell L25) from the Round 2 section 5506 award effective in this cost reporting period (1.b., 2.00, Tab 2, cell L22). If a hospital's cumulative section 5506 Round 2 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 2, then the Round 2 section 5506 award will "cancel" any temporary cap adjustment associated with Round 2 displaced FTEs. Only if the amount of Round 2 displaced FTEs exceeds the Round 2 section 5506 award will some amount of temporary cap adjustment be provided for the Round 2 displaced FTEs. Specifically, take the lower of ( $13.00 - 2.00 - 0.00$ ) or ( $6.00 - 2.00$ ) (not absolute value). 4.00 is less than 11.00, and the result of 4.00 means that the

Round 2 section 5506 award of 2.00 “cancels” the temporary cap adjustment of 2 out of the 6 displaced FTEs associated with Round 2. Therefore, 4.00 FTEs is the amount of temporary adjustment that will be provided in this cost reporting period for Round 2 displaced FTEs (automatic input into Tab 2, cell L32 = 4.00).

d. Add 4.a., 4.b., and 4.c. ( $2.00 + 0 + 4.00 = 6.00$ ). This sum is the portion of the displaced FTEs that is added after the rolling average to the numerator of the current year IRB ratio (automatic input into Tab 2, cell L33, and Tab 1, cell I29 = 6.00). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E59 = 107.00). Note that  $6.00 + 107.00 = 113.00$ , the current year total unweighted allopathic and osteopathic FTEs in Tab 1, cell I21. All of the hospital’s 113 FTEs are accounted for.

To compute the prior year IRB ratio, complete cells I34 through I41 on Tab 1. Using the FTE information provided about Hospital X at the beginning of this example, manually input 100.00 into cell I34, 0 into cell I35, and 0 into cell I37. Cell I38 should automatically calculate 6.00 FTEs as the displaced FTEs to add to the numerator of the prior year IRB ratio, and cell I39 should automatically calculate 106.00 as the prior year numerator. Next, manually input 300 beds into cell I40, and the revised IRB ratio of 0.353333 should automatically calculate in cell I41.

See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. Choose Form 2552-10 for the current cost report because the FYE is 12/31/11, and choose Form 2552-96 as the prior year cost report because Form 2552-96 is the form to use for FYE 12/31/10.

## **DIRECT GME**

### **1. Section 5506 Cap Calculation**

a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab2, cell L36 = 36.80.

b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab2, cell L22 Tab2, cell L37 = 2.00.

### **2. Identification of the Displaced FTE Residents**

a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L39 = 7.00).

b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input Tab 2, cell L40 = 6.00).

c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period (first manually input into Tab 1, cell D19 = 15.00, and then automatic input into Tab 2, cell L42 = 15.00.)

d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L41 = 2.00).

### 3. Determination of FTE Caps and Counts

- a. Determine the direct GME adjusted FTE cap, including the section 5506 cap increase(s). This amount is reported on worksheet E-4, line 5 of Form CMS 2552-10 (manual input into Tab 1, cell D14 = 100.00).
- b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell D17 = 98.00).
- c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell D21 = 113.00)
- d. Of the total unweighted displaced FTEs from 2.c. (15.00), determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. (113.00) is greater than the adjusted cap from 3.a. (100.00), then the hospital might be eligible for a temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell D24 = 13.00). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell D26 (automatic input) is the amount of displaced FTEs that are not over the cap (should say 2.00). This means that of the 15 total displaced FTEs, 13.00 are over the cap, and potentially may be exempt from the rolling average. However, 2.00 displaced FTEs are covered by the FTE cap and *for this portion of FTEs*, no temporary cap adjustment to the rolling average is necessary.
- e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell D28 and automatic input into Tab 2, cell L43 should say 13.00). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount of 13.00.

### 4. Temporary Adjustment Calculation

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

- a. Take the lesser of the potential for a temporary cap adjustment from 3.e. (13.00) or the displaced FTE count of closures not associated with either Round 1 or Round 1 from 2.d. (2.00). This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L45, should say 2.00).
- b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1. (13.00 – 2.00 = 11.00 remaining). This step offsets the number of displaced FTEs associated with Round 1 (2.a., 7.00 FTEs, Tab 2, cell L39) from the Round 1 section 5506 award effective in this cost reporting period (1.a., 36.80, Tab 2, cell L36 ). If a hospital's cumulative section 5506 Round 1 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 1, then the Round 1 section 5506 award will “cancel” any temporary cap adjustment associated with Round 1 displaced FTEs. Only if the amount of Round 1 displaced FTEs exceeds the Round 1 section 5506 award will some amount of temporary cap adjustment be provided for the Round 1 displaced FTEs. Specifically, take the lower of (13.00 – 2.00) or (7.00 – 36.80) (not absolute value). While there are 11 slots potentially available from which to provide a temporary cap adjustment under Round 1, since the Round 1 section 5506 award of 36.80 effective in this cost reporting period exceeds the 7.00 Round 1 displaced FTEs, the section 5506 award “cancels” any temporary cap adjustment for Round 1 displaced FTEs. Mathematically, since 7.00 – 36.80 equals a negative number, this means that there is no temporary cap adjustment provided in this cost reporting period for Round 1 displaced FTEs (automatic input into Tab 2, cell L46 = 0).

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. Since none of 11 available slots were assigned to Round 1, there are still 11 slots potentially available to be added after the rolling average for Round 2 displaced FTEs. This step offsets the number of displaced FTEs associated with Round 2 (2.b., 6.00 FTEs, Tab 2, cell L40) from the Round 2 section 5506 award effective in this cost reporting period (1.b., 2.00, Tab 2, cell L37). If a hospital's cumulative section 5506 Round 2 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 2, then the Round 2 section 5506 award will "cancel" any temporary cap adjustment associated with Round 2 displaced FTEs. Only if the amount of Round 2 displaced FTEs exceeds the Round 2 section 5506 award will some amount of temporary cap adjustment be provided for the Round 2 displaced FTEs. Specifically, take the lower of  $(13.00 - 2.00 - 0.00)$  or  $(6.00 - 2.00)$  (not absolute value). 4.00 is less than 11.00, and the result of 4.00 means that the Round 2 section 5506 award of 2.00 "cancels" the temporary cap adjustment of 2 out of the 6 displaced FTEs associated with Round 2. Therefore, 4.00 FTEs is the amount of temporary adjustment that will be provided in this cost reporting period for Round 2 displaced FTEs (automatic input into Tab 2, cell L47 = 4.00).

d. Add 4.a., 4.b., and 4.c. ( $2.00 + 0.00 + 4.00 = 6.00$ ). This sum is the *unweighted direct GME* portion of the displaced FTEs that is exempt from the rolling average (automatic input into Tab 2, cell L48, and Tab 1, cell D29 should say 6.00). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E54 should say 107.00). Note that  $6.00 + 107.00 = 113.00$ , the current year total unweighted allopathic and osteopathic FTEs in Tab 1, cell D21. All of the hospital's 113 FTEs are accounted for.

##### 5. Calculation of Weighted FTE Counts

Convert unweighted FTE counts to weighted FTE counts and determine a weighted portion to be added after the primary care & OB/GYN rolling average and the weighted portion to be added after nonprimary care rolling average:

a. Determine the ratio of the unweighted temporary cap adjustment to the total displaced FTEs (automatic input into Tab 1, cell D30 should say 0.40).

b. Determine the current year weighted primary care and OB/GYN displaced FTEs (manual input into Tab 1, cell D32 = 8.00).

c. Determine the current year weighted non-primary care displaced FTEs (manual input into Tab 1, cell D34 = 2.00).

d. Determine the weighted temporary cap adjustment/amount to be added to the primary care & OB/GYN rolling average (multiply the ratio in 5.a. by the weighted primary care & OB/GYN displaced FTEs in 5.b. =  $0.40 \times 8.00$ , automatic input into Tab 1, cell D36 = 3.20)

e. Determine the weighted temporary cap adjustment/amount to be added to nonprimary care rolling average (multiply the ratio in 5.a. by the weighted non-primary care displaced FTEs in 5.c.,  $0.40 \times 2.00$ , automatic input into Tab 1, cell D38 = 0.80).

The remaining portion of the weighted displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count, and in the weighted primary care & OB/GYN and nonprimary care FTE counts. Using the information about Hospital X provided at the beginning of this example, complete Tab 1, cells D41 and D44, entering the current year allopathic and osteopathic weighted

primary care/OB/GYN and nonprimary care FTEs, respectively, including displaced FTEs. (D41 = 45.00 and D44 = 38.00).

See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. Choose Form 2552-10 for the current cost report because the FYE is 12/31/11, and choose Form 2552-96 as the prior year cost report because Form 2552-96 is the form to use for FYE 12/31/10.

### III. Timeframe for Implementation

Contractors shall complete the business requirements in this CR as part of the normal settlement and reopening processes. If the SSI ratios for a fiscal year are not available (e.g., FY 2010), those cost reports that are impacted by CR 7746 shall not be settled.

Once a hospital’s CMS Form 2552-96 or Form 2552-10 cost report has been adjusted and is ready to be settled, contractors shall issue a Notice of Program Reimbursement (NPR) for open cost reports and a revised NPR for those cost reports reopened for purposes of including the section 5506 direct GME and/or IME cap increase(s).

At this point, we are not instructing contractors to issue revised tentative settlements on any open cost reports for any cost report revisions made pursuant to this CR resulting in additional monies due to the hospitals. However, if an extended period of time occurs between proposing the adjustments to incorporate the DGME and/or IME cap increases and the final settlement of the cost report, contractors may consider issuing a subsequent tentative settlement.

Contractors shall use the provider’s IME and direct GME FTE resident caps as adjusted by section 5506 when completing the next scheduled interim rate review for these hospitals.

## II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)								
		A / B  M A C	D M M A C	F I	C A R R I E R	R H R I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
7746.1	Contractors shall refer to the hospital’s section 5506 award letter or CMS website (go to <a href="http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html">http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html</a> , and for Round 1, click on <a href="#">Section 5506 Cap Increases Related to Applications Due April 1, 2011</a> in the Downloads section, and for Round 2, click on the “Section 5506 Cap Increases Round 2 – Applications due Dec 1, 2011” link in the Downloads section of the page) to identify any cap increases that are effective during cost reports that have	x		x						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M M A C	F I  M A C	C A R R I E R	R A H R I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	already been filed.										
7746.2	Contractors and hospitals shall use the excel spreadsheet called CR 7746 Section 5506 Temp Adj Calc.xlsx that is provided with this CR to determine the proper FTE counts and section 5506 adjustments to be reported on each applicable cost report in which there were displaced residents and/or a section 5506 cap increase.	x		x							
7746.3	Contractors shall determine if the hospital's cost report was filed on CMS Form 2552-96 or CMS Form 2552-10. If it was filed on CMS Form 2552-96, then proceed to BR 7746.4. If it was filed on CMS Form 2552-10, then skip to BR 7746.10.	x		x							
7746.4	If the Form 2552-96 cost report has been settled as of the implementation date of this CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount.	x		x							
7746.5	If the Form 2552-96 cost report has NOT been settled, and the desk review/audit has not been completed as of the date of this CR, when the contractor performs the desk review/audit for this cost report, the contractor shall proceed to BR 7746.7 and incorporate the applicable steps in this CR into the desk review.	x		x							
7746.6	If the Form 2552-96 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall proceed to BR 7746.7 and complete the applicable steps in this CR before settling the cost report.	x		x							
7746.7	<u>For Form 2552-96 Cost Reports:</u> Contractors shall report the amount of the section 5506 cap increase for IME and/or direct GME respectively that <i>is effective during the cost report that the contractors are amending on</i> worksheet S-3, Part I, line 17. Contractors shall use column 7 for the IME cap increase and column 8 for the direct GME cap increase. Proceed to BR 7746.8.	x		x							
7746.8	<u>IME:</u> On worksheet E, Part A, line 3.06, contractors shall enter the amount of the section 5506 cap increase applicable to this cost reporting period. If the effective date of the cap increase is not the same as the fiscal year begin date, then prorate the cap increase accordingly.	x		x							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R A H R I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	Contractors shall proceed through lines 3.07 through 3.24 on worksheet E, Part A, to recalculate the hospital's IME payment on that cost report.										
7746.9	<u>Direct GME:</u> On worksheet E-3, Part IV, line 3.03, contractors shall enter the amount of the section 5506 cap increase applicable to this cost reporting period. If the effective date of the cap increase is not the same as the fiscal year begin date, then prorate the cap increase accordingly. Contractors shall proceed through lines 3.04 through 6.08 on worksheet E-3, Part IV, to recalculate the hospital's direct GME payment on that cost report.	x		x							
7746.10	<u>For Form 2552-10 Cost Reports:</u> If the Form 2552-10 cost report has been settled as of the date of the CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount.	x		x							
7746.11	If the Form 2552-10 cost report has NOT been settled and the desk review/audit has NOT been completed as of the date of the CR, when the contractor performs the desk review/audit for this cost report, the contractor shall proceed to BR 7746.13 and incorporate the applicable steps in this CR into the desk review.	x		x							
7746.12	If the Form 2552-10 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall proceed to BR 7746.13 and complete the applicable steps in this CR before settling the cost report.	x		x							
7746.13	<u>IME:</u> Contractors shall report the amount of the section 5506 cap increase for IME on worksheet E, Part A, line 8.02 <i>applicable to this cost reporting period</i> , and proceed through the rest of Worksheet E, Part A, making revisions as necessary. The number of times line 8.02 and its subscripts are filled out shall equal the number of times the hospital receives awards on the web file and the number of award letters the hospital receives for each respective round. Line 8.02 shall only be subscribed to report slots awarded from <i>different</i> rounds of section 5506; that is, from different CMS application processes.	x		x							
7746.14	<u>Direct GME:</u> Contractors shall report the amount of the section 5506 cap increase for direct GME on worksheet	x		x							



Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B  M A C	D M E  M A C	F I  M A C	C A R R I E R	R H R I	Shared-System Maintainers			
					F I S S	M C S	V M S	C W F		
	available (e.g., FY 2010), those cost reports that are impacted by CR 7746 shall not be settled. Once a hospital's CMS Form 2552-96 or Form 2552-10 cost report has been adjusted and is ready to be settled, contractors shall issue a Notice of Program Reimbursement (NPR) for open cost reports and a revised NPR for those cost reports reopened for purposes of including the section 5506 direct GME and/or IME cap increase(s).									
7746.19	Contractors shall use the provider's IME and direct GME FTE resident caps as adjusted by section 5506 when completing the next scheduled interim rate review for these hospitals.									

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B  M A C	D M E  M A C	F I  M A C	C A R R I E R	R H R I	Shared-System Maintainers			
					F I S S	M C S	V M S	C W F		
7746.20	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	x		x						

### IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A**

*Use "Should" to denote a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:

**Section B: For all other recommendations and supporting information, use this space: N/A**

**V. CONTACTS**

**Pre-Implementation Contact(s):**

Miechal Lefkowitz (212) 616-2517, Renate Dombrowski (410) 786-4645

**Post-Implementation Contact(s):**

Contact your Contracting Officer’s Representative (COR) or Contractor Manager, as applicable.

**VI. FUNDING**

**Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:***

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: For *Medicare Administrative Contractors (MACs):***

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**Attachment**

Provider Name  
 Provider No.  
 FYB  
 FYE

**Displaced Resident Cost Report Calculation**

**PURPOSE:** To report IME and DGME displaced resident FTEs due to the closure of another teaching hospital and/or program on the Medicare cost report  
 Complete Tab1 if the provider has displaced residents but no section 5506 cap awards, OR complete Tab1 if the provider has displaced residents *and* section 5506 award(s)

= Input cell

**DGME**

DGME adjusted cap, including ACA 5506 add-on (E-4 line 5)

CY unwt'd A&O FTEs w/o displaced residents

CY unwt'd A&O displaced resident FTEs

CY total unwt'd A&O FTEs (including displaced residents) 0.00

FTEs over the CAP 0.00

Portion of unwt'd displaced FTEs not over the cap (if negative or zero, all displaced FTEs are in excess of cap)

Potential unwt'd temp. cap adjustment for displaced residents 0.00

Unwt'd temp cap adj for displaced residents 0.00

Ratio of unwt'd temp cap adj to total displaced FTEs 0.00

CY weighted displaced FTEs Prim. Care&OBGYN

CY weighted displaced FTEs Non Primary Care

Final temp. cap adj. wght'd displ. FTEs Prim. Care&OBGYN 0.00

Final temp. cap adj. wght'd displ. FTEs Non-Primary Care 0.00

CY wght'd primary care and OBGYN FTEs (including displaced residents)

CY wght'd NonPrim.Care FTEs (excl. dent. & podiatry) (including displaced residents)

CY Cost Reporting Form: 2552-10  
 (2552-96 or 2552-10) Click on cell C47 to access the down arrow to toggle between 2552-96 and 2552-10.

Prior Year Cost Reporting Form 2552-10  
 (2552-96 or 2552-10) Click on cell C49 to access the down arrow to toggle between 2552-96 and 2552-10.

**IME**

IME adjusted cap, including ACA 5506 add-on (E Part A line 9)

CY unwt'd A&O FTEs w/o displaced residents

CY unwt'd A&O displaced resident FTEs

CY total unwt'd A&O FTEs (including displaced residents) 0.00

FTEs over the CAP 0.00

Portion of unwt'd displaced FTEs not over the cap (if negative or zero, all displaced FTEs are in excess of cap)

Potential Temp. cap adjustment for displaced residents 0.00

Total temp. cap adjustment for displaced residents 0.00

**Prior Year Resident-to-Bed Ratio:**

Prior Year allowable IME FTEs (PY E part A line 12)

Add on for increase in affiliation FTEs

Add on for new programs in initial yrs

Add on for CY displaced residents 0.00

Prior Year numerator 0.00

Prior Year available beds (PY E Part A line 4)

Revised IRB Ratio 0.000000

formula = (PY FTE+affiliation increase+new programs in initials years + CY add on for displaced residents)/PY Beds

**COST REPORT ENTRIES:**

W/S	Line	Column	Adjustment
E-4		6	1 0.00
E-4		8	1 0.00
E-4		16	1 0.00
E-4		8	2 0.00
E-4		16	2 0.00
E, part A		10	1 0.00
E, part A		17	1 0.00
E, part A		20	1 0.000000

**Regulation** 42 CFR Sec. 412.105(f)(1)(v), 413.79(h) & (i) & (m)  
**Reference** CMS Pub 15-2 Sec. 4030.1, 4034

Provider Name  
 Provider No.  
 FYB  
 FYE

**Displaced Resident Cost Report Calculation**

**PURPOSE:** To calculate the net temporary cap adjustment for displaced residents when there is also a round 1 or round 2 ACA 5506 cap award

Complete this worksheet only IF:

- The provider was training displaced residents from closed hospitals in this cost reporting period
- AND
- A portion of the displaced residents were from closed hospitals that had caps slots redistributed under round 1 or round 2 of ACA 5506
- AND
- The provider received cap awards from round 1 or 2 of ACA 5506 for this cost reporting period
- OTHERWISE
- Leave this schedule blank

<b>1) IME Calculation</b>		
a. Section 5506 cap awards applicable to this cost report from round 1		0.00
b. Section 5506 cap awards applicable to this cost report from round 2		0.00
c. unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 1 of section 5506		
d. unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 2 of section 5506		
e. Remaining unweighted A&O displaced FTE resident count (not associated with round 1 or round 2)		0.00
f. Total displaced FTE resident count		0.00
g. Portion of displaced FTE residents potentially eligible for temporary cap adjustment		0.00
h. Priority 1 - Temporary adj. for displaced residents not associated with round 1 or 2 awards		0.00
i. Priority 2 - Temporary adj. for round 1 displaced residents (portion in excess of cap less round 1 section 5506 award)		0.00
j. Priority 3 - Temporary adj. for round 2 displaced residents (portion in excess of cap less round 2 section 5506 award)		0.00
k. Total allowable temporary cap adjustment for displaced residents		0.00
<b>2) DGME Calculation</b>		
a. Section 5506 cap awards applicable to this cost report from round 1		0.00
b. Section 5506 cap awards applicable to this cost report from round 2		0.00
c. unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 1 of section 5506		
d. unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 2 of section 5506		
e. Remaining unweighted A&O displaced FTE resident count (not associated with round 1 or round 2)		0.00
f. Total displaced FTE resident count		0.00
g. Portion of displaced FTE residents potentially eligible for temporary cap adjustment		0.00
h. Priority 1 - Temporary adj. for displaced residents not associated with round 1 or 2 awards		0.00
i. Priority 2 - Temporary adj. for round 1 displaced residents (portion in excess of cap less round 1 section 5506 award)		0.00
j. Priority 3 - Temporary adj. for round 2 displaced residents (portion in excess of cap less round 2 section 5506 award)		0.00
k. Unwtd temp cap adj for displaced residents		0.00
l. Determine what portion of step k. should be added to the primary care rolling avg and/or to the non-primary care rolling avg		
m. Weighted portion to be added to the primary care/OB/GYN rolling avg on 2552-96 E-3 Pt IV line 3.22 or 2552-10 E-4 line 16		0.00
n. Weighted portion to be added to the non-primary care rolling avg on 2552-96 E-3 Pt IV line 3.16 or 2552-10 E-4 line 16		0.00
o. Total adjustment to DGME rolling average		0.00









































Provider Name  
Provider No.  
FYB  
FYE

**ACA 5506 IME and DGME FTE Cap Awards**

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Total 0.00

