Medicare

Provider Reimbursement Manual -

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

Department of Health and Human Services (DHHS)

Centers for Medicare and Medicaid Services (CMS)

Transmittal 18 **Date: May 2008**

This transmittal is being reissued to correct the month and year of issue on the forms and specifications to May 2008. All other information remains the same, including the transmittal number.

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NEW/REVISED MATERIAL--EFFECTIVE DATE:

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

Significant Revisions:

- Worksheet S-2 - Question 40.01 is revised to capture the FI/Medicare contractor name and FI/contractor number that receives the Home Office cost statement.
- Worksheet S-2 - Questions 61 and 62 are added to capture data on campus-specific facilities that are part of multi-campus facility.
- Worksheet S-3, Part II & III - Clarifies the instructions relating to the collection of wage data to ensure consistent and accurate reporting of such data.
- Worksheet S-5 - Questions 16 through 19 are added to capture data associated with Darbepoetin Alfa (Aranesp) for renal patients.
- Worksheet A - Revises the surgical procedure threshold to fewer than 800 to qualify for a waiver from the nonphysician anesthetists fee schedule in accordance with 412.113(c).
- Worksheet B-2 - Line 3 and 4 are added to accommodate post stepdown adjustments for Darbepoetin Alfa (Aranesp).
- Worksheet E, Part A - Revised the DRG placement chart.
- Worksheet E, Part B - Revised to reflect that interns and residents not in approved programs and professional services of teaching physicians is not subject to the lower of reasonable costs or customary charges (LCC).
- Worksheet E-3, Part I - Revised the outlier reconciliation section to this worksheet combining capital and operating outliers.
- Worksheets D, Parts III & IV - Clarified instructions regarding certified registered nurse anesthetists (CNRA).
- Worksheet D, Part V - Medicare, Medicaid, and SCHIP Extension Act of 2007, section 107 extends reasonable cost payments for certain clinical laboratory tests furnished to hospital patients in certain rural areas.
- Worksheet M-2 - Line 1 is clarified to emphasize that physician data (FTEs and visits) for services furnished to facility patients by staff physicians working under a contractual agreement with an RHC on a regular ongoing basis in the RHC facility are placed on line 1 and are subject to productivity standards in accordance with 42 CFR 491.8.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after April 30, 2008.

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

4. Round to 5 decimal places:
   a. Sequestration (e.g., 2.092 percent is expressed as .02092)
   b. Payment reduction (e.g., capital reduction, outpatient cost reduction)

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

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

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

A&G	-	Administrative and General
AHSEA	-	Adjusted Hourly Salary Equivalency Amount
ASC	-	Ambulatory Surgical Center
BBA	-	Balanced Budget Act
BBRA	-	Balanced Budget Reform Act
BIPA	-	Benefits Improvement and Protection Act
CAH	-	Critical Access Hospitals (10/97)
CAPD	-	Continuous Ambulatory Peritoneal Dialysis
CAP-REL	-	Capital-Related
CBSA	-	Core Based Statistical Areas
CCN	-	*CMS Certification Number (formerly known as a provider number)*
CCPD	-	Continuous Cycling Peritoneal Dialysis
CCU	-	Coronary Care Unit
CFR	-	Code of Federal Regulations
CMHC	-	Community Mental Health Center
CMS	-	Center for Medicare and Medicaid Services
COL	-	Column
CORF	-	Comprehensive Outpatient Rehabilitation Facility
CRNA	-	Certified Registered Nurse Anesthetist
CTC	-	Certified Transplant Center
DRA	-	Deficit Reduction Act of 2005
DRG	-	Diagnostic Related Group
DSH	-	Disproportionate Share
EACH	-	Essential Access Community Hospital
ESRD	-	End Stage Renal Disease
FQHC	-	Federally Qualified Health Center
FR	-	Federal Register
FTE	-	Full Time Equivalent
GME	-	Graduate Medical Education
HHA	-	Home Health Agency
HMO	-	Health Maintenance Organization
HSR	-	Hospital Specific Rate
I & Rs	-	Interns and Residents
ICF/MR	-	Intermediate Care Facility for the Mentally Retarded (9/96)
ICU	-	Intensive Care Unit
IME	-	Indirect Medical Education
INPT	-	Inpatient
IPF	-	Inpatient Psychiatric Facility
IRF	-	Inpatient Rehabilitation Facility
LIP	-	Low Income Patient

LOS	-	Length of Stay
LCC	-	Lesser of Reasonable Cost or Customary Charges
LTCH	-	Long Term Care Hospital
MA	-	*Medicare Advantage (previously known as M+C)*
M+C	-	Medicare + Choice (also known as Medicare Part C)
MCP	-	Monthly Capitation Payment
MDH	-	Medicare Dependent Hospital (10/97)
MED-ED	-	Medical Education
MMA	-	Medicare Prescription Drug Improvement and Modernization Act of 2003
MSA	-	Metropolitan Statistical Area (10/97)
MSP	-	Medicare Secondary Payer
NF	-	Nursing Facility
NHCMQ	-	Nursing Home Case Mix and Quality Demonstration
NPI	-	National Provider Identifier
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
PBP	-	Provider-Based Physician
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PRO	-	Professional Review Organization
PS&R	-	Provider Statistical and Reimbursement System
PT	-	Physical Therapy
RCE	-	Reasonable Compensation Equivalent
RHC	-	Rural Health Clinic
RPCH	-	Rural Primary Care Hospitals
RT	-	Respiratory Therapy
RUG	-	Resource Utilization Group
SCH	-	Sole Community Hospitals
SCHIP	-	State Children Health Insurance Program
SNF	-	Skilled Nursing Facility
SSI	-	Supplemental Security Income
TEFRA	-	Tax Equity and Fiscal Responsibility Act of 1982
TOPPS	-	Transitional Corridor Payment for Outpatient Prospective Payment System
UPIN	-	Unique Physician Identification Number
WKST	-	Worksheet

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

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

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

“N” for no. For CAHs the response is always “N” as the optional reimbursement method is not available to CAHs.

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

Line 30.01--Is this cost reporting period the initial 12-month period for which the facility operated as an RPCH? Enter "Y" for yes and "N" for no. For cost reporting periods beginning on or after October 1, 1997 RPCHs are eliminated and critical access hospitals are established and paid on the basis of reasonable costs. This question does not apply to CAHs (10/1/97b).

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

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

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

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

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

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

Line 33--Is this a new hospital under 42 CFR 412.300 (PPS capital)? Enter "Y" for yes or "N" for no in column 1. If yes, for cost reporting periods beginning on or after October 1, 2002, do you elect to be reimbursed at 100 percent Federal capital payment? Enter "Y" for yes or "N" for no in column 2.

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

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

Line 36--Do you elect the fully prospective payment methodology for capital costs? (See 42 CFR 412.340.) (This also includes providers that were previously hold harmless, but are now considered

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

Line 36.01--Does your facility qualify and receive payments for disproportionate share in accordance with 42 CFR 412.320? Enter "Y" for yes and "N" for no. If you are eligible as a result of the Pickle amendment, enter "P" instead of "Y." Do not complete this line if you answered no on line 36, except for new providers certified prior to October 1, 2001.

Line 37--Do you elect the hold harmless payment methodology for capital costs? (See 42 CFR 412.344.) Enter "Y" for yes or "N" for no in the applicable columns. (Not applicable for cost reporting periods beginning on or after October 1, 2001, except for new providers certified prior to October 1, 2001. If a new provider's response is "Y", complete Worksheet A, line 90 and Worksheet B, Parts II and III.)

Line 37.01--If you are a hold harmless provider, are you filing on the basis of 100 percent of the Federal rate even though payment on this basis may result in lower payment under the hold harmless blend? Enter "Y" for yes or "N" for no in the applicable columns. (Not applicable for cost reporting periods beginning on or after October 1, 2001, except for new providers certified prior to October 1, 2001.)

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

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

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

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

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

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

Line 39--Do not use this line.

Line 40--Are there any related organization or home office costs claimed? Enter "Y" for yes or "N" for no. If yes, complete Worksheet A-8-1. If you are claiming home office costs enter in column 2 the home office chain number (10/0). If this facility is part of a chain enter the name, home office number, FI/contractor number, street address, post office box (if applicable), the city, state, zip code of the home office on lines 40.01 through 40.03. *Also, enter on line 40.01, column 2, the FI/ Contractor Name, who receives the Home Office cost statement and in column 3, the FI/Contractor Number.*

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

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

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

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

Line 61—Is the hospital part of a multi-campus? Enter "Y" for yes, "N" for no. (3/31/2008)

Line 62--If you responded "Y" to question 61, 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. (3/31/2008)

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

This worksheet consists of three parts:

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

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

Column Descriptions

Column 1--Effective for discharges occurring on or after October 1, 2004, refer to 42 CFR 412.105(b) and Vol. 69 of the Federal Register 154, dated August 11, 2004, page 49093 to determine the facility bed count. Indicate the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes. (See CMS Pub. 15-I, §2205.)

Column 2--Enter the total bed days available. Bed days are computed by multiplying the number of beds available throughout the period in column 1 by the number of days in the reporting period. If there is an increase or decrease in the number of beds available during the period, multiply the number of beds available for each part of the cost reporting period by the number of days for which that number of beds was available. For CAHs only, subscript column 2 to accumulate the aggregate number of hours all CAH patients spend in each category on lines 1 and 6 through 10, effective for (August 31, 2002) and later cost reports. This data is for informational purposes only.

Columns 3 through 5--Enter the number of inpatient days or visits, where applicable, for each component by program. Do not include HMO except where required (line 2, columns 4 and 5) (10/97), organ acquisition, or observation bed days in these columns. Observation bed days are reported in column 6, line 26. For LTCH, enter in column 4 the number of covered Medicare days (from the PS&R) and in column 4.01 the number of noncovered days (from provider's books and records) for Medicare patients and continue to capture this data even after the LTCH has transitioned to 100 percent PPS.

Report the program days for PPS providers (acute care hospital, LTCH, and IRF) in the cost reporting period in which the discharge is reported. This also applies to providers under the TEFRA/PPS blend. TEFRA providers should report their program days in the reporting period in which they occur.

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

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

Column 7--Enter the number of intern and resident full time equivalents (FTEs) in an approved program determined in accordance with 42 CFR 412.105(f) for the indirect medical education adjustment. The FTE residents reported by an IPF PPS facility or an IRF PPS facility (whether freestanding or a unit reported on line 14 or 14.01 of an IPPS hospital's cost report) shall be determined in accordance with 42 CFR 412.424(d)(1)(iii) for IPFs and in accordance with the Federal Register, Vol. 70, number 156, dated August 15, 2005, pages 47929-30 for IRFs.

Column 8--When interns and residents are used by the hospital to perform the duties of an anesthetist, the related FTEs must be excluded from the interns and residents count in column 9. (See 42 CFR 412.105(g)(iv)). Enter the FTEs relating to the interns and residents performing in anesthesiology who are employed to replace anesthesiologists. Do not include interns and residents in an approved anesthesiology medical education program. Do not complete effective for cost reporting periods beginning on or after August 1997.

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

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

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

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

Line Descriptions

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

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

Line 3--Enter the Medicare covered swing bed days (which are considered synonymous with SNF swing bed days) for all Title XVIII programs where applicable. See 42CFR 413.53(a)(2). Exclude all M+C days from column 4, include the M+C days in column 6.

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

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

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

Line 12--Enter the sum of lines 5 - 11 for columns 1 - 6, and for columns 12 - 15, enter the amount

from line 1. For columns 7 - 11, enter the total for each from your records.

Line 13--Enter the number of outpatient visits for cost reporting periods beginning prior to October 1, 1997, for a rural primary care hospital by program and total. An outpatient RPCH visit is defined

in 42 CFR 413.70(b)(3)(iii). Begin reporting visits for CAHs for cost reporting periods beginning on or after October 1, 2000.

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

Line 15--If your State recognizes one level of care, complete this line for titles V, XVIII, and XIX.

Do not complete line 16. If you answered yes to line 38.03 of Worksheet S-2, complete all columns. **Exclude NHCMQ days in column 4.**

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

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

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

Line 19--Do not use this line.

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

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

Line 22--Do not use this line.

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

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

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

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

inpatients but only the hours up to the time of discharge). The amount in column 5 must equal the sum of columns 5.01 and 5.02 and the amount in column 6 must equal the sum of columns 6.01 and 6.02. (10/1/2004b)

Line 27--Enter in column 4 the number of ambulance trips, as defined by section 4531(a)(1) of The BBA, provided for Medicare patients for ambulance services on or after October 1, 1997. For cost reporting periods that overlap October 1 and July 1, 2001 see §3604, line 56 for proper subscripting (10/97). Effective for services rendered on or after December 21, 2000, ambulance costs for a CAH are reimbursed on costs if Worksheet S-2, column 1, line 30.03 is answered yes. If yes, separate the trips in accordance with Worksheet S-2, line 56 and subscripts. *For cost reporting periods that overlap January 1, 2006, subscript line 27 reporting the number of trips prior to January 1, 2006 on line 27 and the number of trips occurring on or after January 1, 2006 on line 27.01. Do not subscript this line for cost reporting periods beginning on or after January 1, 2006, but report all ambulance trips on this line.*

Line 28--Enter in column 6 the employee discount days if applicable. These days are used on Worksheet E, Part A, line 4.01 (DSH), Worksheet L, line 4 (capital IME), and Worksheet E-3, Part I, line 1.04 (LIP). Subscript this line for IRF subproviders to capture Employee discount days in column 6. (1/1/02b)

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

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

Column 1

Line 1--Enter from Worksheet A, column 1, line 101, the wages and salaries paid to hospital employees increased by amounts paid for vacation, holiday, sick, paid-time-off, severance, and bonus pay if not reported in column 1.

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

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

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

Do not include clinical nurse specialists, *nurse practitioners, and nurse midwives.* (10/00).

Line 3--Enter the non-physician anesthetist salaries included in line 1, subject to the fee schedule and

paid under Part B by the carrier. Do not include salary costs for clinical nurse specialists, nurse practitioners, and *nurse midwives.* (10/99).

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

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

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

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

Lines 8 and 8.01--Enter the amount reported on Worksheet A, column 1 for line 34 for the SNF. On line 8.01, enter from Worksheet A, column 1, the sum of lines 21, 24, 31, 35, 35.01, 36, 64, 65, 68 through 71, 82 through 86, 89, 92 through 94, and 96 through 100 (10/00). *DO NOT* include on lines 8 and 8.01 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 8.01.

Line 9--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. Do not include costs applicable to excluded areas reported on line 8 and 8.01 Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and 6 respectively). For cost reporting periods beginning before October 1, 2000, DO NOT include costs for pharmacy and laboratory services furnished under contract and subscript this line to report these costs on line 9.01 and 9.02 respectively (10/97). For cost reporting periods beginning on or after October 1, 2000, DO NOT use lines 9.01 and 9.02, but include on line 9 contract pharmacy and laboratory wage costs as defined below in lines 9.01 and 9.02.

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

Include the amount paid for ***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 9.03 or 22.01; 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 Form CMS-339, for direct patient care, pharmacy and laboratory contracts, the types of services, wages, and associated hours; for *top level* management contracts, the aggregate wages and hours (10/00).

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

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

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

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

Line 9.03--Enter the amount paid for **management and administrative services** furnished under contract, rather than by employees. *Include on this line contract management and administrative services associated with cost centers other than those listed on lines 21 through 35 (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 9.03 include department directors, administrators, managers, ward clerks, and medical secretaries. Report only those personnel costs associated with the contact. DO NOT include on line 9.03 any contract labor costs associated with lines 21 through 35 and subscripts for these lines. DO NOT include the costs for contract top level management: chief executive officer, chief operating officer, and nurse administrator; these services are included on line 9. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. (10/1/2003b).

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

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

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

If a wage related cost associated with the home office is not "core" (as described in Part I of Exhibit *6* of the Form-CMS -339) and is not a category included in "other" wage related costs on line 14 (see Part II of Exhibit *6* of Form CMS-339 and line 14 instructions below), the cost cannot be included on line 11. For example, if a hospital's employee parking cost does not meet the criteria for inclusion as a wage-related cost on line 14, any parking cost associated with home office staff cannot be included on line 11 (10/97).

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

Lines 13 through 20--*In general, the amount reported for wage-related costs must meet the "reasonable cost" provisions of Medicare. For example, in developing pension and deferred compensation costs, hospitals must comply with the requirements in 42 CFR 413.100 and the PRM, Part I, §§ 2140, 2141 and 2142 (see discussion in 70 FR 47369, August 12, 2005).*

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. Hospital are required to complete Form CMS-339, *E*xhibit 6, section *III*, a reconciliation worksheet to aid hospital and intermediaries in implementing GAAP when developing wage-related costs. Upon request by the intermediary or CMS, hospitals must provide a copy of the GAAP pronouncement, or other documentation, showing that the reporting practice is widely accepted in the hospital industry and/or related field as support for the methodology used to develop the wage-related costs. If a hospital does not complete Form CMS-339, exhibit 6 section 3, or, the hospital is unable, when requested, to provide a copy of the standard used in developing the wage-related costs, the intermediary may remove the cost from the hospital's Worksheet S-3 due to insufficient documentation *to substantiate the wage-related cost relevant to GAAP. (3/31/2008)*

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

Line 13--Enter the core wage-related costs as described in Exhibit 6 of Form CMS-339. (See note below for costs that are not to be included on line 13). Only the wage-related costs reported on Part I of Exhibit 6 are reported on this line. (Wage-related costs are reported in column 2, not column 1, of Worksheet A.)

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

Health Insurance and Health-Related Wage Related Costs:

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

Line 14--Enter the wage-related costs that are considered an exception to the core list. (See note below for costs that are not to be included on line 14.) A detailed list of each additional wage-related cost must be shown on Exhibit *6*, Part II of Form CMS-339. In order for a wage-related cost to be considered an exception, it must meet all of the following tests:

a. The cost is not listed on Exhibit *6*, Part I of Form CMS-339,

b. The wage-related cost has not been furnished for the convenience of the provider,

c. The wage-related cost is a fringe benefit as defined by the Internal Revenue Service and, where required, has been reported as wages to IRS (e.g., the unrecovered cost of employee meals, education costs, auto allowances), and

d. The total cost of the particular wage-related cost for employees whose services are paid under IPPS exceeds 1 percent of total salaries after the direct excluded salaries are removed (Worksheet S-3, Part III, column 3, line 3). Wage-related cost exceptions to the core list are not to include those wage-related costs that are required to be reported to the Internal Revenue Service as salary or wages (i.e., loan forgiveness, sick pay accruals). Include these costs in total salaries reported on line 1 of this worksheet.

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

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

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

Lines 21 through 35--Enter the direct wages and salaries from Worksheet A column 1 for the appropriate cost center identified on lines 21 through 35, respectively, increased by the amounts paid for vacation, holiday, sick, and paid-time-off if not reported in column 1 of these lines. These lines provide for the collection of hospital wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. These lines are completed by all hospitals if the ratio of Part II, column 4, sum of lines 8 and 8.01 divided by the result of column 4, line 1 minus the sum of lines 2, 3, 4.01, 5, **5.01**, 6, 6.01, and 7 equals or exceeds a threshold of 15 percent. However, all hospitals with a ratio greater than 5 percent must complete line 13 of Part III for all columns. Calculate the percent to two decimal places for purposes of rounding.

Lines 22.01, 26.01, and 27.01--Enter the amount paid for services *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 22, 26, and 27), the amounts paid for services rendered by employees not under contract. (10/1/2003b)

Line 22.01--A&G costs are expenses a hospital incurs in carrying out its administrative and/or general management functions. Include on line 22.01 the contract services that are included on Worksheet A, line 6 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 22.01. Do not include on line 22.01 the costs for top level management contracts (these costs are reported on line 9).

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

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

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

Column 4--Enter on each line the number of **paid** hours corresponding to the amounts reported in column 3. Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave hours, paid time-off hours, and hours associated with severance pay. For Part II, lines 1 through 12 (including subscripts), *lines 21 through 35 (including subscripts),* and Part III, line 13, if the hours cannot be determined, then the associated salaries must not be included in columns 1 through 3 (10/97).

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

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

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

3605.3 Part III - Hospital Wage Index Summary.--This worksheet provides for the calculation of *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 5--Follow the same instructions discussed in Part II, except for column 5, line 5.

Line 1--From Part II, enter the result of line 1 minus the sum of lines 2, 3, 4.01, 5, 5.01, 6, 6.01 (10/00), and 7 (10/97). *Add to this amount line: 22.01, 26.01 and 27.01. (04/08)*

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

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

Line 4--From Part II, enter the sum of lines 9, *9.03*, 10, 11, and 12 and subscripts if applicable (10/97).

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

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

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

Line 13--Enter from Part II above, the sum of lines 21 through 35, *including lines 22.01, 26.01, and 27.01.* If the hospital's ratio for excluded area salaries to net salaries is greater than 5 percent, the hospital must complete all columns for this line. (See instructions in Part II, lines 21 through 35 for calculating the percentage.)

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

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under titles V, XVIII, and XIX. The statistics required on this worksheet pertain to a hospital-based home health agency. The data maintained is dependent upon the services provided by the agency, number of program home health aide hours, total agency home health aide hours, program unduplicated census count, and total unduplicated census count. In addition, FTE data are required by employee staff, contracted staff, and total. Complete a separate S-4 for each hospital-based home health agency.

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

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

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

through 18.

Enter the number of hours in your normal work week.

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

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

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

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

Line 19--For HHA services rendered on or after January 1, 2006,geographic areas are identified as CBSAs. Enter in column 1 the number of MSAs and in column 1.01 the number of CBSAs you serviced during this cost reporting period (1/1/2006s).

Line 20--Identify each MSA where the reported HHA visits are performed. Subscript the lines to accommodate the number of MSA's you service (10/97). For HHA services rendered on or after January 1, 2006, enter the 5 digit CBSA code and Non-CBSA (rural). Rural CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the state of Maryland the rural CBSA code is 99921 and rural MSA codes are assembled by placing the digits "99" in front of the two digit State code, e.g., for the state of Maryland the rural MSA code is 9921.

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

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

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

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

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

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

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

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

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

Use lines 21 through 32 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 33 and 35 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 36 identifies the total number of episodes completed for each episode payment category. Line 37 identifies the total number of outlier episodes completed for each episode payment category. Outlier episodes do not apply to 1) Full Episodes without Outliers and 2) LUPA Episodes. Line 38 identifies the total medical supply charges incurred for each episode payment category. Column 7 displays the sum total of data for columns 1 through 6. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report and only pertain to services rendered on or after October 1, 2000.

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

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

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

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

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

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

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

NOTE: Lines 36 and 37 are mutually exclusive.

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

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

3607. WORKSHEET S-5 - HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to the renal dialysis department. The data maintained, depending on the services provided by the hospital, includes patient data, the number of treatments, number of stations, and home program data.

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

Line Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

Line 13--Enter the direct product cost net of discount and rebates for Epoietin (EPO). Include all EPO cost for patients receiving outpatient, home (method I or II), or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Report on this line the amount *of EPO cost* included in line 57 of Worksheet A (10/97).

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

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

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

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

Line 16--Enter the direct product cost net of discount and rebates for Darbepoetin Alfa (Aranesp) Include all Aranesp cost for patients receiving outpatient, home (method I or II), or training dialysis treatments. This amount includes Aranesp cost furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Report on this line the amount of Aranesp cost included in line 57 of Worksheet A. (3/31/2008)

Line 17--Based on the instructions contained on line 16, enter the dollar amount of Aranesp included on line 64 (home dialysis program) from Worksheet A. (3/31/2008)

Line 18--Enter the number of micrograms (mcgrs) of Aranesp furnished relating to the renal dialysis department. (3/31/2008)

Line 19--Enter the number of micrograms of Aranesp furnished relating to the home dialysis program. (3/31/2008)

Column Descriptions

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

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

If an asset for which the Medicare program had recognized depreciation during the base period is disposed of subsequent to the base period, the hospital-specific rate is not revised to recognize the portion of the gain or loss allocated to the base period.

Lines 3 and 4--New capital costs are defined as all allowable Medicare inpatient capital-related costs that do not meet the definition of old capital costs. Betterment or improvement costs related to old capital costs are new capital assets. (See 42 CFR 412.302(a).) Capital costs incurred as a result of extraordinary circumstances are new capital. (See 42 CFR 412.348(e).) Direct assignment of new capital costs must be done in accordance with CMS Pub. 15-I, §2313.

Line 6--Enter administrative and general (A & G) costs on this line. If this line is componentized into more than one cost center, eliminate line 6. Componentized A & G lines must begin with subscripted line 6.01 and continue in sequential order (e.g., 6.01 Nonpatient Telephones; 6.02 Data Processing; 6.03 Purchasing, Receiving, Stores; 6.04 Admitting; 6.05 Cashiering, Accounts; and 6.06 Other A & G).

Line 14--This cost center normally includes only the cost of nursing administration. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks.

However, if your accounting system fails to specifically identify all direct nursing services to the applicable patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 17--This cost center includes the direct costs of the medical records cost center including the medical records library. The general library and the medical library are not included in this cost center but are reported in the A & G cost center.

Line 20--Effective for services rendered on or after January 1, 1989, the services of a nonphysician anesthetist generally are paid for by the Part B carrier based on a fee schedule rather than on reasonable cost basis through the cost report. As such, the salary and fringe benefit costs included on line 20 generally are not reimbursed through the cost report.

NOTE: Only such salary and fringe benefit costs are included on this line.

However, payment for the nonphysician anesthetists on a fee basis may not apply to a rural hospital during 1991 if the hospital employed or contracted with not more than one FTE nonphysician anesthetist and, if (1) in 1987, the hospital had 250 or fewer surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services and (2) each nonphysician employed by or under contract with the hospital has agreed not to bill under Part B of title XVIII for professional services furnished. Further, payment under the fee schedule applies to hospitals during 1991 unless the hospital establishes, before the beginning of each of these years, that it *did not exceed 800* surgical procedures requiring anesthesia in the previous year. *42 CFR 412.113(c)(2)(ii) (10/1/2002)*

Hospitals which do not qualify for the exception and are therefore subject to the fee schedule payment method must remove the salary and fringe benefit costs from line 20. The total amount is reported on Worksheet A-8, line *33* and in column 6, line 20 of this worksheet. This removes these costs from the cost reported in column 7.

Lines 21 and 24--For cost reporting periods beginning on or after October 1, 1990, if you operate an approved nursing or allied health education program that meets the criteria of 42 CFR 413.85 and 412.113(b), both classroom and clinical portions of the costs are allowable as pass through costs as defined in 42 CFR 413.85.

Classroom costs are those costs associated with formal, didactic instruction on a specific topic or subject in a classroom that meets at regular, scheduled intervals over a specific time period (e.g., semester or quarter) and for which a student receives a grade.

Clinical training is defined as involving the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. While it may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques, it involves no class room instruction.

For cost reporting periods beginning on or after October 1, 1990, if you do not operate the program, the classroom portion of the costs are not allowable as pass through costs and therefore not reported on lines 21 and 24 of the Form CMS-2552-96. They may, however, be allowable as routine service operating cost. (See CMS Pub. 15-I, §404.2.) The clinical portions of these costs are allowable as pass through costs if the following conditions as set forth in §4004(b) of OBRA 1990 are met:

1. The hospital must have claimed and have been paid for clinical costs (described below) during its latest cost reporting period that ended on or before October 1, 1989.

2. The proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program and allowable under §4004(b)(1) of OBRA 1990 during a cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the hospital's most recent cost reporting period ending on or before October 1, 1989.

3. The hospital receives a benefit for the support it furnishes to the education program through the provision of clinical services by nursing and allied health students participating in the program.

4. The clinical training costs must be incurred by the provider or by an educational institution related to the provider by common ownership or control as defined by 42 CFR 413.17b (cost to related organizations). Costs incurred by a third party, regardless of its relationship to either the provider or the educational institution, are not allowed.

5. The costs incurred by the hospital for the program do not exceed the costs that would have been incurred by the hospital if the program had been operated by the hospital.

Line 21--Enter the cost for the nursing school.

Line 22--Enter the cost of intern and resident salaries and salary-related fringe benefits. Do not include salary and salary-related fringe benefits applicable to teaching physicians which are included in line 23.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 46--Include the direct expenses incurred in obtaining blood directly from donors as well as whole blood and packed red blood cells from suppliers. Do not include in this cost center the processing fee charged by suppliers. The processing charge is included in the blood storing, processing, and transfusion cost center. Identify this line with the appropriate cost center code (Table 5 - electronic reporting specifications) for the cost of administering blood clotting factors to hemophiliacs. Enter on subscripted line 46.30 the applicable costs for blood clotting factors to hemophiliacs. (See §4452 of BBA 1997, OBRA 1989 & 1993.)

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

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

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

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

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

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

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

Line 61--Enter the costs of the emergency room cost center.

Line 62--Do not use this line on this worksheet. If you have an area specifically designated for observation (e.g., observation patients are not placed in a general acute care area bed), report this on a subscripted line 62.01.

NOTE: It is possible to have both a distinct observation bed area and a non-distinct part. For example, 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 63--Use this line to report the costs of provider-based RHCs and FQHCs. If more than one are maintained and/or other services are reported on this line, subscript the line. See Table 5 in §3695 for the proper cost center code for RHCs and FQHCs. When reporting RHCs and FQHCs on these lines, subscript the line beginning with lines 63.50 through 63.59 and 63.85 through 63.99 for RHC and 63.60 through 63.84 for FQHC.

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 carrier. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Lines 64 through 68 and 70--Use these lines for other reimbursable cost centers (other than HHA, CORF, and CMHC).

Line 64--Use this line to accumulate the direct costs incurred for self-care home dialysis. For purposes of determining overhead attributable to the drugs Epoeitin *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 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 63 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 65--Report all ambulance costs on this line for both owned and operated services and services under arrangement. No subscripting is allowed for this line (9/96).

Lines 66 and 67--Use these lines to report durable medical equipment rented or sold, respectively.

For the hospital-based SNF, report support surfaces by subscripting line 67 and use the proper cost center code.

Line 69--This cost center accumulates the direct costs for outpatient rehabilitation providers, CORF, CMHC, OPT, OOT, and OSP. If you have multiple components, subscript this line using the proper cost center code.

Line 70--Use this line if your hospital operates an intern and resident program not approved by Medicare.

Line 71--This cost center accumulates costs specific to HHA services. If you have more than one certified hospital-based HHA, subscript line 71 for each HHA.

Provider-based HHAs are operated and managed in a variety of ways within the context of the health care complexes of which they are components. In some instances, there are discrete management and administrative functions pertaining to the HHA, the cost of which is readily identifiable from the books and records.

In other instances, the administration and management of the provider-based HHA is integrated with the administration and management of the health care complex to such an extent that the cost of administration and management of the home health agency can be neither identified nor derived from the books and records of the health care complex. In other instances, the cost of administration and management of the HHA is integrated with the administration and management of the health care complex, but the cost of the HHA administration and management can be derived through cost finding. However, in most cases, even when the cost of HHA administration and management can be either identified or derived, the extent to which the costs are applicable to the services furnished by the provider-based HHA is not readily identifiable.

Even when the costs of administration and management of a provider-based HHA can be identified or derived, such costs do not generally include all of the general service costs (i.e., overhead costs) applicable to the HHA. Therefore, allocation of general service costs through cost finding is necessary for the determination of the full costs of the provider-based HHA.

When the provider-based HHA can identify discrete management and administrative costs from its books and records, these costs are included on line 71.

Similar situations occur for the services furnished by the provider-based HHA. For example, in some instances, physical therapy services are furnished by a discrete HHA physical therapy department. In other instances, physical therapy services are furnished to the patient of the provider-based HHA by an integrated physical therapy department of a hospital health care complex in such a manner that the direct costs of furnishing the physical therapy services to the patients of the provider-based HHA cannot be readily identified or derived. In other instances, physical therapy services are furnished to patients of the provider-based HHA by an integrated physical therapy department of a hospital health care complex in such a manner that the costs of physical therapy services furnished to patients of the provider-based HHA can be readily identified or derived.

When you maintain a separate therapy department for the HHA apart from the hospital therapy department furnishing services to other patients of the hospital health care complex or when you are able to reclassify costs from an integrated therapy department to an HHA therapy cost center, make a reclassification entry on Worksheet A-6 to the appropriate HHA therapy cost center. Make a

Line 36---Enter, if applicable, the sum of the amounts from Worksheet A-8-3, Part VII, line 76 for speech pathology services prior to April 10, 1998 and Worksheet A-8-4, line 69 for services on and after April 10. For cost reporting periods beginning on or after April 10, 1998, use A-8-4 only. (See line 25 above for proper subscripting of this line.)

Lines 37 - 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 37 through 49. The grossing up of costs in accordance with provisions of CMS Pub. 15-I, §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 intermediary 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 carrier. 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 lines 57, 64, or both, these costs should include the cost of the drugs Epoietin *and Aranesp*. Do not report the cost of the*se* drug*s* claimed in any other cost center. These costs will be removed later on Worksheet B-2 (10/00).

If the hospital is paying membership dues to an organization which perform 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.

3614. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organization, except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the hospital by organizations related to you or costs associated with the home office. In addition, it shows certain information concerning the related organizations with which you have transacted business as well as home office costs. (See CMS Pub. 15-I, chapter 10, and §2150 respectively.)

Part A--Cost applicable to home office costs, services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.

Part B--Use this part to show your relationship to organizations identified in Part A. Show the requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to you, a common ownership with you, or control over you as defined in CMS Pub. 15-I, chapter 10 in columns 1 through 6, as appropriate.

Complete only those columns which are pertinent to the type of relationship which exists.

Column 1--Enter the appropriate symbol which describes your relationship to the related organization.

Column 2--If the symbol A, D, E, F, or G is entered in column 1, enter the name of the related individual in column 2.

Column 3--If the individual indicated in column 2 or the organization indicated in column 4 has a financial interest in you, enter the percent of ownership as a ratio.

Column 4--Enter the name of the related corporation, partnership, or other organization.

Column 5--If you or the individual indicated in column 2 has a financial interest in the related organizations, enter the percent of ownership in such organization as a ratio.

Column 6--Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen service).

Column 7--Enter the specific column of Worksheet A-7, Part III columns 9 through 14 impacted by the adjustment (10/97).

	To Worksheet D-l, Part III
Line 34 - SNF	Line 71 for the SNF
Sum of lines 34 and 35	Line 71 for the NF
	To Worksheet D, Part II
Lines 37-59 - Ancillary Services	Column 2, lines 37-59
Lines 60, 61, subscripts of 62, and 63 - Outpatient Service Cost	Column 2, lines 60, 61, subscripts of 62, and 63
Lines 64, 65, and 68 - Other Reimbursable Cost Centers	Column 2, lines 64, 65, and 68
	To Worksheet C, Part II, Column 2
Lines 37-68	Lines 37-68

3619. WORKSHEET B-2 - POST STEP DOWN ADJUSTMENTS

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

Column Descriptions

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

Column 2--Make post step down adjustments on Worksheets B, Parts I through III, and L-1. Enter the worksheet part to which the post step down adjustment applies. For lines 57 and/or 64 remove the amount for Epoietin *and Aranesp* reported on Worksheet S-5 lines 13, 13.01*, 16 ,and 17.*

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

Code	Worksheet
1	B, Part I
2	B, Part II
3	B, Part III
4	L-1, Part I

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

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

Line Descriptions

Line 1--Enter the amount of the *EPO* adjustment for the renal dialysis inpatient department.

Line 2--Enter the amount of the *EPO* adjustment for the home dialysis program.

Line 3--Enter the amount of the Aranesp adjustment for the renal dialysis inpatient department. (3/31/2008)

Line 4--Enter the amount of the Aranesp adjustment for the home dialysis program. (3/31/2008)

Lines *5* - 59--Enter any additional adjustments that 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, use additional Worksheets B-2.

3620. WORKSHEET C - COMPUTATION OF RATIO OF COST TO CHARGES AND OUTPATIENT CAPITAL REDUCTION

This worksheet consists of five parts:

Part I - Computation of Ratio of Cost to Charges
Part II - Computation of Outpatient Services Cost to Charge Ratios Net of Reductions
Part III - Computation of Total Inpatient Ancillary Costs - Rural Primary Care Hospitals
Part IV - Computation of Inpatient Operating Costs - Rural Primary Care Hospitals
Part V - Computation of Outpatient Cost Per Visit - Rural Primary Care Hospitals

NOTE: Rural primary care designation is replaced with critical access hospital beginning October 1, 1997. For cost reporting periods beginning after October 1, 1997, Parts III through V are not applicable.

3620.1 Part I - Computation of Ratio of Cost to Charges.--This worksheet computes the ratio of cost to charges for inpatient services and, for providers not subject to the outpatient capital reduction, the outpatient ratio of cost to charges. *All charges entered on this worksheet must comply with PRM-I, sections 2202.4 and 2203.* This ratio is used on Worksheet D, Part V, for titles V and XIX and for title XVIII costs not subject to the outpatient capital reduction; Worksheet D-4; Worksheet D-6; Worksheet H-4, 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 PPS, TEFRA, or other.

42 CFR 413.106(f)(4) 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 (prospective payment).

42 CFR 405.482(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)(4) and 42 CFR 405.482(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 PPS or TEFRA (e.g., hospital-based SNFs). Also use this ratio for Part B services still subject to cost reimbursement but not subject to outpatient capital reduction. 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 a PPS inpatient ratio. This ratio reflects the add-back of RT/PT and RCE limitations to total cost since inpatient hospital services covered by PPS 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 PPS or TEFRA, e.g., outpatient services costs not subject to outpatient capital reduction, are classified as "Cost or Other."

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

	Columns		
Type of Service	Cost or Other	TEFRA Inpatient	PPS Inpatient
Inpatient routine service cost centers (lines 25-36)	1	1-3	1-5
Inpatient ancillary (lines 37-68)	1, 8, 9	1-3, 8-10	1-9, 11
Outpatient ancillary and outpatient cost centers (for costs not subject to capital reduction)	1, 8, 9	1-3, 8-10	1-9, 11

Column 1--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 27. Transfer the amount on line 62 from Worksheet D-1, Part IV, line 85, if you do not have a distinct observation bed area. If you have a distinct observation bed area, subscript line 62 into line 62.01, and transfer the appropriate amount from Worksheet B, Part I, column 27. In a complex comprised of an acute care hospital with an excluded unit, the acute care hospital reports the observation bed costs. Subproviders (hospital only, i.e. psychiatric, rehabilitation, or long term care facility) with separate provider numbers from the main hospital may report observation bed costs if a separate outpatient department is maintained within the subprovider unit. If the subprovider is reporting observation bed days (Worksheet S-3, line 26.01), add the amount reported by both the hospital and the subprovider from Worksheet D-1, line 85, and enter the sum on line 62. The RHC/FQHC costs on lines 63.50 through 63.99, for cost reporting periods which overlap the January 1, 1998, effective date will be transferred to this worksheet from Worksheet B, column 27. For cost reporting periods beginning on or after January 1, 1998, no cost or charges are reported on this worksheet for the RHC/FQHC. However, 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 63.50 through 63.99 (1/98). Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 27. However, report the charges applicable to such cost centers with a credit balance in column 6 of the appropriate line on Worksheet C, Part I.

Column 2--Enter the amount of therapy limits applied to the cost center on lines 49 to 52. Obtain these amounts from Worksheet A-8, lines 25, 26, 35 and 36 respectively.

NOTE: Complete this column only when the hospital or subprovider is subject to PPS (see 42 CFR 412.1(a) through 412.125) or the TEFRA rate of increase ceiling. (See 42 CFR 413.40.) 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 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 7--Enter on each line the total patient days, excluding swing bed days, for that cost center. For line 25, enter the total days reported on Worksheet S-3, Part I, column 6, the sum of lines 1 and 26. For lines 26 through 33, enter the days from Worksheet S-3, Part I, column 6, lines 6 through 10, 14, and 11 respectively. For subprovider, line 31, add to line 14 of worksheet S-3, the observation bed days, if applicable, reported on the subscripts of line 26.

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

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type inpatient hospital days for purposes of computing the intensive care type inpatient hospital unit per diem. However, count the program days as general routine days in computing program reimbursement. (See CMS Pub. 15-I, §2217.) Add any program days for general care patients of the component who temporarily occupied beds in an intensive care or other special care unit to line 25, and decrease the appropriate intensive care or other special care unit by those days.

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

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

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

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

3621.2 Part II - Apportionment of Inpatient Ancillary Service Capital Costs.--This worksheet is provided to compute the amount of capital costs applicable to hospital inpatient ancillary services for titles V, XVIII, Part A, and XIX. Complete a separate copy of this worksheet for each subprovider for titles V, XVIII, Part A, and XIX, as applicable. In this case, enter the subprovider component number in addition to showing the provider number.

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

Column 1--Enter on each line the old capital-related costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 27. For the hospital component or subprovider, if applicable, enter on line 62 the amount from Worksheet D-1, Part IV, column 5, line 86.

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

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

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

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

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

Column 5--Divide the old capital cost of each cost center in column 1 by the charges in column 3 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round 0321514 to .032151. Enter the resultant departmental ratio in column 5.

Column 6--Multiply the old capital ratio in column 5 by the program charges in column 4 to determine the program's share of old capital costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

Column 7--Divide the new capital cost of each cost center in column 2 by the charges in column 3 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round 0321514 to .032151. Enter the resultant departmental ratio in column 7.

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

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

Column 1--For PPS hospitals and components which qualify for the exception to the implementation of the CRNA fee schedule, enter on each line the nonphysician anesthetist cost for each cost center, as appropriate. (See §3610, line 20 description for more information.) Obtain this amount from Worksheet B, Part I, column 20 after taking into consideration any post step down adjustments that may have been made after cost finding.

Column 2--Enter on each line (after taking into consideration any post step down adjustments applicable to direct medical education costs made after cost finding) the direct medical education cost for each cost center, as appropriate. Obtain this amount from Worksheet B, Part I, sum of columns 21 and 24 plus or minus post step down adjustments (reported on Worksheet B-2) applicable to direct medical education costs for nursing school and paramedical education. For SNF/NFs enter the sum of columns 21 through 24 unless the hospital is receiving graduate medical education payments reported on worksheet E-3, Part IV (Worksheet S-2, line 25.02 with a yes response); then report the sum of columns 21 and 24 only.

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

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

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

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

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

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

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

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

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

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

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

Column 1--Enter on each line (after any adjustments made after cost finding) the nonphysician anesthetist cost for hospitals and components qualifying for the exception to the CRNA fee schedule. (See §3610, line 20 description for more information.) Obtain this amount from Worksheet B, Part I, column 20 plus or minus any adjustments reported on Worksheet B, Part I, column 26 for

nonphysician anesthetist. For the hospital and subprovider (if applicable) components only, enter on line 62, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 88.

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

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

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

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

Enter the costs of administering blood clotting factors to hemophiliacs in column 2.03, line 46.30 from Worksheet B, column 27, subscript of line 46 containing the corresponding costs. Complete only columns 2.03 and 3 through 7 for this entry. (8/31/02) (see §4452 of BBA 1997)

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

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

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

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

Column 5.01--For cost reporting periods ending on or after 4/1/2003, column 5 will be subscripted. Divide the cost of each cost center in column 3.01 by the charges in column 4 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to .032151. Enter the resultant departmental ratio in column 5.01.

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

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

Column 8--Enter on each line titles XVIII, Part B, V or XIX (if applicable) outpatient charges from Worksheet D, Part V, column 5.01, 5.03, and 5.04, if applicable. Do not include in Medicare charges any charges identified as MSP/LCC (8/00).

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

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

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

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

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

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

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

For cost reporting periods that end on or after October 1, 1997, and before September 30, 1998, subscript columns 2 through 4 and 6 through 8 and report the charges and cost during the period for services prior to October 1, 1997, in columns 2 through 4 and 6 through 8 and report the charges and costs for the periods on or after October 1, 1997, and before September 30, 1998 in columns 2.01 through 4.01 and 6.01 through 8.01. The subscripting is required as a result of the change in

calculating the different payment methodologies on Worksheet E, Parts C, D, and E regarding the application of deductibles and coinsurance. Subscripting is not required for cost reporting periods ending on or after September 30, 1998. Revert back to reporting the charges and costs for these services in columns 2 through 4 and 6 through 8. For services rendered on and after August 1, 2000, outpatient services are subject to prospective payment. For cost reporting periods that overlap the effective date, subscript the columns to accommodate the proper reporting of cost reimbursement prior to August 1, 2000, and prospective payment on and after August 1, 2000.

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

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

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

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

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

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

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

For cost reporting periods overlapping 4/1/2002 and after subscript line 65 for ambulance services in accordance with the subscripts on Worksheet S-2, line 56 and report charges separately on line 65 and subscripts for the applicable periods. Do not subscript line 65 for cost reporting periods beginning on or after 1/1/2006, as the ambulance PPS payment blend will transition to 100 percent fee based payments *and do not report charges for ambulance services rendered on or after January 1, 2006.*

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

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

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

Columns 9, 9.01, and 9.02--Multiply the charges in column 5 by the ratios in column 1, and enter the result. For hospitals subject to outpatient prospective payment, multiply the charges in column 5.01 and 5.02, or any additional subscripted column of column 5 by the ratios in column 1.01, and enter the result in columns 9.01 and 9.02 or additional subscripts, respectively. For SNFs subscript this column and report the result of multiplying the ratio in column 1 by the charges in columns 5 and 5.01 for physical and occupational therapies, and speech pathology. For lines 50 through 52 only, for services rendered on and after January 1, 1998, enter in column 9.01, 90 percent of the result of multiplying the ratio in column 1 by the charges in column 5.01. For SNF services rendered on and after January 1, 1999, make no entry for therapy services paid under a fee schedule for lines 50 through 52. The amount entered on line 65 of this column, Ambulance, for all providers, cannot exceed the payment limit calculated from Worksheet S-2, column 2, lines 56 and 56.01 (if applicable), times the amount on Worksheet S-3, Part I, column 4, line 27 and 27.01 (if applicable) respectively, for ambulance services on or after October 1, 1997. For cost reporting periods which overlap the October 1, 1997, effective date, enter in column 9 the lower of the cost (column 1 times column 5, rounded to zero, or the limit (Worksheet S-2, Column 2, line 56, times, Worksheet S-3, Part I, column 4, line 27, rounded to zero), added to column 1 times column 5.01 rounded to zero). Hospitals with cost reporting periods that overlap August 1, 2000, subscript column 9 in accordance with column 5 instructions.

For cost reporting periods beginning on or after October 1, 1997, costs for ambulance services are calculated from column 5 charges only. For cost reporting periods which overlap August 1, 2000, to calculate the ambulance costs, multiply the charges reported in column 5 by the appropriate ratio in column 1and multiply the charges reported in columns 5.01 by the appropriate ratio in column 1.01 and add the results. Compare that to the limit amount calculated as indicated above and enter the lesser of the two in column 9.02.

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

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

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

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

Line Descriptions

Line 44--Generally, for title XVIII, Medicare outpatient covered clinical laboratory services are paid on a fee basis, and should not be included on this line. Outpatient CAH clinical laboratory services rendered on or after November 29, 1999 will be paid on a reasonable cost basis not subject to deductibles and coinsurance. In addition, hospital outpatient laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area will also be paid on a reasonable cost basis not subject to deductibles and coinsurance, for cost reporting periods beginning on or after July 1, 2004, but *before July 1, 2008* (Medicare, Medicaid, and SCHIP Extension Act of 2007, section 107). For title V and XIX purposes, follow applicable State program instructions.

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

Outpatient

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

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

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

Titles V and XIX

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

Title XVIII

			From		
Description	Worksheet D-4, Column 6, col. 2		Worksheet D, Part V cols. 2-5 (& subscripts of col. 5)		Less Part A Only Charges
Clinic	line 20	line 60	plus line 60	minus	From
Emergency	line 21	line 61	plus line 61	minus	Provider
Observation Beds	line 22	line 62	plus line 62	minus	Records
Other Outpatient	line 23	line 63	plus line 63	minus	

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

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

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

Transfer program expenses.

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

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

Subprovider: line 10	TO	Worksheet E-3, Part III, line 3
Other Nursing Facility: line 13	TO	Worksheet E-3, Part III, line 3

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

Hospital: Sum of lines 9 and 24	TO	Worksheet E, Part B, line 2
Subprovider: line 10	TO	Worksheet E, Part B, line 2
Skilled Nursing Facility: line 12	TO	Worksheet E, Part B, line 2

3623.2 Part II - In Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only).--This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicare beneficiaries who have Part B coverage and are not entitled to benefits under Part A. (See CMS Pub. 15-I, chapter 4, and §2120.) 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)*. *(8/1/2000s)*

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

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

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

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

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

exceptions to the reporting of these payments.) If you answered yes to question 21.02 on Worksheet S-2, subscript column 1 and report the payments before the reclassification in column 1.01 and on or after the reclassification in column 1. For discharges occurring on or after April 1, 2001 through September 30, 2001 a modification has been made to the IME formula. See lines 1.07 and 1.08 for identifying payments made on or after that date. In addition, for discharges occurring on or after April 1, 2004 through September 30, 2004 a modification has been made to the DSH payment percentages. See lines 1.07 and 1.08 for identifying payments made on or after these dates.

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

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

The chart provided below is to assist with the placement of DRG amounts in accordance with the instructions for Worksheet E, Part A.

*Cost Reports **Without** Dates of Services 4/1/2001 - 9/30/2001 or 4/1/2004 - 9/30/2004*

DRG Payments	Line 1	Line 1.01	Line 1.02
Medicare Managed Care Payments	*Line 1.03*	*Line 1.04*	*Line 1.05*
Cost Reporting Period			
1/1 -12/31	1/1 - 9/30	10/1 - 12/31	
2/1 - 1/31	2/1 - 9/30	10/1 - 12/31	1/1 - 1/31
3/1 - 2/28-29	3/1 - 9/30	10/1 - 12/31	1/1 - 2/28-29
4/1 - 3/31	*4/1- 9/30*	10/1 - 12/31	*1/1 - 3/31*
5/1 - 4/30	5/1 - 9/30	10/1 - 12/31	*1/1 - 4/30*
6/1 - 5/31	6/1 - 9/30	10/1 - 12/31	*1/1 - 5/31*
7/1 - 6/30	7/1 - 9/30	10/1 - 12/31	*1/1 - 6/30*
8/1 - 7/31	8/1 - 9/30	10/1 - 12/31	*1/1 - 7/31*
9/1 - 8/31	9/1 - 9/30	10/1 - 12/31	*1/1 - 8/31*
10/1 - 9/30		10/1 - 12/31	1/1 - 9/30
11/1 - 10/31	10/1 - 10/31	11/1 - 12/31	1/1 - 9/30
12/1 - 11/30	10/1 - 11/30	12/1 - 12/31	1/1 - 9/30

*Cost Reports **With** Dates of Services 4/1/2001 - 9/30/2001 or 4/1/2004 - 9/30/2004*

DRG Payments	*Line 1*	*Line 1.01*	*Line 1.02*	*Line 1.07*
Medicare Managed Care Payments	*Line 1.03*	*Line 1.04*	*Line 1.05*	*Line 1.08*
Cost Reporting Period				
1/1 -12/31	*1/1 - 3/31*	*10/1 - 12/31*		*4/1 - 9/30*
2/1 - 1/31	*2/1 - 3/31*	*10/1 - 12/31*	*1/1 - 1/31*	*4/1 - 9/30*
3/1 - 2/28-29	*3/1 - 3/31*	*10/1 - 12/31*	*1/1 - 2/28-29*	*4/1 - 9/30*
4/1 - 3/31		*10/1 - 12/31*	*1/1 - 3/31*	*4/1 - 9/30*
5/1 - 4/30	*5/1 - 9/30*	*10/1 - 12/31*	*1/1 - 3/31*	*4/1 - 4/30*
6/1 - 5/31	*6/1 - 9/30*	*10/1 - 12/31*	*1/1 - 3/31*	*4/1 - 5/31*
7/1 - 6/30	*7/1 - 9/30*	*10/1 - 12/31*	*1/1 - 3/31*	*4/1 - 6/30*
8/1 - 7/31	*8/1 - 9/30*	*10/1 - 12/31*	*1/1 - 3/31*	*4/1 - 7/31*
9/1 - 8/31	*9/1 - 9/30*	*10/1 - 12/31*	*1/1 - 3/31*	*4/1 - 8/31*
10/1 - 9/30		*10/1 - 12/31*	*1/1 - 3/31*	*4/1 - 9/30*
11/1 - 10/31	*10/1 - 10/31*	*11/1 - 12/31*	*1/1 - 3/31*	*4/1 - 9/30*
12/1 - 11/30	*10/1 - 11/30*	*12/1 -12/31*	*1/1 - 3/31*	*4/1 - 9/30*

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

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

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

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

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

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

Line 1.05--Enter the total managed care "simulated payments" from the PS&R on or after January 1 but before April 1/October 1.

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

Line 24--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. *Only FI/contractors complete line 24.99 by entering the sum of lines 52, 53, 55, and 56.*

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

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

Enter the amount of any excess depreciation taken as a negative amount.

Line 26--Enter the amount due you (i.e., the sum of the amounts on line 22 plus or minus lines 24 and 25 minus line 23).

Line 27--Enter the sequestration adjustment amount, if applicable.

Line 28--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 28.01. Include in interim payment the amount received as the estimated nursing and allied health managed care payments.

Line 29--Enter line 26 minus the sum of lines 27 and 28. Transfer to Worksheet S, Part II.

Line 30--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.

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

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

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

Line 51--Enter the original capital outlier amount from worksheet L, part I, line 3.01.

Line 52--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-4, Chapter 3, §20.1.2.5-§20.1.2.7

Line 53--Enter the capital outlier reconciliation amount in accordance with CMS Pub. 100-4, Chapter 3, §20.1.2.5 - §20.1.2.7

Line 54--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 55--Enter the time value of money for operating related expenses line 52 times line 54.

Line 56--Enter the time value of money for capital related expenses line 53 times line 54.

NOTE: If a cost report is reopened more than one time, subscript lines 50 through *56*, respectively, one time for each time the cost report is reopened.

For all other hospital enter one of the following:

c. If line 1.05 is = > 90 percent but < 100 percent, enter 60 percent of the result of line 1.04 minus line 1.02.

d. If line 1.05 is < 90 percent, enter 6 percent of line 1.04.

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

a. If line 1.02 is < line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the result of line 1.04 minus line 1.02.

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

a. If line 1.02 is < line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y" and Worksheet E, Part A, line 3 is =< 100 enter the result of line 1.04 minus line 1.02.

b. If line 1.02 is < line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y", and Worksheet E, Part A, line 3 is =< 100, and Worksheet S-2, line 26 is => 1 (sole community hospitals (SCH)) enter the result of line 1.04 minus line 1.02.

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

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

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

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

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

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

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

Line 1.07--Enter the pass through amount from worksheet D, Part IV, columns 9, 9.01 and 9.02, line 101.

Line 2--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

Provider/Component	Title XVIII Hospital	Title XVIII Subprovider	Title XVIII Skilled Nursing Facility
Hospital	Part I, col. 9, line 9 plus line 24; or Part II, col. 7, line 34; or Part III, col. 6, line 41	Part I, col. 9, line 10; or Part II, col. 7, line 35, or Part III, col. 6, line 42	Part I, col. 9, line 12; or Part II, col. 7, line 37; or Part III, col. 6, line 44

Line 3--If you are an approved CTC, enter the cost of organ acquisition from Worksheet D-6, Part III, column 2, line 61 when Worksheet E is completed for the hospital or the hospital component of a health care complex. Make no entry on line 3 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 4--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost *(see 42 CFR 415.160 and* CMS Pub. 15-I, §2148), enter the amount from Worksheet D-9, Part II, column 3, line 17.

Line 5--Enter the sum of lines 1 through 4 excluding subscripts in column 1.

Computation of Lesser of Reasonable Cost or Customary Charges.--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e).

NOTE: RPCHs/CAHs are not subject to the computation of the lesser of reasonable costs or customary charges. If the component is an RPCH/CAH, do not complete lines 6 through 16. Instead, enter on line 17 the amount computed on line 5.

Line Descriptions

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter the total reasonable cost from line 5 directly on line 17. Still complete lines 6 through 16 to insure that you meet one of the criteria for this exemption.

Lines 6 through 10--These lines provide for the accumulation of charges which relate to the reasonable cost on line 5.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-I, §2104.3) and (2) charges to beneficiaries for excess costs. (See CMS Pub. 15-I, §§2570-2577.)

Line 6--For total charges for medical and other services, enter the sum of Worksheet D, Part V, columns 5 and 5.01 (for hospitals and subproviders with cost reporting periods which overlap October 1, 1997, for ambulance services, and SNFs with cost reporting periods beginning prior to January 1, 1998), line 104 and Worksheet D, Part VI, line 2. For cost reporting periods overlapping 8/1/2000 and after, for hospital and subprovider services, enter the sum of D, Part V, columns 5, 5.02, and 10, line 104, plus D, Part VI, line 2.

For cost reporting periods beginning 1/1/99 for SNF services enter the sum of Worksheet D, Part V, column 5, line 104 and D, Part VI, line 2.

NOTE: If the amounts on Worksheet D, Part V include charges for professional services, eliminate the amount of the professional component from the charges entered on line 6. Submit a schedule showing these computations with the cost report.

Line 7--*Enter zero (0) on this line because the hospital/component cannot bill separate charges for services of residents (in unapproved or approved programs) which are reimbursed under Part B.*

Line 8--When Worksheet E is completed for a CTC hospital component for title XVIII, enter the organ acquisition charges from Worksheet D-6, Part III, column 4, line 61.

Line 9-- *Enter zero (0) on this line because the hospital/component cannot bill separate charges for the direct patient care services rendered by physicians in teaching hospitals under the election described in 42 CFR 415.160.*

Line 10--Enter the sum of lines 6 through 9.

Lines 11 through 14--These lines provide for the reduction of program charges when you do not actually impose such charges in the case of most patients liable for payment for services on a charge basis or fail to make reasonable efforts to collect such charges from those patients. If line 13 is greater than zero, multiply line 10 by line 13, and enter the result on line 14. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 11 through 13. Enter on line 14 the amount from line 10. In no instance may the customary charges on line 14 exceed the actual charges on line 10. (See 42 CFR 413.13(e).)

Line 15--Enter the excess of the customary charges over the reasonable cost. If line 14 exceeds *the sum of lines 1 and 3,* enter the difference.

Line 16--Enter the excess of reasonable cost over the customary charges. If *the sum of lines 1 and 3,* exceeds line 14, enter the difference.

Line 17-- Enter *the amount from line 5, less any amount on reported on line 16 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, lines 47-51), enter the reasonable costs from line 5.

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

Line 17.01--Enter the sum of lines 1.02, 1.06, and 1.07, all columns.

Line 18--Enter the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for coinsurance enter on this line the full coinsurance amount not the discounted amount.

Line 18.01--Enter the deductible and coinsurance relating to the amounts reported on line 17.01.

NOTE: If these services are exempt from LCC as a result of charges being equal to or less than 60 percent of cost (refer to Worksheet S-2, lines 47-51, columns 1-5, as applicable), enter the Part B deductibles billed to program beneficiaries only. Do not enter any Part B coinsurance. For CAHs with cost reporting periods beginning on or after 7/1/2002, enter the deductibles on line 18 and the coinsurance on line 18.01.

Line 19--Subtract line 18 and 18.01 from line 17 and 17.01 respectively.

NOTE: If these services are exempt from LCC, line 17 minus line 18 times 80 percent. Add to that result line 17.01 minus line 18.01.

For critical access hospitals *(CAHs)*, with cost reporting periods beginning before July 1, 2002, exempt from LCC, multiply 80 percent times the result of line 17 minus (sum of line 18 plus Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus Worksheet D, Part VI, line 3). Add back Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus Worksheet D, Part VI, line 3. Prorate on a days to days basis lab services for cost reporting periods overlapping 11/29/99. For cost reporting periods beginning on or after 11/29/2004 no prorating is required.

For CAHs with cost reporting periods beginning on or after July 1, 2002, and before January 1, 2004, enter the lesser of (line 17 minus the sum of lines 18 and 18.01) or 80 percent times the result of (line 17 minus line 18 minus lab cost (Worksheet D, Part V, column 9, lines 44, 45, and subscripts) minus vaccine cost (Worksheet D, Part VI, line 3). Add back the aforementioned lab and vaccine cost).

For CAHs with cost reporting periods beginning on or after January 1, 2004, enter the lesser of (line 17 minus the sum of lines 18 and 18.01) or 80 percent times the result of (line 17 minus line 18 minus 101% of lab cost (Worksheet D, Part V, column 9, lines 44, 45, and subscripts) minus 101% of vaccine cost (Worksheet D, Part VI, line 3). Add back the aforementioned lab and vaccine cost). (1/1/2004b)

Line 20--This line is used to combine the amounts for medical and other health services, outpatient ambulatory services, outpatient radiology services, and other outpatient diagnostic procedures, for, services rendered prior to August 1, 2000. Enter in column 1 only the sum of the amounts from Worksheet E, Part C, columns 1 plus 1.01, line 21; Part D, columns 1 plus 1.01, line 21; and Part E columns 1 plus 1.01, line 21. For services after August 1, 2000, make no entry.

Line 21--Enter in column 1 the amount from Worksheet E-3, Part IV, line 25. Complete this line for the hospital component only.

Line 22--Enter in column 1 the amount from Worksheet E-3, Part IV, line 11. Complete this line for the hospital component only.

Line 23--Enter in column 1 the sum of columns 1 and 1.01, lines 19 through 22.

Line 24--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- 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 26. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer

resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.)

Line 17--Enter the sum of lines 12, 13, and 13.01 plus or minus lines 15 and 16 minus line 14.

Line 18--Enter the sequestration adjustment amount, if applicable.

Line 19--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlements, report on line 19.01 the amount on line 5.99.

Line 20--Enter line 17 minus the sum of lines 18 and 19. Transfer this amount to Worksheet S, Part II, line as appropriate.

Line 21--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-3, PART I. LINES 50 THROUGH 53 ARE FOR INTERMEDIARY USE ONLY.

Line 50--Enter the original outlier amount from worksheet E-3, Part I, line1.05 (IRF) or 1.09 (IPF).

Line 51--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-4, Chapter 3, §20.1.2.5-§20.1.2.

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

Line 53--Enter the time value of money.

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

3633.2 Part II - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement.--Use Worksheet E-3, Part II, to calculate reimbursement settlement for Medicare Part A services furnished by hospitals, including rural primary care hospitals/critical access hospitals, subproviders, and skilled nursing facilities under cost reimbursement (i.e., neither PPS nor TEFRA).

For cost reporting periods beginning on or after July 1, 1998, SNFs will not complete this form. Use a separate copy of Worksheet E-3 for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3 to indicate the component program for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs:

Hospital (CAH) or Subprovider - Worksheet D-1, Part II, line 49
Skilled Nursing Facility - Worksheet D-1, Part III, line 82
RPCH - Worksheet C, Part IV, line 6 (Not applicable for cost reporting periods beginning after October 1, 1997)

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

Line 2--If you are approved as a CTC, enter the cost of organ acquisition from Worksheet D-6, Part III, column 1, line 61 when this worksheet is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 2 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 3--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter amounts from Worksheet D-9, Part II, column 3, line 16.

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

Line 5--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- 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 12--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients and for which a separate charge is made. These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Medical supplies which are not reported on this line are those minor medical and surgical supplies which would not be expected to be specifically identified in the plan of treatment or for which a separate charge is not made. These supplies (e.g., cotton balls, alcohol prep) are items that are frequently furnished to patients in small quantities (even though in certain situations, these items may be used in greater quantity) and are reported in the administrative and general (A&G) cost center.

Line 13--Enter the costs of vaccines and the cost of administering the vaccines. A visit by an HHA nurse for the sole purpose of administering a vaccine is not covered as an HHA visit under the home health benefit, even though the patient may be an eligible home health beneficiary receiving services under a home health plan of treatment. Section 1862(a)(1)(B) of the Act excludes Medicare coverage of vaccines and their administration other than the Part B coverage contained in §1861 of the Act.

If the vaccine is administered in the course of an otherwise covered home health visit, the visit is covered as usual, but the cost and charges for the vaccine and its administration must be excluded from the cost and charges of the visit. The HHA is entitled to separate payment for the vaccine and its administration under the Part B vaccine benefit.

In accordance with Change Request 4240, dated March 17, 2006, effective for services rendered on or after July 1, 2006, the cost of administering pneumococcal, influenza, and hepatitis B vaccines is reimbursed under the outpatient prospective payment system (OPPS), but the actual cost of the pneumococcal, influenza, and hepatitis B vaccines will remain cost reimbursed. For cost reporting periods ending on or after July 1, 2006, enter on this line the vaccine cost (exclusive of the cost to administer these vaccines) incurred for pneumococcal, influenza, and hepatitis B vaccines. Continue to include the cost of administering the osteoporosis drugs on this line.

Line 13.20.--For cost reporting periods ending on or after July 1, 2006, enter the cost incurred to administer pneumococcal, influenza, *and* hepatitis B vaccines on this line.

Some of the expenses includable in this cost center are the costs of syringes, cotton balls, bandages, etc., but the cost of travel is not permissible as a cost of administering vaccines, nor is the travel cost includable in the A&G cost center. The travel cost is non-reimbursable. Attach a schedule detailing the methodology employed to develop the administration of these vaccines. These vaccines are reimbursable under Part B only.

Line 14--Enter the direct expenses incurred in renting or selling durable medical equipment (DME) items to the patient for the purpose of carrying out the plan of treatment. Also, include all the direct expenses incurred by you in requisitioning and issuing the DME to patients.

Lines 15-23--Lines 15-23 identify nonreimbursable services commonly provided by a home health agency. These include home dialysis aide services (line 15), respiratory therapy (line 16), private duty nursing (line 17), clinic (line 18), health promotion activities (line 19), day care program (line 20), home delivered meals program (line 21), and homemaker service (line 22). The cost of all other nonreimbursable services are aggregated on line 23. If you are reporting costs for telemedicine, these costs are to be reported on line 23.50. Use this line throughout all applicable worksheets.

3642. WORKSHEET H-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

A detailed analysis of salaries and wages compensation is required to explain data entered on Worksheet H, column 1. This data is required by 42 CFR 413.20. A small HHA, as defined in 42 CFR 413.24(d), does not have to complete Worksheet H-1. If Worksheet H-1 is not required, enter all salary and wage amounts in the appropriate cost center on Worksheet H, column 1.

For cost reporting periods beginning on or after October 1, 2000, worksheets H-1, H-2 and H-3 are no longer required to be completed for all home health agencies.

Enter all salaries and wages for the HHA on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. 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 (and any employee-related benefits) is entered on line 5 (administrative and general-HHA) and 25 percent of the administrator's salary (and any employee-related benefits) is entered on line 6 (skilled nursing care).

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 intermediary. Your intermediary 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 intermediary 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 intermediary determines that the method is no longer valid due to changes in your operations.

Definitions

Salary--This is gross salary paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-I, chapter 21.)

Administrators (Column 1)

Possible Titles: President, Chief Executive Officer

Duties: This position is the highest occupational level and is the chief management official. The administrator develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating. The administrator is responsible for the application and implementation of established policies. The administrator may act as a liaison among the governing body, the medical staff, and any departments. The administrator provides for personnel policies and practices that adequately support sound patient care and maintains accurate and complete personnel records. The administrator implements the control and effective utilization of your physical and financial resources.

Directors (Column 2)

Possible Titles: Medical Director, Director of Nursing, or Executive Director

Duties: The medical director is responsible for helping to establish and assure that the quality of medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques. The nursing director is responsible for establishing the objectives for

3647. WORKSHEET H-6 - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs to titles V, XVIII, and XIX. Titles V and XIX use the columns identified as Part A for each program.

3647.1 Part I - Computation of Lesser of Aggregate Program Cost, Aggregate of Program Limitation Cost, or Per Beneficiary Cost Limitation--This part provides for the computation of the reasonable cost limitation to designated program patient care visits and is required by 42 CFR 413.30 and 42 CFR 413.53. For cost reporting periods beginning on or after October 1, 1997, §4601 of the Balanced Budget Act requires a home health agency to be paid based on the lesser of aggregate Medicare cost, aggregate Medicare limitation or the agency specific per beneficiary annual cost limit applied to the unduplicated census count.

Cost Per Visit Computation

Column Descriptions

Column 1--Enter the cost for each discipline from Worksheet H-5, Part I, column 29, lines as indicated. Enter the total on line 7.

Column 2--Where the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the hospital's HHA, complete the amounts entered on lines 2 through 4 in accordance with the instructions contained in §3647.2. Enter the total on line 7.

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

Column 4--Enter the total agency visits from your records for each type of discipline on lines 1 through 6. Total visits reported in column 4 reflect visits rendered for the entire fiscal year and equal the visits reported on S-3, Part I, regardless of when the episode was completed.

Column 5--Compute the average cost per visit for each type of discipline. Divide the number of visits (column 4) into the cost (column 3) for each discipline.

Columns 6 and 9--To determine title XVIII, Part A, V, and XIX cost of service, multiply the number of covered visits in completed episodes made to beneficiaries (column 6) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 9.

NOTE: Statistics in column 7, lines 1 through 16, reflect statistics for services that are part of a home health plan, and thus not subject to deductibles and coinsurance. OBRA 1990 provides for the limited coverage of injectable drugs for osteoporosis. While covered as a home health benefit under Part B, these services are subject to deductibles and coinsurance. Report charges for osteoporosis injections in column 8, line 16, in addition to statistics for services that are not part of a home health plan.

Columns 7 and 10--To determine the Medicare Part B cost of service, not subject to deductibles and coinsurance, multiply the number of visits made in completed episodes to Part B beneficiaries (column 7) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 10. Note if the PS&R reports Part B services separately as "subject to and not subject to" deductibles and coinsurance, add the two reports together for each discipline.

For cost reporting periods that overlap October 1, 2000:

Columns 6, 7, 9, 10 and 12--Subscript these columns and report visits and cost for services rendered prior to October 1, 2000 in columns 6, 7, 8, 9, 10, and 12. For services rendered on and after October 1, 2000 enter visits and costs in columns 6.01, 7.01, 9.01, 10.01, and 12.01. No subscripting

is required for cost reporting periods beginning on or after October 1, 2000.

NOTE: For cost reporting periods which overlap October 1, 2000, the sum of visits reported in columns 6 and 7 and subscripts (if applicable) may not equal the corresponding amounts on Worksheet S-4, column 7, lines 21, 23, 25, 27, 29 and 31, respectively since those visits are reported based upon the completion of the episode during the fiscal year. However, for cost reporting period beginning on or after October 1, 2000, sum of visits reported in columns 6 and 7 must equal the corresponding amounts on Worksheet S-4, column 7, lines 21, 23, 25, 27, 29 and 31, respectively. These visits are reported for episodes completed during the fiscal year.

Columns 8 and 11--Do not use these columns.

Column 12 and 12.01--Enter the total program cost for each discipline (sum of columns 9 and 10). Add the amounts on lines 1 through 6, and enter this total on line 7.

Cost Limitation Computation--Enter for each Metropolitan Statistical Area (MSA) the payment limitation for each discipline for lines 8 through 13. This is supplied by your intermediary. Subscript each discipline line to accommodate multiple MSAs serviced by your home health agency. For cost reporting periods beginning on and after October 1, 2000, the completion of the cost limitation section is no longer required.

Column Descriptions

Column 5--Enter the program limitation (see §1814(b)(1) of the Act) for each discipline on lines 8 through 13. Your fiscal intermediary furnishes these limits to you.

Columns 6 and 9--To determine the program cost limitation for title XVIII, Part A, V, and XIX cost of services, multiply the number of covered visits made to beneficiaries (column 6, lines 1 through 6) (from your records) by the program cost limit amount in column 5 for each discipline. Enter the product in column 9.

Columns 7 and 10--To determine the Medicare cost limitation for Part B cost of services, not subject to deductibles and coinsurance, multiply the number of visits to Part B beneficiaries (column 7, lines 1 through 6) (from your records) by the Medicare cost limit amount in column 5 for each discipline. Enter the product in column 10.

NOTE: Enter in columns 6, 7, 9, and 10 only, the visits rendered through September 30, 2000.

Columns 8 and 11--Do not use these columns for lines 1 through 14.

Column 12--Enter the total program cost limitation for each discipline and subscripts (sum of columns 9 and 10). Add lines 8 through 13 and subscripts, and enter this total on line 14.

Supplies and Drugs Cost Computation.--Certain services covered by the program and furnished by a home health agency are not included in the cost per visit for apportionment purposes. Since an average cost per visit and the cost limit per visit do not apply to these items, develop and apply the ratio of total cost to total charges to program charges to arrive at the program cost for these services.

Column 1--Enter the facility costs in column 1, lines 15 and 16, from Worksheet H-5, Part I, column 29, lines 8 and 9, respectively. For cost reports that overlap October 1, 2000 subscript lines 15 and 16. For cost reporting periods beginning on or after October 1, 2000, do not subscript lines 15 and 16.

Column 2--Enter the shared ancillary costs from Worksheet H-6, Part II, column 3, lines 4 and 5, respectively.

Columns 3 through 5--In column 3, enter the total for lines *15, 16, and 16.20* of columns 1 and 2. *For cost reporting periods ending on or after July 1, 2006, enter in column 4 the total charges for lines 15, 16,and 16.20, respectively, in accordance with the chart under instructions for line 16.20. Refer to §3641, lines 13 and 13.20.* Develop a ratio of total cost (column 3) to total charges (column 4) (from your records), and enter this ratio in column 5.

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

Line Descriptions for Columns 6 through 8

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

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

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

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

For services rendered on and after January 1, 2003, do not enter in column 7 program charges for hepatitis vaccines and its administration as it is fee reimbursed. Enter in column 7 program charges for pneumococcal vaccines and its administration and influenza vaccine and its administration (cost reimbursed) for services rendered on or after January 1, 2003 through June 30, 2006 (for cost reporting periods ending on or after April 30, 2005 (T14) complete only column 7, not column 7.01 (eliminated)). Enter in column 8 the program charges for injectable osteoporosis drugs (cost reimbursed).

Effective for cost reporting periods ending on or after July 1, 2006 (see *§*3641, line 13), line 16 represents*:* pneumococcal, influenza, *and* hepatitis B vaccine *costs* and osteoporosis drugs, but not the administration of these vaccines. See the chart below for proper placement of charges.

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

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

Line 16.20.--Effective for cost reporting periods ending on or after July 1, 2006 (see §3641, line 13), line 16.20 represents the administration of pneumococcal, influenza, and hepatitis B vaccines. See the chart below for proper placement of charges.

Effective for cost reporting periods ending on or after July 1, 2006, enter vaccine charges according to the chart below:

Vaccine Charges

	Column 7	Column 8
Line 16	Enter charges for services on or after 7/1/2006 for hepatitis B vaccines. Enter charges for the full fiscal year for pneumococcal and influenza vaccines. Do not enter charges for pre 7/1/2006 hepatitis B vaccines.	Enter charges for the full fiscal year for osteoporosis drugs.
Line 16.20	Enter charges for pre 7/1/2006 pneumococcal and influenza vaccine administration. Do not enter charges for the full fiscal year for hepatitis B vaccine administration. Do not enter charges for services on or after 7/1/2006 for pneumococcal and influenza vaccine administration. For fiscal years beginning on or after 7/1/2006 enter 0 (zero).	This location is shaded as the administration of the osteoporosis drugs is included in the skilled nursing visit.

Columns 6 and 9--To determine the program cost, multiply the program charges (column 6) by the ratio (column 5) for each line. Enter the product in column 9.

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

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

Per Beneficiary Cost Limitation

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

For cost reporting periods ending on or after July 1, 2006 (see §3647, line 13), transfer the cost of pneumococcal, influenza, and hepatitis vaccines from Worksheet H-6, *Part I,* column 10, line 16, to column 2 of this worksheet, and the cost of osteoporosis drugs from worksheet H-6, column 11, line 16 to column 3 of this worksheet. *Also for cost reporting periods that overlap July 1, 2006 for the portion of the reporting period before July 1, 2006,* transfer the administration of pneumococcal and influenza vaccines from worksheet H-6, *Part I,* column 10, line 16.20, to column 2.

To Worksheet H-7, Line 1	From Worksheet H-6,
Col. 1, Part A	Part I, col. 9, sum of lines 7, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10 & 10.01, sum of lines 7, 15, and 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, lines 15 and 16 added to Part III, sum of columns 3.01 and 4, line 4 for services rendered prior to January 1, 1999

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

To Worksheet H-7, Line 1	From Worksheet H-6,
Col. 1, Part A	Part I, col. 9, sum of lines 14, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 14, 15, and 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, lines 15 and 16 added to Part III, sum of columns 3.01 and 4, line 4 for services rendered prior to January 1, 1999

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

Lines 2 through 6--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1. Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-I, chapter 21) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs. For cost reports that overlap October 1, 2000, enter only the charges for services rendered prior to October 1, 2000. For cost reporting periods beginning on or after October 1, 2000, enter only the charges associated with osteoporosis drugs which continue to be cost reimbursed. For services rendered on or after January 1, 2003, enter the charges for applicable Medicare covered pneumococcal and influenza vaccines (from worksheet H-6, Part I, line 16, column 7.01 (column 7 for cost reporting periods ending on or after 4/30/2005 as column 7.01 is eliminated)).

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

Effective for cost reporting periods ending on or after July 1, 2006, in column 2, enter the charges for Medicare covered pneumococcal, influenza, and hepatitis B vaccines (from worksheet H-6, lines 16 and 16.20, column 7). In column 3, enter the charges for Medicare covered osteoporosis drugs (from worksheet H-6, line 16, column 8).

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

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

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

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

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

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

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

When the primary payer payment does not satisfy the beneficiary's liability, include the covered days and charges in both program visits and charges and total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 9 the primary payer payments that are credited toward the beneficiary's deductible and coinsurance. The primary payer rules are more fully explained in 42 CFR 411.

3650. 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 57 and 64 of Worksheet A. In other words, complete one Worksheet I series for line 57 and one for line 64, if appropriate.

3651. WORKSHEET I-1 - ANALYSIS OF RENAL COSTS

This part provides for recording the direct salaries and other direct expenses applicable to the total inpatient and outpatient renal dialysis cost center or outpatient renal dialysis cost center where you maintain a separate and distinct outpatient renal dialysis cost center. If you have more than one renal dialysis department, and/or more than one home dialysis department, submit one Worksheet I series combining the renal dialysis departments and a separate Worksheet I series combining the home dialysis departments. You must also have on file, as supporting documentation, a Worksheet I series for each renal dialysis department and for each home dialysis department along with the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-I, §2720. Do not combine the cost of the renal dialysis with home program dialysis reported separately on Worksheet A, lines 57 and 64.

This worksheet also provides for recording the indirect expenses applicable to the total renal or outpatient renal dialysis department obtained from Worksheet B, Part 1, columns 1 through 24, line 57 as adjusted for post stepdown adjustments, if any. When completing a separate Worksheet I for home program dialysis, transfer the direct expenses from Worksheet B, Part I, columns 1 through 24, line 64. Do not combine the cost of the renal department with home program dialysis. These costs are listed separately on Worksheet A, lines 57 and 64, respectively.

Column Descriptions

Column 1--Enter on lines 1 through 8 the amounts included from Worksheet A, column 7 for salaries only. Enter on lines 10 through 16 and 18 through 28 the amounts from Worksheet B, Part I, all columns for lines 57 and 64. The subtotal on Worksheet I-1, line 29 agrees with the sum of Worksheet B, Part I, column 27, line 57 or line 64 if a home dialysis cost center was established and used on Worksheet A.

Column 2--This column lists the statistical bases for allocating costs on Worksheet I-3.

Column 3--Enter paid hours per type of staff listed on lines 1 through 6.

Column 4--Enter full time equivalents by dividing column 3 by 2080 hours.

Line Descriptions

Lines 1 through 6--Enter on these lines the direct patients care salaries after adjustments and reclassification that you reported in column 7 of Worksheet A. Direct patient care salary includes only the salary of staff providing direct patient care services. Also include fee paid to non-employees providing direct patient care services. Time spent furnishing administrative or management services by direct patient care personnel is reported on line 8, non-patient care salary.

Line 7--Include on this line amounts paid to physicians for their administrative services of managing the renal department. These payments are subject to the limitation contained in §2723.3 of CMS Pub. 15-I. Also include payments to physicians for their medical services if the box on line 15 of Worksheet S-5 is marked the initial method. A complete description of the initial method is in CMS Pub. 15-I, §2715. For a renal provider to be paid under the initial method, all renal physicians at the provider must elect the initial method. Under the initial method, renal physicians are paid by the provider for their routine renal medical services and the provider's composite payment rate is increased according to 42 CFR 414.313. No payment to physicians for patient medical services should appear on this line if the monthly capitation payment (MCP) box is marked on Worksheet S-5. Under the MCP, carriers pay physicians directly for their medical services.

Line 8--Enter the amount of salaries paid non-patient care personnel after reclassifications and adjustments that you report in column 7 of Worksheet A.

Lines 10 through 16--Include on the appropriate lines costs directly charged to the renal department after reclassifications and adjustments. Report other direct costs on line 16 that cannot be specifically identified on lines 11 through 15.

NOTE: Line 15 should exclude the costs of EPO *and Aranesp* administered to ESRD patients in the renal department and home program identified on Worksheet B-2, lines 1, 2, *3 or 4.*

Lines 18 through 28--Enter the allocated general service costs from Worksheet B, Part I, lines 57 or 64, as listed in the chart below.

Worksheet I-1, Part I, Column 1, Line Number	General Service Cost Centers	Worksheet B, Part I, Lines 57 or 64, Columns
18	Old Capital-Related Costs-Buildings and Fixtures	1
19	Old Capital-Related Costs-Moveable Equipment	2
20	New Capital-Related Costs-Buildings and Fixtures	3
21	New Capital-Related Costs-Moveable Equipment	4
22	Employee Benefits	5
23	Administrative and General	6
24	Maintenance & Repairs, Operation of Plant and Housekeeping	Sum of 7, 8, and 10

Line 5	Line 4
Line 6	Line 5
Line 7	Line 6
Line 8	Line 7
Line 9	Line 8
Line 10	Line 9
Line 11	Line 10

If you complete a Worksheet I-2 for the renal department and the home program dialysis department, complete a separate Worksheet I-4.

Lines 12 through 15--These services are not paid for under the composite payment rate system. Therefore, the costs of these services are not transferred to Worksheet I-4. Exclude these costs in the calculation of reimbursement composite payment rate bad debts. (See 42 CFR 413.170(e).)

Line 12.--Report inpatient costs. Inpatient dialysis services are paid under the DRG system for Medicare patients.

Line 13.--Report the costs of support services furnished to Method II home patients. Payment for Method II home patient dialysis services are subject to the rules in 42 CFR 414.330. Under Method II, a renal provider is only allowed to bill for support services and not dialysis equipment or supplies. Payment for support services is limited to the lower of the provider's reasonable cost or the payment limit as defined in the regulation, which is $125 per patient per month. This amount includes payment for support services and routine laboratory tests furnished to home patients.

Line 14.--Report the direct costs of EPO net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter EPO amount for informational purposes only. This amount is not included in the total on line 16.

Line 14.01.--Report the direct costs of Aranesp net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes Aranesp cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter Aranesp amount for informational purposes only. This amount is not included in the total on line 16.

Line 15.--Report the costs of other services furnished and billed in the renal department that are paid for outside the composite payment rate.

Line 16--Add columns and enter totals. Since *lines* 14 *and 14.01*, column 9 *are* shaded, no costs for EPO *and Aranesp* are included in the total for line 16, column 9 and column 6, *lines* 14 *and 14.01* should be excluded from total.

Line 17--Enter the amount of medical educational program costs from Worksheet I-1, line 25. Payment for medical educational program costs allocated to the renal department is not included in the composite payment rate.

Line 18--Add lines 16 and 17. This total agrees with the sum of Worksheet I-1, column 1, line 33.

Column Description

Columns 1 through 8--For each line, multiply the unit cost multiplier on Worksheet I-3, line 17 by the statistical base, and enter the result on the corresponding line and column on Worksheet I-2.

Column 9--Add columns 1 through 8 for each line, except *lines* 14 (EPO) *and 14.01 (Aranesp)*, and enter the total.

Column 10--Multiply the unit cost multiplier on Worksheet I-3, column 10, line 17 by the line amounts in column 9 of Worksheet I-2, and enter the amount in column 10.

Column 11--Add columns 9 and 10 for each line, and enter the result.

3653. WORKSHEET I-3 - DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

To accomplish the allocation of your direct and indirect costs reported on Worksheet I-1 to the different services provided in the department, you must maintain renal department statistics. To facilitate the allocation process, the format of Worksheets I-2 and I-3 is identical.

Line 1--Transfer the amounts on Worksheet I-2, line 1, columns 1 through 10 to Worksheet I-3, line 1, columns 1 through 10.

Lines 2 through 15--Enter on these lines and in the appropriate columns, the statistic for allocating costs to the appropriate line item. The statistical basis used in each column is defined in the column heading and on Worksheet I-1.

NOTE: If you wish to change your allocation basis for a particular general cost center, you must receive written approval from your intermediary before the start of your cost reporting period for which the alternative method is used. (See §3617 for Worksheets B and B-1.)

Line 12--Enter, in the area provided, the number of inpatient dialysis treatments furnished during the cost reporting period.

Line 16--Add the statistical basis for each column, except columns 9 and 10.

Line 17--Calculate the unit cost multiplier by dividing the amount on line 1 by the total statistical basis on line 16 for each column. Multiply the unit cost multiplier by the statistical base, and enter the cost on the appropriate line and column number on Worksheet I-2.

Column Descriptions

Column 1--Use the square footage of the renal department to allocate capital and maintenance building costs.

Column 2--Use percentage of time to allocate capital and maintenance equipment costs.

Columns 3 and 4--Use paid hours to allocate registered nurses and direct patient care salary.

Column 5--Use total direct patient care salaries in columns 4 and 5 of Worksheet I-2 to allocate employee benefits.

Columns 6 and 7--Use cost of requisitions to allocate drug and medical supply costs.

Column 8--Use routine laboratory charges to allocate laboratory costs.

Column 10--Use subtotal costs in column 9, Worksheet I-2 to allocate overhead cost. To compute the unit cost multiplier, transfer the amount from Worksheet I-2, line 16, column 9 to Worksheet I-3, line 16, column 10. Do not allocate overhead costs to *lines* 14 (EPO) *or 14.01 (Aranesp).*

3654. WORKSHEET I-4 - COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

This worksheet records the apportionment of total outpatient cost to the types of dialysis treatment furnished by you and shows the computation of expenses of dialysis items and services that you furnished to Medicare dialysis patients. This information is used for overall program evaluation, determining the appropriateness of program reimbursement rates, and meeting statutory requirements for determining the cost of ESRD care.

Complete a separate worksheet for reporting costs for the renal dialysis department and the home program dialysis department. If the cost reporting period covers a time when you had more than one rate for a particular treatment type, complete a separate Worksheet I-4 for each rate.

If you have more than one renal dialysis and/or home dialysis department, submit one Worksheet I-4 combining the renal dialysis departments and/or one Worksheet I-4 combining the home dialysis departments. You must also have on file, as supporting documentation, a Worksheet I-4 for each renal dialysis department and one for each home dialysis department with appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-I, §2720. Enter on the combined Worksheet I-4 each provider's satellite number if you are separately certified as a satellite facility.

In accordance with section 1881(b)(12)(A) of the Act, as added by section 623(d)(1) of MMA 2003, effective for services rendered on or after April 1, 2005, the ESRD payment is replaced by a calculated ESRD composite rate.

Columns 1 through 3 refer to total outpatient statistics, i.e., to all outpatient dialysis services furnished, whether reimbursed directly by the program or not.

Column 1--Enter on the appropriate lines the total number of outpatient treatments by type for all renal dialysis patients from your records. These statistics include all treatments furnished to all patients in the outpatient renal department, both Medicare and non-Medicare.

Column 2--Enter on the appropriate lines the total cost transferred from Worksheet I-2, columns 11, lines as appropriate.

Column 3--Determine the amounts entered on the appropriate lines by dividing the cost entered on each line in column 2 by the number of treatments entered on each line in column 1.

Line 9--Report continuous ambulatory peritoneal dialysis (CAPD) in terms of weeks. Compute patient weeks by totaling the number of weeks each Method I patient was dialyzed at home using CAPD.

Line 10--Report continuous cycling peritoneal dialysis (CCPD) in terms of weeks. Compute patient weeks by totaling the number of weeks each Method I patient was dialyzed at home by CCPD.

Medicare Treatments

Columns 4 through 7 refer only to treatments furnished to Medicare beneficiaries that were billed to the facility and reimbursed by the program directly. (Amounts entered in these columns are reconcilable to your records.)

Column 4--Enter on the appropriate lines the number of treatments billed to the Medicare program directly. Obtain this information from your records. For cost reporting periods which straddle April 1, 2005, subscript this column by adding column 4.01 to identify total treatments rendered on or after April 1, 2005. Enter in column 4 the total number of treatments rendered prior to April 1, 2005. For cost reporting periods beginning on or after April 1, 2005, eliminate column 4.01 and enter all treatments in column 4.

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 separate Worksheets I-2 and I-3, add the sum of the cost from this column, line 11, and transfer the total to Worksheet I-5, line 1. For cost reporting periods which straddle April 1, 2005, enter the result of column 3 times the sum of columns 4 and 4.01.

Column 6--Enter your Medicare program payment rates by the type of treatment for the reporting period. If the cost reporting period covers a time when you had more than one rate for a particular treatment type (e.g., the composite rate may have been updated or an exception amount approved during the period), complete a separate Worksheet I-4 for columns 4 through 7 to calculate the total payment due for each composite rate. When you complete a separate Worksheet I-4 because more than one payment rate was in effect during the cost reporting period, do not complete column 6 *on the summary worksheet I-4*. Columns 4, 5, and 7 consist of the sum of the total computed on the separate Worksheets I-4 for each payment rate. For cost reporting periods which straddle April 1, 2005, subscript this column by adding column 6.01 and enter the average composite rate by type of treatment for services rendered on or after April 1, 2005. Enter in column 6 the standard payment rate for services rendered prior to April 1, 2005. For cost reporting periods beginning on or after April 1, 2005, eliminate column 6.01 and enter all average composite rates in column 6.

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. For cost reporting periods which straddle April 1, 2005, columns 4 and 6 must be subscripted. (see CR 3720 dated February 18, 2005)

Column 7--Determine the amounts entered on the appropriate lines by multiplying the number of treatments entered on each line in column 4 by the payment rate entered on each corresponding line in column 6. For cost reporting periods which straddle April 1, 2005, add results of column 4 times column 6 and column 4.01 times column 6.01.

Line 11--Transfer the total payment from this column, line 11 to Worksheet I-5, line 2. If you complete separate worksheets (as a result of the updating of the composite payment rate during the period), add the sum of the cost from this column, line 11 and transfer the total to Worksheet I-5, line 2.

Worksheet S-2. (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 5 through 5.02, and enter 11.89 percent on line 5.03.

Line 5--Enter the percentage of SSI recipient patient days (from your intermediary or your records) to Medicare Part A patient days. This amount agrees with the amount reported on Worksheet E, Part A, line 4.

Line 5.01--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12, plus line 2, minus the sum of lines 3 and 4) divided by total days reported on Worksheet S-3, column 6, line 12, minus the sum of lines 3 and 4. Increase total patient days by any employee discount days reported on Worksheet S-3, Part I, line 28.

For cost reporting periods beginning on or after October 1, 2004, enter the percentage resulting from the calculation of the total Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, minus the sum of lines 3 and 4, plus column 5.01, line 26) to total days reported on Worksheet S-3, column 6, line 12, minus the sum of lines 3 and 4, plus column 6.01, line 26. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

Line 5.02--Add lines 5 and 5.01, and enter the result.

Line 5.03--Enter the percentage that results from the following calculation: $(e^{.2025 \times \text{line } 5.02})-1$ where e equals 2.71828.

Line 5.04--Multiply line 5.03 by the sum of lines 2 and 3(do not include line 3.01), and enter the result.

Line 6--Enter the sum of lines 1, 2, 3, 3.01, 4.03, and 5.04. For title XVIII, transfer the amount on line 6 to Worksheet E, Part A, line 9. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, column 1, line 26.

3660.2 Part II - Hold Harmless Method.--This part computes settlement under the hold harmless method only as defined in 42 CFR 412.344. Use the hold harmless method for PPS capital settlement when the hospital's base year hospital-specific rate exceeds the established Federal rate. Do not complete this part for cost reporting periods beginning on and after October 1, 2001 for hospitals paid 100 percent, except for new providers as defined in 42 CFR 412.300(b) (response to Worksheet S-2, line 33, column 1 is "Y" and column 2 is either "Y" or "N"). Formerly hold harmless providers (other than new providers) should consider themselves fully prospective for purposes of completing Part I of the Worksheet.

NOTE: If you have elected payments at 100 percent of the Federal rate (as indicated on Worksheet S-2, line 37.01), complete only lines 5 and 10 of this part.

Line Descriptions

Line 1--Enter the amount of program inpatient new capital costs. This amount is the sum of the program inpatient routine service new capital costs from the appropriate Worksheet D, Part I, column 12, sum of lines 25 through 30 and 33 for the hospital and line 31 for the subproviders and program inpatient ancillary service new capital costs from Worksheet D, Part II, column 8, line 101.

Line 2--Enter the amount of program inpatient old capital costs. This amount is the sum of the program inpatient routine service old capital costs from the appropriate Worksheet D, Part I, column 10, sum of lines 25 through 30 and 33 for the hospital and line 31 for the subproviders and program inpatient ancillary service old capital costs from Worksheet D, Part II, column 6, line 101.

Line 3--Enter the sum of lines 1 and 2.

Line 4--Enter the ratio of new capital costs on line 1 to the total capital cost on line 3. Carry the ratio to six decimal places.

3663. WORKSHEET M-2 - ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Use this worksheet only if you operate a certified provider-based RHC or FQHC as part of your complex. If you have more than one provider-based RHC and/or FQHC, complete a separate worksheet for each RHC and FQHC facility.

Visits and Productivity.--Worksheet M-2 summarizes the number of facility visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 list the types of practitioners (positions) for whom facility visits must be counted and reported.

Column descriptions

Column 1--Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility's practice. (See *CMS* Pub. 27, §503 for a definition of FTEs).

Column 2--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2401(b) defining a visit.

Column 3--Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each nonphysician practitioner. You are not subject to the productivity standards if you answered yes to question 13 of Worksheet S-8. If so, then enter the revised standards established by you and your fiscal intermediary.

Column 4--For lines 1 through 3, enter the product of column 1 and column 3. This is the minimum number of facility visits the personnel in each staff position are expected to furnish.

Column 5--On line 4, enter the greater of the subtotal of the actual visits in column 2 or the minimum visits in column 4.

Intermediaries have the authority to waive the productivity guideline in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the intermediary will substitute your actual visits if an exception is granted.

On lines 5 through 7 and 9, enter the actual number of visits for each type of position.

Line descriptions

Line 1--Enter the number of FTEs and total visits furnished to facility patients by staff physicians working at the facility on a regular ongoing basis. Also include on this line, physician data (FTEs and visits) for services furnished to facility patients by staff physicians working under contractual agreement with you on a regular ongoing basis in the RHC facility. These physicians are subject to productivity standards. See 42 CFR 491.8

Line 8--Enter the total of lines 4 through 7.

Line 9--Enter the number of visits furnished to facility patients by physicians under agreement with you *who do not furnish services to patients on a regular ongoing basis in the RHC facility.* Physicians services under agreements with you are (1) all medical services performed at your site by a *nonstaff* physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in RHC/FQHC services, 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 27.

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 27 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 22 and 23 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 worksheet M-1 completed), divide the total visits reported on line 16 of Worksheet S-8 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).

3664. WORKSHEET M-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet applies to title XVIII only and provides for the reimbursement calculation. Use this worksheet to determine the interim all inclusive rate of payment and the total program payment due you for the reporting period for each RHC or FQHC being reported.

Determination of Rate For RHC/FQHC Services.--Worksheet M-3 calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line descriptions

Line 1--Enter the total allowable cost from Worksheet M-2, line 20.

Line 2--Do not complete this line. For services rendered on and after August 1, 2000 report vaccine costs on this line from Worksheet M-4.

Line 3--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4--Enter the greater of the minimum or actual visits by the health care staff from Worksheet M-2, column 5, line 8.

Line 5--Enter the visits made by physicians under agreement from Worksheet M-2, column 5, line 9.

Line 6--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

Lines 8 and 9--The limits are updated every January 1 (except calendar year 2003 updates that occurred January 1 and March 1 (see PM A-03-021)). Complete columns 1, 2 and 3, if applicable (add a column 3 for line 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 intermediary. If Worksheet S-8, line 17 was answered yes, subscript (add column 3) to accommodate the exclusion of the limit.

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, line3),* in accordance with 42 CFR §412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2. (* Substitute for the asterisk in the denominator for the number of days in the cost reporting period.)

NOTE: For services rendered on or after July 1, 2001, RHCs that are based in small urban hospital with less than 50 beds (as calculated above) will also be exempt from the per visit limit. RHCs based in a small urban hospital with cost reporting periods overlapping July 1, 2001, will add a column 3 for lines 9 through 14 and complete according to the instructions. Enter in column 3, line 9 the amount from line 7. Column 3, line 10 through 14 will be completed in accordance with the instructions. For RHCs based in small urban hospitals with cost reporting periods beginning on or after July 1, 2001, 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 26 to determine the total program payment due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period. Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

Line descriptions

Line 10--Enter the number of program covered visits excluding visits subject to the outpatient mental health services limitation from your intermediary records.

Line 11--Enter the subtotal of program cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered program beneficiary visits for RHC/FQHC services during the reporting period).

Line 12--Enter the number of program covered visits subject to the outpatient mental health services limitation from your intermediary records.

Line 13--Enter the program covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14--Enter the limit adjustment. This is computed by multiplying the amount on line 13 by the outpatient mental health service limit of 62 ½ percent. This limit applies only to therapeutic services not initial diagnostic services.

Line 15--Enter the amount of GME pass through costs determined by dividing the (program intern and resident visits reported on Worksheet S-8, line 16 by the total visits reported on Worksheet M-2, column 5,) sum of lines 8 and 9. Multiply that result by the allowable GME costs equal to the sum of Worksheet M-1, column 7, line 20 and Worksheet M-2, line 17.

Line 16--Enter the total program cost. This is equal to the sum of the amounts in columns 1 and 2 (and 3 if applicable), lines 11, 14, and 15.

Line 16.01--Enter the primary payer amounts from your records (1/98).

Line 17--Enter the amount credited to the RHC's program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the intermediary from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the intermediaries. FQHCs enter zero on this line as deductibles do not apply.

Line 18--Enter the net program cost, excluding vaccines. This is equal to the result of subtracting the amounts on lines 16.01 and 17 from the amount on line 16.

Line 19--For title XVIII, enter 80 percent of the amount on line 18.

Line 20--Do not use this line. For services rendered on and after August 1, 2000 enter the amount from Worksheet M-4, line 16.

Line 21--Enter the total reimbursable Medicare cost, sum of the amounts on lines 19 and 20.

Line 22--Enter your total reimbursable bad debts, net of recoveries, from your records. If recoveries exceed the current year's bad debts, line 22 will be negative.

Line 22.01--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 21. (4/1/2004b)