
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 19

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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). This transmittal also reflects further clarification to existing instructions and incorporates select Federal Register provisions. The effective date for instructional changes will vary due to various implementation dates.

Significant Revisions:

- Worksheet S-2 -Questions 23.01 through 24.01 are revised and/or added to capture transplant facility termination date.
 - Questions 61 and 62 are revised to reflect the correct effective date of cost reporting periods ending on or after April 30, 2008.
 - Question 30.04 is revised to emphasize that subproviders in a CAH are reimbursed for GME on Worksheet E-3, Part IV, while the CAH is reimbursed for GME at 101 percent of reasonable cost.
 - Question 33 is revised to reflect that providers are considered new for initial cost reporting periods beginning on or after October 1, 2002 for Federal capital payment purposes.
- Worksheet S-3, Part II - Question 13 is revised to reflect the correct effective date of cost reporting periods ending on or after April 30, 2008.
- Worksheet S-5 - Questions 16 through 19 are revised to reflect the correct effective date of cost reporting periods ending on or after April 30, 2008.
- Worksheet A-8-2 - Columns 2 and 11 are revised to reflect the use of generic physician identifiers (Dr. A, Dr. B, etcetera) as opposed to confidential or traceable identifiers such as the physician's name, NPI, UPIN or social security number, etcetera.
- Worksheet E, Part A - Questions 5, 5.01, and 5.03 are revised to replace the standard DRGs with MS-DRGs (Medicare Severity Diagnosis-Related Groups) used to calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104 as revised by the Federal Register 161, Vol. 73, dated August 19, 2008, page 48755.
 - Question 3.19 is revised to reflect the residents in teaching programs in the current year.
 - Question 24.98 is added to capture all credits received from manufacturers for replaced medical devices in accordance with change request 5680, transmittal 1509, dated May 9, 2008.
 - Question 51 is revised to correct the citation for outlier reconciliation policy.
- Worksheet E-3, Part VI - Questions 2 and 13 clarified to reflect that if the resulting reduced direct GME cap is less than zero (0), then zero must be entered on these lines.
- Worksheet I-1 - Line 17 instructions are added to clarify the calculations of ESRD costs and their relationship to worksheet A; and line 26 instructions clarify the adjustment for EPO and Arenesp.
- Worksheet L, Part I - Lines 2 and 4.01 through 4.03 are revised to reflect the phrase out of the IME adjustment factor in accordance with the August 19, 2008 **Federal Register**, Vol. 73, No. 161 on page 48672. The IME adjustment factor is reduced by 50 percent for services rendered during the period 10/1/2008 through 9/30/2009; and is eliminated for services on or after 10/1/2009.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after October 31, 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)
<i>MS-DRG</i>	-	<i>Medicare Severity Diagnosis-Related Group</i>
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).

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

Line 22--Are you classified as a referral center? Enter "Y" for yes and "N" for no.

Line 23--Does your facility operate a transplant center? If yes, enter the certification dates below.

Line 23.01--If this is a Medicare certified kidney transplant center, enter the certification date in column 2 *and termination date in column 3*. Also complete Worksheet D-6.

Line 23.02--If this is a Medicare certified heart transplant center, enter the certification date in column 2 *and termination date in column 3*. Also complete Worksheet D-6.

Line 23.03--If this is a Medicare certified liver transplant center, enter the certification date in column 2 *and termination date in column 3*. Also complete Worksheet D-6.

Line 23.04--If this is a Medicare certified lung transplant center, enter the certification date in column 2 *and termination date in column 3*. Also, complete Worksheet D-6.

Line 23.05--If Medicare pancreas transplants are performed, enter the more recent date of July 1, 1999 (coverage of pancreas transplants) or the certification dates for kidney transplants *and termination date in column 3*. Also, complete Worksheet D-6.

Line 23.06--If this is a Medicare certified intestinal transplant center, for services rendered on or after October 1, 2001, enter the certification date in column 2 *and termination date in column 3*. Also, complete Worksheet D-6.

Line 23.07--If this is a Medicare certified islet transplant center, with an effective date for discharges on or after October 1, 2004, enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-6.

Line 24--If this is an organ procurement organization (OPO), enter the OPO number in column 2, *the certification date or recertification date (after December 26, 2007) in column 3*.

Line 24.01--If this is a Medicare transplant center; enter the CCN (provider number) in column 2, the certification date or recertification date (after December 26, 2007) in column 3.

Line 25--Is this a teaching hospital or is your facility affiliated with a teaching hospital and receiving payment for I&R? Enter "Y" for yes and "N" for no.

Line 25.01--Is this a teaching program approved in accordance with CMS Pub. 15-I, chapter 4? Enter "Y" for yes and "N" for no.

Line 25.02--If line 25.01 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? Enter "Y" for yes and complete Worksheet E-3, Part IV or "N" for no and complete Worksheets D, Parts III and IV and D-2, Part II, if applicable.

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

Line 25.03--As a teaching hospital, did you elect cost reimbursement for teaching physicians as defined in CMS Pub. 15-I, §2148? Enter "Y" for yes, "N" for no. If yes, complete Worksheet D-9.

Line 25.04--Are you claiming costs on line 70, column 7, of Worksheet A? Enter "Y" for yes and "N" for no. If yes, complete worksheet D-2, Part I.

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

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

Line 26--If this is a sole community hospital (SCH), enter the number of periods (0, 1 or 2) within this cost reporting period that SCH status was in effect. Enter the beginning and ending dates of SCH status on line 26.01. Use line 26.02 if more than 1 period is identified for this cost reporting period and enter multiple dates. Note: Worksheet C Part II must be completed for the period not classified as SCH (9/96). Multiple dates are created where there is a break in the date between SCH status, i.e., for calendar year provider SCH status dates are 1/1/00-6/30/00 and 9/1/00-12/31/00.

Line 27--If this hospital has an agreement with CMS under either §1883 or §1913 of the Act for swing beds, enter "Y" for yes in column 1 and indicate the agreement date in column 2 (mm/dd/yyyy).

Line 28--If this facility contains a hospital-based SNF, which has been granted an exemption from the cost limits in accordance with 42 CFR 413.30(e), enter "Y" for yes and "N" for no (not applicable for cost reporting periods beginning on or after July 1, 1998). For cost reporting periods beginning on or after July 1, 1998 are all patients identified as managed care patients or did your facility fail to treat Medicare eligible patients (no utilization). Enter "Y" for yes or "N" for no. If no complete lines 28.01 and 28.02 and Worksheet S-7 (7/98).

Line 28.01--If this facility contains a hospital-based SNF, enter in column 1 the payment transition period of 1 = 25/75, 2 = 50/50, 3 = 75/25; or 100. Enter in columns 2 the wage adjustment factor in effect before October 1, and in column 3 the adjustment in effect on or after October 1. SNFs servicing immune-deficient patients may continue 50/50 blend through September 30, 2001.

Line 28.02--Enter the updated hospital based SNF facility rate supplied by your fiscal intermediary if you have not transitioned to 100 percent SNF PPS payment. Enter in column 2 the classification of the SNF at the end of the cost reporting period, either (1) for urban or (2) for rural. Enter in column 3 the SNF's MSA code. Where the cost reporting period overlaps October 1, 2005, enter in column 3 the SNF's MSA code for services rendered prior to October 1, 2005, and enter in column 4 the SNF's CBSA code for services rendered on or after October 1, 2005. For cost reporting periods which begin on or after October 1, 2005, enter in column 4 the SNF's CBSA code. If you are located in a rural area enter your State code as your MSA or CBSA code, as applicable.

Lines 28.03 through 28.20--A notice published in the August 4, 2003, **Federal Register**, Vol. 68, No. 149 provided for an increase in RUG payments to Hospital based Skilled Nursing Facilities (SNF) for payments on or after October 1, 2003, however, this data is required for cost reporting periods beginning on or after October 1, 2003. Congress expected this increase to be used for direct patient care and related expenses. Subscript line 28 into the following lines: 28.03 - Staffing, 28.04 - Recruitment, 28.05 - Retention of Employees, 28.06 - Training, and 28.07-28.20 - Other. Enter in column 1 the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. For each line, indicate in column 2 whether the increased RUG payments received for cost reporting periods beginning on or after October 1, 2003 reflects increases associated with direct patient care and related expenses by responding "Y" for yes. Indicate "N" for no if there was no increase in spending in any of these areas. If the

increased spending is in an area not previously identified in areas one through four, identify on the "Other (Specify)" line(s), the cost center(s) description and the corresponding information as indicated above.

Line 29--Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional reimbursement method? Enter "Y" for yes and "N" for no. For CAHs the response is always "N" as the optional reimbursement method is not available to CAHs.

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

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

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

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

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

Line 30.04--If this facility qualifies as a CAH is it eligible for cost reimbursement for I&R training programs? Enter a "Y" for yes or an "N" for no. If yes, the GME elimination is not made on Worksheet B, Part I, column 26 and the program would be cost reimbursed. *Also, if applicable,* 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 new providers with initial* 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 412.304(c)(2), with initial cost reporting periods beginning on or after October 1, 2002, for which the response may be "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 *capital* 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."

NOTE: *Questions 37 and 37.01 are not applicable for cost reporting periods beginning on or after October 1, 2008.*

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 the third thru tenth cost reporting period of* new providers *under 42 CFR 412.324(b)(2)* certified prior to October 1, 1999. 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 *the third thru tenth cost reporting periods of* new providers *under 42 CFR 412.324(b)(2)* certified prior to October 1, 1999.)

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. 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 42--Are physical therapy services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, you may be required to complete A-8-3 and/or A-8-4 for services rendered before and on or after April 10, 1998, respectively (4/98).

Line 42.01--Are occupational therapy services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, you may be required to complete parts of Worksheet A-8-4 for services rendered on or after April 10, 1998 (4/98).

Line 42.02--Are speech pathology services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, complete all parts of Worksheet A-8-4 for services rendered on or after April 10, 1998 (4/98).

Line 43--Are respiratory therapy services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, you may be required to complete all parts of Worksheet A-8-3 and/or A-8-4 where applicable, for services rendered before and on or after April 10, 1998, respectively (4/98).

Line 44--If you are claiming costs for renal services on Worksheet A, are they inpatient services only? Enter "Y" for yes and "N" for no. If yes, do not complete Worksheet S-5 and the Worksheet I series.

Line 45--Have you changed your cost allocation methodology from the previously filed cost report? Enter "Y" for yes or "N" for no. If yes, enter the approval date in column 2.

Line 45.01--Was there a change in the statistical basis? Enter a "Y" for yes or an "N" for no.

Line 45.02--Was there a change in the order of allocation? Enter a "Y" for yes or an "N" for no.

Line 45.03--Was there a change to the simplified cost finding method? Enter a "Y" for yes and an "N" for no (9/96).

Line 46--If the provider-based SNF participates in the NHCMQ demonstration during this cost reporting period, identify the phase of the demonstration. If the SNF is participating, complete Worksheets S-7 and E-3, Part V. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration.

Lines 47 through 51--If you are a provider (public or non public) that qualifies for an exemption from the application of the lower of cost or charges as provided in 42 CFR 413.13, indicate the component and/or services that qualify for the exemption. Subscript as needed for additional components.

Line 52--Does this hospital claim expenditures for extraordinary circumstances in accordance with 42 CFR 412.348(e)? Enter "Y" for yes and "N" for no. If yes, complete Worksheet L-1.

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

Line 53--If this is a Medicare dependent hospital (MDH), enter the number of periods within this cost reporting period that MDH status was in effect. Enter the beginning and ending dates of MDH status on line 53.01. Subscript line 53.01 if more than 1 period is identified for this cost reporting period and enter multiple dates (10/97).

Line 54--Enter in the appropriate category your annual malpractice premiums. If malpractice costs are being reported in other than the Administrative and General cost center complete line 54.01, and submit supporting schedules listing the cost centers and the amounts contained therein (10/97).

Line 55--Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes and "N" for no (10/97).

Line 56--Are you claiming ambulance costs? Enter a "Y" for yes or a "N" for no. If yes, enter in column 2, for services rendered on and after October 1, 1997, the ambulance payment per trip limit provided by your intermediary. The per trip rate is updated October 1st of each year. For cost reporting periods which overlap October 1, report the payment rate prior to October 1, on line 56, column 2 and the payment rate applicable for services on October 1 to the end of the cost reporting period on line 56.01. For cost reporting periods beginning October 1st no subscribing is required. If this is your first year of providing and reporting ambulance services, you are not subject to the payment limit, however you are still subject to the fee/cost blend. Enter a "Y" for yes or an "N" for no in column 3 (10/97). For services beginning on or after January 1, 2001 the limit will be changed to a calendar year basis. There is an additional update established by regulation for July 1, 2001. Report your ambulance trip limits (column 2) chronologically, in accordance with your fiscal year. Applicable chronological dates (column 0) should be 1/1/2001, 7/1/2001, 1/1/2002, 4/1/2002 (effective date of blend), 1/1/2003, 1/1/2004, 1/1/2005, and 1/1/2006. For services rendered on or after 4/1/2002, enter in column 4 the gross fee schedule amounts (from the PS&R or your records) for the reporting period. For services on and after 4/1/2002 through 12/31/2005 ambulance services will be subject to a blend until 100 percent fee schedule amount is transitioned on 1/1/2006. For cost reporting periods that straddle 1/1/2006, only report ambulance fee schedule amounts for services rendered before 1/1/2006.

CAHs exempt from the ambulance limits (Worksheet S-2, line 30.03, column 1 equals "Y") complete columns 1 and 2 only. (10/1/97b) If you are eligible for cost reimbursement of ambulance services for the entire cost reporting period complete line 56 only, no subscripts are required. A CAH exempt from the ambulance PPS (Worksheet S-2, line 30.03, column 1 equals "Y") is cost reimbursed and not subject to the fee/cost blend or the ambulance per trip limits.

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

Line 57--Are you claiming nursing and allied health costs? Enter "Y" for yes and "N" for no. If yes you must subscript column 2 of Worksheet D, Parts III and IV to separately identify nursing and allied health (paramedical education) from all other medical education costs (1/1/00s).

Line 58--Are you an Inpatient Rehabilitation Facility (IRF) or do you contain an IRF subprovider? Enter in column 1 "Y" for yes and "N" for no. If you are an IRF or if the hospital complex contains an IRF subprovider, have you made the election for 100 percent Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. Complete only column 2 for cost reporting period beginning on or after January 1, 2002 and before October 1, 2002. The response in column 2 determines the IRF payment system, i.e., a response of "N" indicates the payment system as "T" for TEFRA or TEFRA BLEND and follows the TEFRA calculation while a response of "Y" indicates the payment system as "P" for PPS and follows the PPS calculation. All IRFs will be reimbursed at 100 percent Federal PPS for cost reporting periods beginning on or after 10/1/2002.

Line 58.01--If this facility is an IRF or contains an IRF subprovider (response to line 58, column 1 is "Y" for yes), did the facility train residents in teaching programs in the most recent cost reporting

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

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

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

Line 60.01--*If this facility is an IPF or is an IPF subprovider, were residents training in this facility 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)? Enter in column 2 “Y” for yes or “N” for no. (Note: questions 1 and 2 must have opposite answers, i.e., if column 1 is “Y”, then column 2 must be “N” and vice versa; columns 1 and 2 cannot be “Y” simultaneously, columns 1 and 2 can be “N” simultaneously.) If yes, enter a “1”, “2”, or “3”, respectively, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program’s existence that begins during the current cost reporting period. If the current cost reporting period covers the beginning of the fourth academic year of the first new teaching program’s existence, enter the number “4” in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program’s existence, enter the number “5” in column 3.

Line 61--Is the hospital part of a multi-campus? Enter “Y” for yes, “N” for no. (4/30/2008)

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. (4/30/2008)

Line 63--*Was this cost report filed using the PS&R (either in its entirety or for total charges and days only)? Enter “Y” for yes or “N” for no in column 1. If “Y”, enter the “paid through” date in column 2 (mm/dd/yyyy).*

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.

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, Exhibit 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. (4/30/2008)

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).

NOTE: Lines 36 and 37 are mutually exclusive.

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

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

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

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

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

Line Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

Line 13--Enter the direct product cost net of discount and rebates for Epoetin (EPO). Include all EPO cost for patients receiving outpatient, home (method I or II), or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Report on this line the amount 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 Epoetin included on line 64 (home dialysis program) from Worksheet A (10/97).

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

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

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

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. (4/30/2008)

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. (4/30/2008)

Line 18--Enter the number of micrograms (mcgrs) of Aranesp furnished relating to the renal dialysis department. (4/30/2008)

Line 19--Enter the number of micrograms of Aranesp furnished relating to the home dialysis program. (4/30/2008)

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.**

3615. WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 415.55, 42 CFR 415.60, 42 CFR 415.70, and 42 CFR 415.102(d), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider or which represent availability services in a hospital emergency room under specified conditions. (See 42 CFR 415.150 and 42 CFR 415.164 for an exception for teaching physicians under certain circumstances.) 42 CFR 415.70 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost you incur. 42 CFR 415.60 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services such as research. Only provider services are reimbursable to you through the cost report. This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 415.70. The methodology used in this worksheet applies the RCE limit to the total physician compensation attributable to provider services reimbursable on a reasonable cost basis. Enter the total provider-based physician adjustment for personal care services and RCE limitations applicable to the compensation of provider-based physicians directly assigned to or reclassified to general service cost centers. RCE limits are not applicable to a medical director, chief of medical staff, or to the compensation of a physician employed in a capacity not requiring the services of a physician, e.g., controller. RCE limits also do not apply to critical access hospitals, however the professional component must still be removed on this worksheet. CAHs need only complete columns 1 through 5 and 18 (10/1/97b). Transfer for CAHs the amount from column 4 to column 18.

NOTE: 42 CFR 415.70(a)(2) provides that limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services paid for under the prospective payment system implemented under 42 CFR Part 412.

Limits established under this section apply to inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40), outpatient services for all titles, and to title XVIII, Part B inpatient services.

Since the methodology used in this worksheet applies the RCE limit in total, make the adjustment required by 42 CFR 415.70(a)(2) on Worksheet C, Part I. Base this adjustment on the RCE disallowance amounts entered in column 17 of Worksheet A-8-2.

Where several physicians work in the same department, see CMS Pub. 15-I, §2182.6C for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

NOTE: The adjustments generated from this worksheet for physician compensation are limited to the cost centers on Worksheet A, lines 5-69, 82-86, and 92 and subscripts as allowed (9/96).

Column Descriptions

Columns 1 and 10--Enter the line numbers from Worksheet A for each cost center that contained compensation for physicians who are subject to RCE limits.

Columns 2 and 11--Enter the description of the cost center used on Worksheet A. When RCE limits are applied on an individual basis to each physician in a department, list each physician on successive lines directly under the cost center description line, or list the first physician on the same line as the cost center description line and then each successive line below for each additional physician in that cost center (10/97).

List each physician using an individual identifier (*not the physician's* name, NPI, UPIN or social security number of the individual, *but rather*, Dr. A, Dr. B, *Dr. AA, Dr. BB, etc.*). However, the identity of the physician must be made available to your fiscal intermediary upon audit. When RCE limits are applied on a departmental basis, insert the word "aggregate" (instead of the physician identifiers) on the line below the cost center description.

Columns 3-9 and 12-18--When the aggregate method is used, enter the data for each of these columns on the aggregate line for each cost center. When the individual method is used, enter the data for each column on the individual physician identifier lines for each cost center.

Column 3--Enter the total physician compensation paid by you for each cost center. Physician compensation means monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services) that you or other organizations furnish a physician in return for the physician's services. (See 42 CFR 415.60(a).) Include the compensation in column 3 of Worksheet A or, if necessary, through appropriate reclassifications on Worksheet A-6 or as a cost paid by a related organization through Worksheet A-8-1.

Column 4--Enter the amount of total remuneration included in column 3 applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B carrier in accordance with 42 CFR 415.102(a). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 415.60(f).)

Column 5--Enter the amount of the total remuneration included in column 3, for each cost center, applicable to general services to you (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 415.60(f).)

NOTE: 42 CFR 405.481(b) requires that physician compensation be allocated between physician services to patients, the provider, and nonallowable services such as research. Physicians' nonallowable services must not be included in columns 4 or 5. The instructions for column 18 insure that the compensation for nonallowable services included in column 3 is correctly eliminated on Worksheet A-8.

Column 6--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the **Federal Register** before any allowable adjustments. The final notice on the annual update to RCE limits published in the **Federal Register**, Vol. 50, No. 34, February 20, 1985, on page 7126 contains Table 1, Estimates of FTE Annual Average Net Compensation Levels for 1984. An update was published in the **Federal Register** on May 5, 1997. Another update was published in the **Federal Register** on August 1, 2003, Vol. 68, No. 148 on page 45459. Obtain the RCE applicable to the specialty from this table. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable: non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million.

Column 7--Enter for each line of data the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040 in this column. The hours entered are the actual hours for which the physician is compensated by you for furnishing services of a general benefit to your patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered. Time records or other documentation that supports this allocation must be

training program or did not participate in Medicare during the base period, but either condition changed in a cost reporting period beginning on or after July 1, 1985, a per resident amount must be established *using the information in a base period defined in 42 CFR 413.77(e)*. Any GME costs incurred during a cost reporting period prior to the base period are reimbursed based on reasonable cost. Do not include in column 26 the intern and resident costs from columns 22 and 23.

If you are CAH and responded "Y" to worksheet S-2, question 30.04, (indicating that you have an I&R training program) the GME costs are reimbursed on a reasonable cost basis. Consequently, do not include in column 26 the intern and resident costs from columns 22 and 23.

Worksheet B-1, Column 6A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, Part I, column 5A, line 103 and the accumulated cost reported on Worksheet B-1, column 6, line 6. Enter any amounts reported on Worksheet B, Part I, column 5A for (1) any service provided under arrangements to program patients and which is not grossed up and (2) negative balances. Enter a negative one (-1) in the accumulated cost column to identify the cost center which should be excluded from receiving any A & G costs. If some of the costs from that cost center are to receive A & G costs then enter in the reconciliation column the amount not to receive A & G costs to assure that only those costs to receive overhead receive the proper allocation. Including a statistical cost which does not relate to the allocation of administrative and general expenses causes an improper distribution of overhead. In addition, report on line 6 the administrative and general costs reported on Worksheet B, Part I, column 6, line 6 since these costs are not included on Worksheet B-1, column 6 as an accumulated cost statistic.

For componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 6.03 (Other A&G), the reconciliation column designation must be 6A.03.

Worksheet B-1, Column 6--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-1, column 6, line 6, is the difference between the amounts entered on Worksheet B, Part I, column 5A and Worksheet B-1, column 6A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

Worksheet B-1, Column 24--Enter the appropriate statistics based on assigned time. If, however, the use of assigned time is not appropriate for that paramedical education program (i.e., a non-direct patient care cost center), a different statistical basis may be used. For example, if you have a paramedical education program for hospital administration, using assigned time as the statistical basis may be inappropriate. Use accumulated costs as the statistical basis for allocating hospital administrative paramedical education program costs.

3618. WORKSHEET B, PART II - ALLOCATION OF OLD CAPITAL-RELATED COSTS AND WORKSHEET B, PART III - ALLOCATION OF NEW CAPITAL-RELATED COSTS

These worksheets provide for the determination of direct and indirect capital-related costs allocated to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within your organization, other general service cost centers, inpatient routine service cost centers, ancillary service cost centers, outpatient service cost centers, other reimbursable cost centers, special purpose cost centers, and nonreimbursable cost centers. For cost reporting periods beginning on and after October 1, 2001, hospitals receiving 100 percent Federal rate (Worksheet S-2, line 36 has a yes response) for PPS capital payments complete Worksheet B, Part III in its entirety. (In this situation both the old and new capital are reported on worksheet B, Part III.) New providers certified prior to 10/1/2001 that elect hold harmless payment methodology for capital costs (Worksheet S-2, line 37 has a yes response) will complete Worksheet B, Parts II and III.

NOTE: Except for non-PPS providers, unless there is a change in ownership or the provider has elected the alternative method described in §3617, the hospital must continue the same cost finding methods (including its cost finding bases) in effect in the hospital's last cost reporting period ending on or before October 1, 1991. (See 42 CFR 412.302 (d).) If there is a change in ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices. (See CMS Pub. 15-I, §2313.)

Parts II and III are completed by all PPS hospitals and excluded hospitals which were part of a complex subject to PPS. Freestanding hospitals excluded from PPS are not required to complete Part II. (See 42 CFR 412.23 for classification of excluded units.) Also, PPS hospitals claiming 100 percent Federal for capital payment are not required to complete Part II. Caution should be taken if the provider later determines an alternative method of capital payment, i.e. hold harmless, is appropriate and that adequate data for old and new capital is not maintained.

See the instructions for Worksheet A, lines 1 through 4, for a discussion of old and new capital-related costs.

Use these worksheets in conjunction with Worksheets B, Part I and B-1. The format and allocation process employed are identical to that used on Worksheets B, Part I and B-1. Any cost centers, subscripted lines, and/or columns added to Worksheet A are also added to Worksheet B, Parts II and III, in the same sequence.

Column 0--Where capital-related costs have been directly assigned to specific cost centers on Worksheet A, column 7, in accordance with CMS Pub. 15-I, §2307, enter in this column those amounts directly assigned from your records. Where you include cost incurred by a related organization, the portion of these costs that are capital-related costs is considered directly assigned capital-related costs of the applicable cost center. For example, if you are part of a chain organization that includes some costs incurred by the home office of the chain organization in your administrative and general cost center, the amount so included represents capital-related costs included in this column.

Columns 1 through 4--Obtain the amounts entered in columns 1 through 4, lines 5 through 100, from the corresponding columns and lines on Worksheet B, Part I.

Column 4A--Enter the sum of columns 0 through 4 for each line.

Enter on line 105 of Worksheet B-1 for each column the capital-related costs allocated. Report these costs on the first line of each column on Worksheet B, Part II. (See exceptions below.) Complete a unit cost multiplier for each column by dividing the amount on line 105 of Worksheet B-1 by the statistic reported on the first line of the same column. Enter the unit cost multiplier

	<u>To Worksheet D-1, Part III</u>
Line 34 - SNF	Line 71 for the SNF
Sum of lines 34 and 35	Line 71 for the NF
	<u>To Worksheet D, Part II</u>
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
	<u>To Worksheet C, Part II, Column 2</u>
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 Epoetin 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:

<u>Code</u>	<u>Worksheet</u>
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. (4/30/2008)

Line 4--Enter the amount of the Aranesp adjustment for the home dialysis program. (4/30/2008)

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.

Line 8--Enter the total swing bed-NF type inpatient days, including private room days, after December 31 of your cost reporting period. If you are on a calendar year end, enter zero. This line includes title V, title XIX, and all other payers. The sum of lines 7 and 8 equals Worksheet S-3, Part I, line 4, column 6.

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

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

<u>Type of Provider</u>	<u>From</u>
Hospital	Wkst. S-3, Part I, cols. 3, 4, or 5, line 1
Subprovider	Wkst. S-3, Part I, cols. 3, 4, or 5, line 14
SNF	Wkst. S-3, Part I, cols. 3, 4, or 5, line 15
NF	Wkst. S-3, Part I, cols. 3, 4, or 5, for SNF only level of care; line 15. If line 38.03 of Wkst S-2 is a "Y", two D-1s must be completed for title XIX using line 15 for SNF level of care and line 16 for the NF level of care; or line 16 only for NF level of care.

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

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

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

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

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

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

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

Line 15--Enter, for titles V or XIX only, the total nursery inpatient days from Worksheet S-3, Part I, column 6, line 11.

Line 16--Enter, for titles V or XIX only, the total nursery inpatient days applicable to the program from Worksheet S-3, Part I, columns 3 and 5, respectively, line 11.

Lines 17 through 27--These lines provide for the carve out of reasonable cost of extended care services furnished by a swing bed hospital. Under the carve out method, the total costs attributable to SNF type and NF type routine services furnished to all classes of patients are subtracted from total

general inpatient routine service costs before computing the average cost per diem for general routine hospital care. The rates on lines 17 through 20 are supplied by your intermediary.

Line 17--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 5 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-I, §2230ff.) Critical access hospitals do not complete this line (12/00).

Line 18--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 6 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-I, §2230ff.) Critical access hospitals do not complete this line (12/00).

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

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

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

For titles V, XVIII, and XIX, enter the amounts from Worksheet C, Part I, line 25 for adults and pediatrics or line 31 for the subprovider, as appropriate:

COST or OTHER	Inpatient - Column 1
TEFRA	Inpatient - Column 3, for IRFs & LTCHs if Wksht. S-2, line 58 (IRF) or 59 (LTCH), respectively, columns 1 and 2 are "Y" & "N", respectively.
PPS	Inpatient - Column 5, for IRFs & LTCHs if Wksht. S-2, line 58 (IRF) or 59 (LTCH), respectively, columns 1 and 2 are "Y" & "Y", respectively.

SNF/NF Inpatient Routine--For title XVIII, transfer this amount from Worksheet C, Part I, column 5, line 34 (SNF) (7/1/98b). For titles V and XIX, transfer this amount from Worksheet B, Part I, column 27, line 35 (NF) or 35.01 ICF/MR.

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

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

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

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

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

For critical access hospitals, for cost reporting periods beginning on or after December 21, 2000, subtract the sum of lines 24 and 25 from the amount reported on line 21. Divide that result by the patient days equal to lines 2, 5, and 6 above to arrive at a per diem (Retain this amount for the calculation required on lines 38, 60 and 61). Multiply the per diem by the total days reported on lines 5 and 6. Add that result to the amounts reported on lines 24 and 25.

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

Lines 28 through 36--All providers must complete lines 28 through 36. PPS providers complete these lines for data purposes only. However, if line 3 equals line 2 above you are not to complete these lines.

Line 28--Enter the total charges for general inpatient routine services, excluding charges for swing bed-SNF type and NF type inpatient services (from your records).

Line 29--Enter the total charges for private room accommodations, excluding charges for private room accommodations for swing bed-SNF type and NF type inpatient services (from your records).

Line 30--Enter the total charges for semi-private room and ward accommodations, excluding semi-private room accommodation charges for swing bed-SNF type and NF type services (from your records).

Line 31--Enter the general inpatient routine cost to charge ratio (rounded to six decimal places) by dividing the total inpatient general routine service costs (line 27) by the total inpatient general routine service charges (line 28).

Line 32--Enter the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the amount on line 29 by the days on line 3.

Line 33--Enter the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the amount on line 30 by the days on line 4.

Line 34--Subtract the average per diem charge for all semi-private accommodations (line 33) from the average per diem charge for all private room accommodations (line 32) to determine the average per diem private room charge differential. If a negative amount results from this computation, enter zero on line 34.

Line 35--Multiply the average per diem private room charge differential (line 34) by the inpatient general routine cost to charge ratio (line 31) to determine the average per diem private room cost differential (rounded to two decimal places).

Line 36--Multiply the average per diem private room cost differential (line 35) by the private room accommodation days (excluding private room accommodation days applicable to swing bed-SNF type and NF type services) (line 3) to determine the total private room accommodation cost differential adjustment.

Line 37--Subtract the private room cost differential adjustment (line 36) from the general inpatient routine service cost net of swing bed-SNF type and NF type costs (line 27) to determine the adjusted general inpatient routine service cost net of swing bed-SNF type service costs, NF type service costs, and the private room accommodation cost differential adjustment. If line 3 equals line 2, enter the amount from line 27 above.

3622.2 Part II - Hospital and Subproviders Only--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX and the calculation of program excludable cost for all hospitals and subproviders. For hospitals reimbursed under TEFRA, it provides for the application of a ceiling on the rate of cost increase for the hospital and subproviders. When the worksheet is completed for a component, show both the hospital and component numbers.

NOTE: This is not completed for RPCH providers. (See Worksheet S-2, line 31ff.) RPCH providers complete Worksheet C, Part IV, in lieu of this part. For cost reporting periods beginning after October 1, 1997 CAHs will complete this worksheet.

Line Descriptions

Line 38--For non-PPS providers (includes IRFs and LTCHs during the TEFRA/PPS blend), divide the adjusted general inpatient routine service cost (line 37) by the total general inpatient routine service days including private room (excluding swing bed and newborn) days (line 2) to determine the general inpatient routine service average cost per diem (rounded to two decimal places). For PPS providers (includes IRFs and LTCHs under 100 percent PPS), divide the sum of lines 36 and 37 by the inpatient days reported on line 2. For CAHs the per diem, unless there is an adjustment for private room differential, should be equal to the per diem calculated in the formula on line 26. If this is a CAH and there is a private room differential, process as a non PPS provider,

Line 39--Multiply the total program inpatient days including private room (excluding swing bed and newborn) days (line 9) by the adjusted general inpatient routine service average cost per diem (line 38) to determine the general inpatient service cost applicable to the program.

Line 40--Multiply the medically necessary private room (excluding swing bed) days applicable to the program (line 14) by the average per diem private room cost differential (line 35) to determine the reimbursable medically necessary private room cost applicable to the program. PPS providers including IRF, IPF and LTCH, reimbursed at 100 percent Federal rate enter zero.

Line 41--Add lines 39 and 40 to determine the total general inpatient routine service cost applicable to the program.

Line 42--This line is for titles V and XIX only and provides for the apportionment of your inpatient routine service cost of the nursery, as appropriate.

Column 1--Enter the total inpatient cost applicable to the nursery from Worksheet C, Part I, line 33.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient	Column 5

Column 2--Enter the total inpatient days applicable to the nursery from line 15.

Column 3--Divide the total inpatient cost in column 1 by the total inpatient days in column 2 (rounded to two decimal places).

Column 4--Enter the program nursery days from line 16.

Column 5--Multiply the average per diem cost in column 3 by the program nursery days in column 4.

Lines 43 through 47--These lines provide for the apportionment of the hospital inpatient routine service cost of intensive care type inpatient hospital units (excluding nursery) to the program.

Column 1--Enter on the appropriate line the total inpatient routine cost applicable to each of the indicated intensive care type inpatient hospital units from Worksheet C, Part I, lines 26 through 30, as appropriate.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient	Column 5

Column 2--Enter on the appropriate line the total inpatient days applicable to each of the indicated intensive care type inpatient units. Transfer these inpatient days from Worksheet S-3, Part I, column 6, lines 6 through 10, as appropriate.

3.12 are completed, enter the sum of (line 3.09 times line 3.11) plus the lesser of (line 3.10 times line 3.12) or (line 3.10 times line 3.07). Add that result to the amount on line 3.13. Calculate the rolling average count for cost reporting periods beginning on or after October 1, 1997.

Line 3.15--Enter the total allowable FTE count from line 3.14 or line 3.01 of the prior year. Do not include residents in the initial years of the program. However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 43 CFR 412.105(f)(i)(v)) expired, enter on this line the allowable FTE count from line 3.14 plus the count of FTE residents in that specific program included in line 3.17 of the prior year's cost report. If you had no approved teaching program make no entry (10/97). See comment for line 3.08. If you did not have any FTE's reported for this period but you did have an approved teaching program, enter a (1) in column 0 (applicable for cost reporting periods ending before 6/30/2006).

Line 3.16--Enter the total allowable FTE count for the penultimate year from line 3.14 if that year ended on or after September 30, 1997. If you had no approved teaching program make no entry. Do not include residents in the initial years of the program (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 43 CFR 412.105(f)(i)(v)) expired, enter on this line the allowable FTE count from line 3.14 plus the count of FTE residents in that specific program included in line 3.17 of the penultimate year's cost report. (10/97) See comment for line 3.08. If you did not have any FTE's reported for this period but you did have an approved teaching program, enter a (1) in column 0 (applicable for cost reporting periods ending before 6/30/2006).

Line 3.17--Enter the sum of lines 3.14 through 3.16 and divide by the number of these lines greater than zero, unless a 1 is entered in column zero on lines 3.15 and 3.16 then count those lines. (See 42 CFR 413.79(d).) Add to that result the number of FTE residents in the initial years of the program that meet the rolling average exception in 42 CFR 413.79(d)(5) and (e)(6). Effective for discharges occurring on or after October 1, 2001, add to this amount any temporary adjustments for FTE residents that were displaced by program or hospital closure (42 CFR 412.105(f)(1)(ix)).

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

This change is date sensitive and column zero only applies to cost reporting periods ending on or after June 30, 2006.

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

Line 3.19--In general, for cost reporting periods beginning on or after October 1, 1997, enter from the prior year cost report the intern and resident to bed ratio by dividing line 3.14 by line 3. *However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e), add to the numerator of the prior year intern and resident to bed ratio the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program (i.e., the period of years is the minimum accredited length of the program). If the provider is participating in a Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap and current year FTE count due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator and the prior year numerator, and b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior year's numerator (see FR Vol. 66, No. 148 dated August 1, 2001, page 39880).* Effective for cost reporting periods beginning on or after October 1, 2002, if the current year is the first cost reporting period in which a receiving hospital trains FTE residents displaced by the closure of another hospital or program, then also adjust the numerator of the prior year ratio for the number of current year FTE residents that were displaced by hospital or program closure (42 CFR 412.105(a)(1)(iii)). Also, in the cost reporting

period following the last year the receiving hospital's FTE cap is temporarily adjusted for the displaced residents, adjust the numerator of the prior year ratio by subtracting the displaced FTE residents reported on line 3.17 of the prior year's cost report. (42 CFR 412.105 (a)(1)(iv)). If no intern and resident to bed ratio was reported in the prior year, calculate the ratio using the FTE count for residents in the initial years of the new program. For prior year cost reporting periods ending prior to October 1, 1997, compute the ratio by dividing line 3.01 by line 3.

Line 3.20--For cost reporting periods beginning on or after October 1, 1997, enter the lesser of lines 3.18 or 3.19.

IME adjustment calculation for hospitals with cost reporting periods beginning prior to October 1. The multiplier of the adjustment factor defined in 42 CFR 412.105(d) is changed every October 1st for discharges occurring on and after: October 1, 1996 - 1.89; October 1, 1997 - 1.72; October 1, 1998 - 1.6; October 1, 1999 - 1.60; October 1, 2000 – through March 31, 2001 - 1.54, April 1, 2001 through September 30, 2001 – 1.66; and, on or after October 1, 2001 through September 30, 2002 – 1.6; and on or after October 1, 2002 through September 30, 2003 – 1.35; On or after October 1, 2003 through March 31, 2004 – 1.35; On or after April 1, 2004 through September 30, 2004 – 1.47; On or after October 1, 2004 through September 30, 2005 – 1.42; On or after October 1, 2005 through September 30, 2006 – 1.37; On or after October 1, 2006 through September 30, 2007 – 1.32; On or after October 1, 2007 – 1.35.

For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, an additional computation will be required for discharges occurring during these periods. See line 3.24 below and the revised payment chart on page 36-136.1 for completion of line 3.24.

Line 3.21--For payments reported on lines 1 and 1.03, enter the result of the following: The appropriate multiplier of the adjustment factor for the payment period identified on line 1 times $\{(1 + \text{line } 3.14/\text{line } 3^*) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{sum of (the amount on line 1) + (line 1.03 times the appropriate percentage identified in the paragraph prior to line 1.03) + Line 2.}^{**}\}$

Line 3.22--For payments reported on lines 1.01 and 1.04, enter the result of the following: The appropriate adjustment factor for the payment period identified on line 1.01 times $\{(1 + \text{line } 3.14/\text{line } 3^*) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{line } 1.01 + (\text{line } 1.04 \text{ times the appropriate percentage identified in the paragraph prior to line } 1.03)\}$.

Line 3.23--For payments reported on lines 1.02 and 1.05, enter the result of the following: The appropriate multiplier of the adjustment factor for the payment period identified on line 1.02 times $\{(1 + \text{line } 3.14/\text{line } 3^*) \text{ to the } .405 \text{ power} - 1\}$ times $(\text{line } 1.02 + \text{line } 1.05 \text{ times the appropriate percentage identified in the paragraph prior to line } 1.03)$.

* For cost reporting periods beginning on or after October 1, 1997, replace $\{(\text{line } 3.14 \text{ divided by line } 3)(\text{adjust line } 3.14 \text{ by the interns and residents in the initial years of the program})\}$ with the ratio reported on line 3.20. ** For discharges prior to October 1, 1997, only; do not include outliers for purposes of the IME calculation for discharges occurring on and after October 1, 1997.

Line 3.24--Enter the sum of lines 3.21 through 3.23. For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, add to this result, the appropriate multiplier of the adjustment factor for the payment period identified on line 1.07 times $\{(1 + \text{line } 3.14/\text{line } 3^*) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{the sum of line } 1.07 + (\text{line } 1.08 \text{ times the appropriate percentage identified in the paragraph prior to line } 1.03)\}$. For cost reporting periods ending on or after July 1, 2005, add to this result the amount from Worksheet E-3, Part VI, line 23.

Disproportionate Share Adjustment.--Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on lines 4

through 4.04. Complete this portion only if you answered yes to line 21.01 of Worksheet S-2. For cost reporting periods which overlap January 20, 2000, do not complete lines 4 through 4.03 and enter on line 4.04 the manually calculated DSH payment adjusted by the appropriate reduction. (See intermediary PM A-99-62 for proper determination of DSH adjustment.) For those hospitals experiencing a change in the DSH percentage as a result of the application of the BIPA provisions effective for services on and after April 1, 2001, or as a result of the application of the MMA provisions effective for discharges on and after April 1, 2004, (i.e., geographic reclassification) subscript column 1 (add column 1.01) for lines 1, 1.01, 1.02, 1.07, 4.03 and 4.04 and apply the appropriate percentage for the DSH payment and reduction in accordance with the payment dates prescribed above. Review the payment chart on page 137 and lines 1, 1.01, 1.02 and 1.07 for proper reporting of payments. Do not subscript the column for lines 4.03 and 4.04, except as applicable for SCH/MDH and geographic reclassification.

Line 4--Enter the percentage of SSI recipient patient days to Medicare Part A patient days. (Obtain the percentage from your intermediary.)

Line 4.01--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12 minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

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

Line 4.02--Add lines 4 and 4.01 to equal the hospital's DSH patient percentage.

Line 4.03--Compare the percentage on line 4.02 with the criteria described in 42 CFR 412.106(c) and (d). Enter the percentage identified in the CFR to be applied against PPS payments.

For cost reporting periods with dates of service in the period April 1, 2001, through September 30, 2001, or April 1, 2004, through September 30, 2004, enter in column 0 the percentage to be applied against PPS payment for the period April 1 through September 30. In addition, for MDH providers for cost reporting periods overlapping October 1, 2006, the rural 12 percent DSH payment cap does not apply for discharges occurring on or after October 1, 2006. Enter in column 1 the percentage to be applied for discharges occurring prior to October 1, 2006, and enter in column 1.01 the percentage to be applied for discharges occurring on or after October 1, 2006.

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

Line 4.04--Multiply line 4.03 by the sum of lines 1, 1.01, 1.02 and 2 and enter the result. For discharges occurring on or after October 1, 1997, multiply line 4.03 by the sum of lines 1, 1.01, and 1.02. For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, add to this amount the product of the payment percentage identified on line 4.03, column 0, applied to the payments identified on line 1.07. Reduce that amount for discharges occurring on or after October 1, 1997, by 1 percent; 2 percent for October 1, 1998, 3 percent for October 1, 1999; 3 percent for October 1, 2000 through March 31, 2001; 1 percent for April 1, 2001 through September 30, 2001; 3 percent for October 1, 2001 through September 30, 2002; and 0 (zero) percent thereafter. Review the payment chart on page 137 for the proper splitting of payments before and on or after October 1 and April 1 for those

cost reports that overlap these dates in order to properly calculate the reduction.

High Percentage of ESRD Beneficiary Discharges Adjustment.--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104.

Line 5--Enter total Medicare discharges reported on Worksheet S-3, *Part I*, excluding discharges for DRGs 302, 316, and 317, *or effective October 1, 2007, excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages and 48520 and 48447).*

Line 5.01--Enter total Medicare discharges for ESRD beneficiaries who received dialysis *treatment* during an inpatient stay (see Vol. 69, FR 154, dated August 11, 2004, page 49087) excluding DRGs 302, 316, and 317, or effective October 1, 2007, *excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48520 and 48447).*

Line 5.02--Divide line 5.01 by line 5. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

Line 5.03--Enter the total Medicare ESRD inpatient days excluding DRGs 302, 316, and 317 or *effective October 1, 2007, MS-DRGs 652, 682, 683, 684, and 685, as applicable.*

Line 5.04--Enter the average length of stay expressed as a ratio to 7 days. Divide line 5.03 by line 5.01 and divide the result by 7 days.

Line 5.05--Enter the average cost per dialysis treatment of \$335 (\$111.67 times the average number of treatments (3)).

Line 5.06--Enter the ESRD payment adjustment (line 5.04 times line 5.05 times line 5.01).

Line 6--Enter the sum of lines 1, 1.01, 1.02, 1.07, 2, 2.01, 3.03 (for cost reporting periods which overlap October 1, 1997, and thereafter, substitute line 3.24 for line 3.03), 4.04 (subscripted columns), and 5.06. For cost reporting periods beginning in the government's fiscal year in 1998 and 1999 and you answered yes to line 55 of Worksheet S-2, add to this sum the amount on line 1.06, if applicable.

Line 7--Sole community hospitals are paid the highest rate of the Federal payment rate, the hospital-specific rate (HSR) determined based on a Federal fiscal year 1982 base period (see 42 CFR 412.73), or the hospital-specific rate determined based on a Federal fiscal year 1987 base period. (See 42 CFR 412.75.) For discharges occurring on or before October 1, 2006, Medicare dependent hospitals are paid the highest of the Federal payment rate, or the Federal rate plus 50 percent of the amount of the excess over the Federal rate of the higher of either the 1982 base period, or the 1987 base period hospital specific rate. For discharges occurring on or after October 1, 2006, Medicare dependent hospitals are paid the highest of the Federal payment rate, or the Federal rate plus 75 percent of the amount of the excess over the Federal rate of the highest rate for the 1982, 1987 or 2002 base period hospital specific rate. For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments.

For sole community hospitals only, the hospital-specific payment amount entered on this line is supplied by your fiscal intermediary. Calculate it by multiplying the sum of the DRG weights for the period (per the PS&R) by the final per discharge hospital-specific rate for the period. For new hospital providers established after 1987, do not complete this line. Use the higher of the hospital-specific rate based on cost reporting periods beginning in FY 1982 or FY 1987. Use the hospital-specific rate (operating cost per discharge divided by the case mix index for 1982 or 1987, as applicable) updated to the beginning of the cost reporting period and adjusted for budget neutrality, if applicable, in this calculation. For services rendered on or after October 1, 2003, use the hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, or 1996.

For MDH discharges occurring on or after October 1, 2006, and before October 1, 2011, an MDH can use a FY 2002 hospital specific rate.

Line 7.01--In addition to the comparison of 1982 and 1987, sole community hospitals can compare the hospital specific rate for cost reporting periods beginning in FY 1996 (CFR 412.77). For SCHs with cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003, enter on this line the hospital-specific payment amount based on the cost reporting period beginning in FY 1996 as supplied by your fiscal intermediary. For services rendered on or after October 1, 2003, do not use this line, but rather use line 7.

Line 8--For SCHs, enter the greater of line 6 or 7. For MDHs (for discharges occurring on or after October 1, 1997, and before October 1, 2006), if line 6 is greater than line 7, enter the amount on line 6. Where line 7 is greater than line 6, enter the amount on line 6, plus 50 percent of the amount that line 7 exceeds line 6. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2011, if line 6 is greater than line 7, enter the amount on line 6. Where line 7 is greater than line 6, enter the amount on line 6, plus 75 percent of the amount that line 7 exceeds line 6. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 6.

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

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

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

Line 9--Enter the payment for inpatient program capital costs from Worksheet L, Part I, line 6; Part II, line 10; or Part III, line 5, as applicable.

Line 10--Enter the exception payment for inpatient program capital, if applicable, from Worksheet L, Part IV, line 13 for cost reporting periods beginning before October 1, 2001. For cost reporting periods beginning on and after October 1, 2001, if the provider continues to qualify for the additional payment for extraordinary circumstances pursuant to 42 CFR 412.348(e) enter the exception payment for inpatient program capital from Worksheet L, Part IV, line 13. If the provider qualifies for the special exceptions payment pursuant to 42 CFR 412.348(g) enter the result of Worksheet L, Part IV, line 13 less Worksheet L, Part IV, line 17. If this amount is negative, enter zero on this line.

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

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

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

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

Line 12--Enter the net organ acquisition cost from Worksheet(s) D-6, Part III, column 1, line 61.

Line 13--Enter the cost of teaching physicians from Worksheet D-9, Part II, column 3, line 16.

Line 14--Enter on the appropriate Worksheet E, Part A, the routine service other pass through costs from Worksheet D, Part III, column 8, lines 25 through 30 for the hospital and line 31 for the subproviders.

Line 15--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101.

Line 16--Enter the sum of lines 8 through 15.

Line 17--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, treat the services as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted by you in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 12. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 17 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductible and coinsurance on line 17.

Enter the primary payer amounts applicable to organ transplants. However, do not enter the primary payer amounts applicable to organ acquisitions. Report these amounts on Worksheet D-6, Part III, line 58.

If you are subject to PPS, include the covered days and charges in the program days and charges, and include the total days and charges in the total days and charges for inpatient and pass through cost apportionment. Furthermore, include the DRG amounts applicable to the patient stay on line 1. Enter the primary payer payment on line 17 to the extent that the primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductibles.

Line 19--Enter from the PS&R or your records the deductibles billed to program patients.

Line 20--Enter from the PS&R or your records the coinsurance billed to program patients.

Line 21--Enter the program reimbursable bad debts, reduced by the bad debt recoveries. If recoveries exceed the current year's bad debts, line 21 and 21.01 will be negative.

Line 21.01--Enter line 21 (including negative amounts) times 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999, and 70 percent for October 1, 2000 and thereafter.

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

Line 22--Enter the sum of lines 18 and 21.01 minus the sum of lines 19 and 20.

Line 23--Enter the programs share of any recovery of accelerated depreciation applicable to prior periods paid under reasonable cost or the hold harmless methodology under capital PPS resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, §§136 - 136.16.)

Line 24--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided. *Effective for discharges occurring on or after October 1, 2008, enter on line 24.98 the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in Change Request 5860, transmittal 1509, dated May 9, 2008.* 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.

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, line 1.05 (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-§20.1.2.7.

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

Line 53--Enter the time value of money.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 2--Reduced Direct GME FTE Cap. Effective for cost reporting periods ending on or after July 1, 2005, enter the reduced direct GME cap as specified under 42 CFR §413.79(c)(3). *However, if the resulting reduced direct GME cap is less than zero (0), enter zero on this line.*

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

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

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

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

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

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

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

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

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

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

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

Line 12--Determine the direct GME payment for managed care days by multiplying line 9 by the managed care patient load computed from worksheet E-3, Part IV: [(line 6.02 + line 6.06)/line 5]. Reduce this amount by the Nursing Allied Health Medicare advantage factor. (See Worksheet E-3, Part IV, line 6.08).

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

Line 13--Reduced IME FTE Cap. Effective for cost reporting periods ending on or after July 1, 2005, enter the reduced IME FTE resident cap for allopathic and osteopathic residents as specified under 42 CFR §412.105(f)(1)(iv)(B). *However, if the resulting reduced direct GME cap is less than zero (0), enter zero on this line.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Column 3--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center enter them on line 22.

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

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

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

Column 7--Enter any reclassifications among cost center expenses in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses as negative amounts.

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

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

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

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

LINE DESCRIPTIONS

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

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 I, 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 17--Add lines 9 through 16. This total in column 1 should agree with the total on Worksheet A, column 7, for line 57 or line 64, less the adjustments for EPO and Aranesp reported on Worksheet B-2, lines 1, 2, 3, or 4 as appropriate.

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.

<u>Worksheet I-1, Part I, Column 1, Line Number</u>	<u>General Service Cost Centers</u>	<u>Worksheet B, Part I, Lines 57 or 64, Columns</u>
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
25	Medical Education Programs	Sum of 21, 22, 23, 24, and 26 (medical education only)
26	Central Services & Supplies	15
27	Pharmacy	16
28	Other Allocated Costs	Sum of 9, 11, 12, 13, 14, 17, 18, 19, and 20

Line 29--Add lines 18 through 28. This total should agree with the total on Worksheet B, column 27, line 57 or line 64 if a home dialysis cost center was established.

Lines 30, 31, and 32--These lines provide for the allocation of costs associated with routine dialysis services furnished to renal patients from other ancillary departments. Multiply charges by the cost to charge ratio from Worksheet C, Part II for the appropriate department. For cost reporting periods beginning on and after August 1, 2000, enter the cost to charge ratio from Worksheet C, Part I, column 9. Payment for routine laboratory services, as defined in §E202 of the ESRD Appendix of the Hospital Manual, is paid for under the composite payment rate. No separate payment is made for routine laboratory tests. The costs of these services are allocated to the renal department based on the provider's laboratory cost to charge ratio as computed on Worksheet C, Part II, column 8, line 44. For cost reporting periods beginning on and after August 1, 2000, enter the cost to charge ratio from Worksheet C, Part I, column 9, line 44. Providers must maintain a log of routine laboratory charges for allocating routine laboratory costs to the renal department. The lab charges reported on Worksheet C do not include the lab charges for ESRD therefore those charges must be grossed up in accordance with PRM-1, § 2314. The cost to charge ratio must be recalculated and applied against the charges reported in column 3 of this worksheet. For cost reporting periods ending on or after April 30, 2003, ESRD charges will no longer be grossed up. Instead, the cost to charge ratio for lab charges reported on Worksheet C will be used.

Line 33--Enter the sum lines 29 through 32.

3652. WORKSHEET I-2 - ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

The purpose of this schedule is to allocate costs to the different services furnished in the renal department. Line 1 combine the costs reported on Worksheet I-1 for allocating costs to the different services furnished in the renal department.

Line 1--Add the costs from Worksheet I-1, and transfer these amounts to line 1 in the following manner:

<u>Worksheet I-2</u>	<u>Worksheet I-2 Column</u>	<u>Worksheet I-1</u>
Capital & Main Building Costs	1	Sum of lines 11, 18, 20, and 24
Capital, Machine & Repair Costs	2	Sum of lines 12, 13, 19, and 21
Registered Nurses Direct Patient Care Salary	3	Line 1
Other Direct Patient Care Salary	4	Sum of lines 2, 3, 4, 5, and 6
Employee Benefits	5	Sum of lines 10 and 22
Drugs	6	Sum of lines 15 and 27
Medical Supplies	7	Sum of lines 14 and 26
Routine Ancillary Services	8	Sum of lines 30, 31, and 32
Subtotal	9	Not applicable
Overhead	10	Sum of lines 7, 8, 16, 23, and 28

Complete columns 1 through 8 and 10 in conjunction with Worksheet I-3, which contains the statistical bases for allocating costs to the proper lines. For each line item in columns 1 through 8 and 10, multiply the statistic entered in the corresponding line and column of Worksheet I-3 by the unit cost multiplier on line 17.

Lines 2 through 11--These lines identify the type of dialysis treatments that are paid for under the composite payment rate system. The total costs (column 11) for these individual dialysis services are transferred to Worksheet I-4.

Transfer the total on Worksheet I-2, column 11 to Worksheet I-4 per the following instructions.

<u>From Worksheet I-2, Column 11</u>	<u>To Worksheet I-4, Column 2</u>
Line 2	Line 1
Line 3	Line 2
Line 4	Line 3

3659. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED
OUTPATIENT REHABILITATION PROVIDER FOR SERVICES RENDERED TO
PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your fiscal intermediary.

Line Descriptions

Line 1--Enter the total program interim payments paid to the outpatient rehabilitation provider. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable.

Line 2--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period. It does not include payments reported on line 1.

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

Line 4--Transfer the total interim payments to the title XVIII Worksheet J-3, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due from the provider to the program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet J-3, line 26.

3660. WORKSHEET L - CALCULATION OF CAPITAL PAYMENT

Worksheet L, Parts I through IV, calculate program settlement for PPS inpatient hospital capital-related costs in accordance with the final rule for payment of capital-related costs on a prospective payment system pursuant to 42 CFR 412, Subpart M. (See the August 30, 1991 **Federal Register**.) Only provider components paid under PPS complete this worksheet.

Worksheet L consists of the following four parts:

- Part I - Fully Prospective Method
- Part II - Hold Harmless Method
- Part III - Payment Under Reasonable Cost
- Part IV - Computation of Exception Payments

COMPLETE ONLY PART I, II, OR III.

At the top of the worksheet, indicate by checking the applicable boxes the health care program, provider component, and the PPS capital payment method for which the worksheet is prepared.

3660.1 Part I - Fully Prospective Method--This part computes settlement under the fully prospective method only, as defined in 42 CFR 412.340. Use the fully prospective method for PPS capital settlement when the hospital's base year hospital-specific rate is below the adjusted Federal rate.

Line Descriptions

Line 1--Enter the amount of the hospital-specific rate portion of capital payments for discharges during the period. Do not complete this line for cost reporting periods beginning on and after October 1, 2001 for hospitals paid 100 percent of the Federal rate.

Line 2--Enter the amount of the Federal rate portion of the capital DRG payments for other than outlier during the period. *Subscript column 1 as indicated in the general instructions for lines 4.02 through 4.03.*

Line 3--Enter the amount of the Federal rate portion of the capital outlier payments made for PPS discharges during the period. (See 42 CFR 412.312(c).) Subscript this line to report outlier payments received for services rendered before October 1, 1997, and on or after October 1, 1997.

Line 4--Enter the result of dividing the sum of total patient days (Worksheet S-3, Part I, column 6, lines 12 and 28) by the number of days in the cost reporting period (365 or 366 in case of leap year). Do not include statistics associated with an excluded unit (subprovider).

NOTE: Reduce total patient days by nursery days (Worksheet S-3, Part I, column 6, line 11), and swing bed days (Worksheet S-3, Part I, column 6, lines 3 and 4).

Line 4.01--Enter the number of interns and residents from Worksheet S-3, Part I, column 9, line 12. For cost reporting periods beginning on or after October 1, 1997 obtain the intern and resident amount from Worksheet E, Part A, line 3.17. In addition, for cost reporting periods beginning on or after July 1, 2005, if the hospital received additional IME FTE resident cap slots under 42 CFR §413.79(c)(4) (Worksheet S-2, line 25.06, column 2, is "Y") add the amount reported on Worksheet E-3, Part VI, line 18). For cost reporting periods that overlap July 1, 2005, multiply the FTE count from Worksheet E-3, Part VI, line 18 by line 1 in order to prorate the number of days in the cost reporting period occurring after July 1, 2005.

Lines 4.02 through 4.03--IME Adjustment Factor Phase Out--In accordance 42 CFR 412.322(c) and (d), the IME adjustment factor is reduced by 50 percent for discharges occurring during the period 10/1/2008 through 9/30/2009; and is eliminated for discharges occurring on or after 10/1/2009. Consequently, for line 2, (above) and lines 4.02 through 4.03, column 1 must be subscripted to accommodate the corresponding portion of the provider's cost reporting period.

Line 4.02--Enter the result of the following calculation: $\{e^{.2822 \times \text{line 4.01}/\text{line 4}}\}-1$ where $e = 2.71828$. (See 42 CFR 412.322(a)(3) for limitation of the percentage of I&Rs to average daily census. Line 4.01 divided by line 4 can not exceed 1.5. *Reduce the IME adjustment factor for discharges occurring during the period 10/1/2008 through 9/30/2009 by 50 percent in accordance with the general instructions for lines 4.02 through 4.03, above. Enter -0- on this line for discharges occurring on or after 10/1/2009.*

Line 4.03--Multiply line 4.02 by the sum of lines 2 and 3. Do not include line 3.01.

Lines 5 - 5.04

NOTE: Enter the amount of the Federal rate portion of the additional capital payment amounts relating to the disproportionate share adjustment. Complete these lines if you answered yes to line 36.01 on 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 (*and subscripted columns*), 3, 3.01, 4.03 (*and subscripted columns*), 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, except for *new providers certified prior to October 1, 1999, that are paid in accordance with 42 CFR 412.324(b)(3)*. Formerly hold harmless providers (other than new providers) should consider themselves fully prospective *and complete* Part I of the Worksheet.

This part (Worksheet L, Part II) is no longer applicable for cost reporting periods beginning on or after October 1, 2008.

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.

Line 5--Enter the amount of payments that would have been made for inpatient program capital costs if the provider were paid at 100 percent of the Federal rate throughout the cost reporting period. This amount is provided by the fiscal intermediary. Compute this amount by grossing up the Federal payments made for new capital by multiplying each part of the capital Federal payment (capital DRG, capital outlier, capital DSH, and capital IME) by a ratio. The numerator of the ratio is 100 and the denominator is the new capital ratio used for interim payment during the period. When there has been any change to the new capital ratio during the period, make a separate computation for each period for which there was a separate new capital ratio. For example, if a 15 percent ratio was used for the first three months and a 20 percent ratio was used for the last nine months, divide the four components of the capital Federal rate data for the first three months by .15 and divide the four components of the capital Federal rate data for the last nine months by .20. Use the interim payment new capital ratio since grossed up payments made during the period were based on the interim ratio payment.

NOTE: If it is necessary to make a year end adjustment to the DSH or IME amounts on Worksheet E, Part A, lines 3 and 4, respectively, to reflect more current data than was used for payment purposes, then also make these adjustments to the data on this line.

Line 6--Hospitals that did not qualify as sole community providers during the cost reporting period enter a reduction factor of 85 percent. SCHs enter 100 percent. If you were an SCH during a portion of the cost reporting period, compute the hold harmless old capital cost reduction percentage by dividing the number of days in your cost reporting period for which you were not a sole community hospital (reduction factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 15 percent, and subtract the amount from 100. Enter the resulting hold harmless old capital cost reduction percentage as a percentage.

Line 7--Multiply line 2 by line 6.

Line 8--Multiply line 5 by line 4.

Line 9--Enter the sum of lines 7 and 8.

Line 10--Enter the greater of line 5 or line 9. If the provider has elected payment based on 100 percent of the Federal rate (see Worksheet S-2, line 37.01), enter the amount from line 5. For title XVIII, transfer this amount 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.

3660.3 Part III - Payment Under Reasonable Cost--This part computes capital settlement under reasonable cost principles subject to the reduction pursuant to 42 CFR 412.324(b). Use the reasonable cost method for capital settlement determinations for new providers *under 42 CFR 412.324(b) for the first two years* or for titles V or XIX determinations, if applicable. *This part may also be completed for cost reporting periods beginning on or after October 1, 2002, for the first two years* for new providers *under 42 CFR 412.304(c)(2)(i)* (response to Worksheet S-2, line 33, column 1 is "Y" and column 2 is "N").

Line Descriptions

Line 1--Enter the amount of program inpatient routine service capital costs. This amount is the sum of the program inpatient routine capital costs from the appropriate Worksheet D, Part I, sum of columns 10 and 12, sum of the amounts on lines 25 through 30 and 33 for the hospital (line 31 for the subprovider).

Line 2--Enter the amount of program inpatient ancillary capital costs. This amount is the sum of the amounts of program inpatient ancillary capital costs from the appropriate Worksheet D, Part II, columns 6 and 8, line 101.

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

Line 4--Enter a reduction factor of 85 percent.

Line 5--Multiply line 3 by line 4. For title XVIII, transfer the amount to Worksheet E, Part A, line 9. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, column 1, line 26.

3660.4 Part IV - Computation of Exception Payments--This part computes minimum payment levels by class of provider with an additional payment exception for extraordinary circumstances for hospitals paid under either the fully prospective method or the hold harmless method pursuant to 42 CFR 412.348. Complete this part only if the provider component completed Parts I or II of this worksheet. For cost reporting periods beginning on or after October 1, 2001, complete this part only if the provider qualifies for an additional payment for extraordinary circumstances pursuant to 42 CFR 412.348(e) (the facility indicates "Y" to question 52 on worksheet S-2) or the special exceptions payment pursuant to 42 CFR 412.348(g) (the facility indicates "Y" to question 52.01 on worksheet S-2).

Line 1--Enter the amount of program inpatient routine service and ancillary service capital costs. This amount is the sum of the program inpatient routine service capital costs from the appropriate Worksheet D, Part I, sum of columns 10 and 12, sum of lines 25 through 30 and 33 for the hospital, line 31 for the subprovider, and program inpatient ancillary service capital costs from Worksheet D, Part II, sum of columns 6 and 8, line 101.

Line 2--Enter program inpatient capital costs for extraordinary circumstances as provided by 42 CFR 412.348(e), if applicable, from Worksheet L-1, sum of Part II, column 7, sum of lines 25 through 30 and 33 for the hospital, line 31 for the subproviders, and Part III, column 5, line 101.

Line 3--Enter line 1 less line 2.

Line 4--Enter the appropriate minimum payment level percentage. The minimum payment levels for portions of cost reporting periods beginning on or after October 1, 2001 are:

- o SCHs (located in either an urban or a rural area) - 90 percent;
- o Urban hospitals with at least 100 beds and a disproportionate patient percentage of at least 20.2 percent - 80 percent; and
- o All other hospitals - 70 percent.

For providers that qualify for the special exceptions payment pursuant to 42 CFR 412.348(g) the appropriate minimum payment level is 70 percent.

The minimum payment levels in subsequent transition years will be revised, if necessary, to keep total payments under the exceptions process at no more than 10 percent of capital prospective payments.

If you were an SCH during a portion of the cost reporting period, compute the minimum payment level percentage by dividing the number of days in your cost reporting period for which you were not an SCH (70 percent factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 70 percent. Divide the number of days in your cost reporting period for which you were an SCH (90 percent factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 90 percent. Add the amounts from steps 1 and 2 to compute the capital cost minimum payment level percentage. Display exception percentage in decimal format, e.g., 70 percent is displayed as .70 or 0.70.

Line 5--Enter the product of line 3 multiplied by line 4.

Line 6--Hospitals that did not qualify as sole community providers during the cost reporting period enter a reduction factor of 85 percent. SCHs enter 100 percent. If you were a sole community hospital during a portion of the cost reporting period, compute the capital cost reduction percentage by dividing the number of days in your cost reporting period for which you were not a sole