Medicare

Provider Reimbursement Manual

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

Department of Health and Human Services (DHHS)

Centers for Medicare and Medicaid Services (CMS)

Transmittal 5 **Date: March 2014**

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NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Overlapping or Beginning on or After October 1, 2013.

This transmittal updates Chapter 40, Hospital and Hospital Health Care Complex Cost Report, (Form CMS-2552-10) to clarify and correct the existing instructions and incorporate statutory and regulatory changes. Effective dates will vary.

Revisions:

- Worksheet A: Corrected instructions for lines 71 and 72, medical supplies charged to patients and implantable devices charged to patients, respectively.
- Worksheet E, Part B: Added line 39.98 to reflect partial or full credits received from manufacturers for replaced devices.

- Modified or added instructions to implement section 3023 of the Affordable Care Act of 2010 as follows:
  - Worksheet E, Part A:
    - Added lines 1.03 and 2.02, and revised lines 22, 28, 34, 47, 62 and 63 for Model 4 bundled payments for care improvement (BPCI) initiative.
  - Worksheet L:
    - Added lines 1.01 and 2.01, and revised the instructions for lines 6, 11 and 12 for Model 4 BPCI initiative.
- Modified or added instructions to implement the provisions of the FFY 2014 IPPS IFC, FR 192, Vol. 78, dated October 3, 2013 as follows:
  - Worksheet S-2, Part I:
    - Added line 22.01 to identify uncompensated care payments.
  - Worksheet E, Part A:
    - Revised the instructions for line 1 and added lines 1.01 and 1.02 for the operating federal specific payment amount (DRG payment).
    - Added lines 35, 35.01, 35.02, 35.03 and 36 to calculate uncompensated care payments.
- Modified or added instructions in accordance with the federal fiscal year (FFY) 2014 IPPS final rule, FR 160, Vol. 78, dated August 19, 2013 as follows:
  - Worksheet S-3, Part I:
    - Opened column 6, line 32 to include Medicare labor and delivery days.
  - Worksheet E-4:
    - Revised instructions for lines 26 and 27 for the Medicare patient load ratio.
- Modified or added instructions to implement select provisions of the FFY 2014 IRF final rule, FR 151, Vol. 78, dated August 6, 2013, page 47869 as follows:
  - Worksheet E-3, Part III:
    - Revised the instructions for lines 1 and 3 for the inpatient rehabilitation facility low income patient adjustment factor and lines 11 through 13 for the teaching adjustment factor.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods overlapping or beginning on or after October 1, 2013.

- The entire electronic reporting specifications have been revised to reflect the appropriate format and pagination in compliance with section 508 of the Rehabilitation Act of 1973. Actual revisions and corrections in this transmittal are identified in red italicized text.

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

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

Section

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CHAPTER 40

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Section

4000. GENERAL

The Paperwork Reduction Act of 1995 requires that you be informed why information is collected and what the information is used for by the government. Section 1886(f)(1) of the Social Security Act (the Act) requires the Secretary to maintain a system of cost reporting for Prospective Payment System (PPS) hospitals, which includes a standardized electronic format. In accordance with §§1815(a), 1833(e), and 1861(v)(1)(A) of the Act, providers of service participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.20(b) requires cost reports on an annual basis. In accordance with these provisions, all hospital and health care complexes to determine program payment must complete Form-CMS-2552-10 with a valid Office of Management and Budget (OMB) control number. In addition to determining program payment, the data submitted on the cost report support management of the federal programs, e.g., data extraction in developing cost limits, data extraction in developing and updating various prospective payment systems. The information reported on Form CMS-2552-10 must conform to the requirements and principles set forth in 42 CFR, Part 412, 42 CFR, Part 413, and in the Provider Reimbursement Manual, Part 1 (CMS Pub. 15-1). The filing of the cost report is mandatory, and failure to do so results in all payments to be deemed overpayment and a withhold up to 100 percent until the cost report is received. (See Provider Reimbursement Manual, Part 2 (CMS Pub. 15-2), chapter 1, §100.) Except for the compensation information, the cost report information is considered public record under the freedom of information act 45 CFR Part 5. The instructions contained in this chapter are effective for hospitals and hospital health care complexes with cost reporting periods beginning on or after May 1, 2010.

NOTE: This form is not used by freestanding skilled nursing facilities.

Worksheets are provided on an as needed basis dependent on the needs of the hospital. Not all worksheets are needed by all hospitals. The following are a few examples of conditions for which worksheets are needed:

- Reimbursement is claimed for hospital swing beds;
- Reimbursement is claimed for a hospital-based inpatient rehabilitation facility (IRF) or inpatient psychiatric facility (IPF);
- Reimbursement is claimed for a hospital-based community mental health center (CMHC);
- The hospital has physical therapy services furnished by outside suppliers (applicable for cost reimbursement and Tax Equity and Fiscal responsibility Act of 1982 (PL97248) (TEFRA providers, not PPS); or
- The hospital is a certified transplant center (CTC).

NOTE: Public reporting burden for this collection of information is estimated to average 108 hours per response, and record keeping burden is estimated to average 565 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to:

- Center for Medicare and Medicaid Services
  7500 Security Boulevard
  Mail Stop C5-03-03
  Baltimore, MD 21244-1855
- The Office of Information and Regulatory Affairs
  Office of Management and Budget
  Washington, DC 20503

Section 4007(b) of the omnibus reconciliation Act (OBRA 1987) states that effective with cost reporting periods beginning on or after October 1, 1989, you are required to submit your cost report electronically unless you receive an exemption from CMS. The legislation allows CMS to delay or waiver implementation if the electronic submission results in financial hardship (in particular for providers with only a small percentage of Medicare volume). Exemptions are granted on a case-by-case basis. (See CMS Pub. 15-2, chapter 1, §130.3 for electronically prepared cost reports and requirements.)

In addition to Medicare reimbursement, these forms also provide for the computation of reimbursement applicable to titles V and XIX to the extent required by individual State programs. Generally, the worksheets and portions of worksheets applicable to titles V and XIX are completed only to the extent these forms are required by the State program. However, Worksheets S-3 and D-1 must always be completed with title XIX data.

Each electronic system provides for the step down method of cost finding. This method provides for allocating the cost of services rendered by each general service cost center to other cost centers, which utilize the services. Once the costs of a general service cost center have been allocated, that cost center is considered closed. Once closed, it does not receive any of the costs subsequently allocated from the remaining general service cost centers. After all costs of the general service cost centers have been allocated to the remaining cost centers, the total costs of these remaining cost centers are further distributed to the departmental classification to which they pertain, e.g., hospital general inpatient routine, subprovider.

The cost report is designed to accommodate a health care complex with multiple entities. If a health care complex has more than one entity reporting (except skilled nursing facilities and nursing facilities which cannot exceed more than one hospital-based facility), add additional lines for each entity by subscripting the line designation. For example, subprovider, line 4, Worksheet S, Part III is subscripted 4.00 for subprovider I and 4.01 for subprovider II.

NOTE: Follow this sequence of numbering for subscripting lines throughout the cost report.

Similarly, add lines 42.00 and 42.01 to Worksheets A; B, Parts I and II; B-1; C; D, Parts I and III; and Worksheet L-1, Parts I and II. For multiple use worksheets such as Worksheet D-1, add subprovider II to the existing designations in the headings and the corresponding component number.

In completing the worksheets, show reductions in expenses in parentheses ( ) unless otherwise indicated.

4000.1 Rounding Standards for Fractional Computations.--Throughout the Medicare cost report, required computations result in fractions. The following rounding standards must be employed for such computations. When performing multiple calculations, round after each calculation. However,

1. Round to 2 decimal places:
   a. Percentages
   b. Averages, standard work week, payment rates, and cost limits
   c. Full time equivalent employees
   d. Per diems, hourly rates

2. Round to 3 decimal places:
   a. Payment to cost ratio

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

4. Round to 5 decimal places:
   a. Payment reduction (e.g., capital reduction, outpatient cost reduction)

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

6. Round to 9 decimal places:
   a. Uncompensated care factor 3

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

4000.2 Acronyms and Abbreviations.--Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

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

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

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

This worksheet consists of two parts:

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

4004.1 Part I - Hospital and Hospital Health Care Complex Identification Data.--The information required on this worksheet is needed to properly identify the provider. The responses to all lines are Yes or No unless otherwise indicated by the type of question.

Line Descriptions

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

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

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

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

If your hospital services various types of patients, indicate "General - Short Term" or "General - Long Term," as appropriate.

NOTE: Long term care hospitals are hospitals organized to provide long term treatment programs with average lengths of stay greater than 25 days. Some hospitals may be certified as other than long term care hospitals, but also have average lengths of stay greater than 25 days.

If your hospital cares for only a special type of patient (such as cancer patients), indicate the special group served. If you are not one of the hospital types described in items 1 through 8 above, indicate 9 for "Other".

Line 3--This is an institution which meets the requirements of §1861(e) or §1861(mm)(1) of the Act and participates in the Medicare program or is a federally controlled institution approved by CMS.

Line 4--The distinct part inpatient psychiatric facility (IPF) is a portion of a general hospital which has been issued a subprovider CCN because it offers a clearly different type of service from the remainder of the hospital with such services reimbursed under inpatient psychiatric PPS. (See 42 CFR 412.25) While an excluded unit (excluded from IPPS) in a hospital subject to IPPS may not meet the definition of a subprovider, treat it as a subprovider for cost reporting purposes.

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

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

Line 7--Medicare swing-bed services are paid under the SNF PPS system (indicate payment system as "P"). CAHs are reimbursed on a cost basis for swing-bed services and should indicate "O" as the payment system. Rural hospitals with fewer than 100 beds may be approved by CMS to use these beds interchangeably as hospital and skilled nursing facility beds with payment based on the specific care provided. This is authorized by §1883 of the Act. (See CMS Pub. 15-1, §§2230-2230.6.)

Line 8--Swing bed-NF services are not payable under the Medicare program but are payable under State Medicaid programs if included in the Medicaid State plan. This is a rural hospital with fewer than 100 beds that has a Medicare swing bed agreement approved by CMS and that is approved by the State Medicaid agency to use these beds interchangeably as hospital and other nursing facility beds, with payment based on the specific level of care provided. This is authorized by §1913 of the Act.

Line 9--This is a distinct part skilled nursing facility that has been issued an SNF identification number and which meets the requirements of §1819 of the Act. For cost reporting periods beginning on or after October 1, 1996, a complex cannot contain more than one hospital-based SNF or hospital-based NF.

Line 10--This is a distinct part nursing facility which has been issued a separate identification number and which meets the requirements of §1905 of the Act. (See 42 CFR 442.300 and 42 CFR 442.400 for standards for other nursing facilities, for other than facilities for the mentally retarded, and for facilities for the mentally retarded.) If your State recognizes only one level of care, i.e., skilled, do not complete any lines designated as NF and report all activity on the SNF line for all programs. The NF line is used by facilities having two levels of care, i.e., either 100 bed facility all certified for NF and partially certified for SNF or 50 beds certified for SNF only and 50 beds certified for NF only. The contractor will reject a cost report attempting to report more than one nursing facility.

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

Line 11--This is any other hospital-based facility not listed above. The beds in this unit are not certified for titles V, XVIII, or XIX.

Line 12--This is a distinct part HHA that has been issued an HHA identification number and which meets the requirements of §§1861(o) and 1891 of the Act. If you have more than one hospital-based HHA, subscript this line, and report the required information for each HHA.

Line 13--This is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and which meets the conditions for coverage in 42 CFR 416, Subpart B. The ASC operated by a hospital must be a separately identifiable entity which is physically, administratively, and financially independent and distinct from other operations of the hospital. (See 42 CFR 416.30(f).) Under this restriction, hospital outpatient

departments providing ambulatory surgery (among other services) are not eligible. (See 42 CFR 416.120(a).)

Line 14--This is a distinct part hospice and separately certified component of a hospital which meets the requirements of §1861(dd) of the Act. No payment designation is required in columns 6, 7, and 8.

Lines 15 and 16--Enter the applicable information for rural health clinics (RHCs) on line 15 and for federally qualified health centers (FQHCs) on line 16. These lines are used by RHCs and/or FQHCs which have been issued a provider number and meet the requirements of §1861(aa) of the Act. If you have more than one RHC, report them on subscripts of line 15. If you have more than one FQHC, report them on subscripts of line 16. Report the required information in the appropriate column for each. RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-04 (Medicare Claims Processing Manual), chapter 9, §30.8. Do not subscript this line if you elect to file under the consolidated cost reporting method. See section 4010 for further instructions.

Line 17--This line is used by hospital-based community mental health centers (CMHCs). Subscript this line as necessary to accommodate multiple CMHCs (lines 17.00-17.09). Also subscript this line to accommodate CORFs (lines 17.10-17.19), OPTs (lines 17.20-17.29), OOTs (lines 17.30-17.39) and OSPs (lines 17.40-17.49). (See §4095 Exhibit 2, Table 4, Part III.)

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

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

Line 20--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR §413.24(f), you are required to submit periodic reports of your operations which generally cover a consecutive 12 month period of your operations. (See CMS Pub. 15-2, chapter 1, §§102.1-102.3 for situations where you may file a short period cost report.)

Line 21--Indicate the type of control under which the hospital operates:

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

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

Line 22.01--For cost reporting periods that overlap or begin on or after October 1, 2013, did this hospital receive interim uncompensated care payments? Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period beginning on or after October 1.

Line 23--Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.

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

Line 24--If line 23 is "3" and this is an IPPS provider, enter the in-state Medicaid paid days in column 1 (report on S-3, Part I, lines 1, *and* 8 through *13, as applicable*, column 7), the in-state Medicaid eligible but unpaid days in column 2 (report on S-3, Part I, line*s* 2 *and 13, as applicable*, column 7), the out-of-state Medicaid paid days in column 3 (report on S-3, Part I, line*s* 2 *and 13, as applicable*, column 7), the out-of-state Medicaid eligible but unpaid days in column 4 (report on S-3, Part I, line*s* 2 *and 13, as applicable*, column 7), Medicaid HMO paid and eligible but unpaid days in column 5 (report on S-3, Part I, line*s* 2 *and 13, as applicable*, column 7). Enter only labor and delivery days (reported on S-3, Part 1, line 32, column 7) as "Other Medicaid days" in column 6. If line 23 is "1" or "2", enter the Medicaid days based on each column description; however, these days may not equal the Medicaid days reported by discharge on Worksheet S-3, Part I. Do not include swing-bed, observation or hospice days in any columns on this line. See 42 CFR 412.106(a)(1)(ii) and 412.106(b)(4).

Line 25--If line 23 is "3" and this provider is an IRF or contains an IRF unit, enter the in-state Medicaid paid days in column 1, (report on S-3, Part I, line 1, column 7 or line 17 for an IRF unit), the in-state Medicaid eligible but unpaid days in column 2 (report on S-3, Part I, line 2, column 7 or line 4 for an IRF unit), the out-of-state Medicaid paid days in column 3 (report on S-3, Part I, line 2, column 7 or line 4 for an IRF unit), the out-of-state Medicaid eligible but unpaid days in column 4 (report on S-3, Part I, line 2, column 7 or line 4 for an IRF unit), Medicaid HMO paid and eligible but unpaid days in column 5 (report on S-3, Part I, line 2, column 7 or line 4 for an IRF unit). Do not enter any days in column 6 *for cost reporting periods beginning on or after October 1, 2012.* If line 23 is "1" or "2", enter the Medicaid days based on each column description; however, these days may not equal the Medicaid days reported by discharge on Worksheet S-3, Part I. Do not include swing-bed, observation or hospice days in any columns on this line.

Line 26--For the Standard geographic classification (not wage), what is your status at the **beginning** of the cost reporting period. Enter "1" for urban or "2" for rural.

Line 27--For the Standard geographic classification (not wage), what is your status at the **end** of the cost reporting period. Enter "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.

Lines 28 - 34--Reserved for future use.

Line 35--If this is a sole community hospital (SCH), enter the number of periods (0, 1 or 2) within this cost reporting period that SCH status was in effect.

Line 36--Enter the beginning and ending dates of SCH status during this cost reporting period. Subscript line 36 if more than 1 period is identified for this cost reporting period and enter multiple dates. Multiple dates are created where there is a break in the date between SCH status, i.e., for calendar year provider SCH status dates are 1/1/2010-6/30/2010 and 9/1/2010-12/31/2010.

Line 37--If this is a Medicare dependent hospital (MDH), enter the number of periods within this cost reporting period that MDH status was in effect.

Line 38--Enter the beginning and ending dates of MDH status during this cost reporting period. Subscript line 38 if more than 1 period is identified for this cost reporting period and enter multiple dates.

Line 39--For cost reporting periods that overlap or begin on or after October 1, 2010, does the hospital qualify for the inpatient hospital adjustment for low volume hospitals for a portion of the cost reporting period? Enter in column 1 "Y" for yes or "N" for no. If column 1 is "Y", does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2, "Y" for yes or "N" for no. Hospitals are required to request low-volume status in writing to their contractor and provide documentation that they meet the mileage criteria.

The response to these questions determines the completion of the low-volume calculation adjustment.

NOTE: 42 CFR §412.101(c)(2) provides for a temporary change in the low-volume adjustment for qualifying hospitals for *federal fiscal year (*FFYs*)* 2011 through 2013 as follows:

•Those hospitals with 200 or fewer Medicare discharges will receive an adjustment of an additional 25 percent for each Medicare discharge; and
•Those with more than 200 and fewer than 1,600 Medicare discharges will receive an adjustment of an additional percentage for each Medicare discharge. This adjustment is calculated using the formula [(4/14) - (Medicare discharges/5600)].

To qualify as a low-volume hospital, the hospital must meet both of the following criteria:

•Be more than 15 road miles from the nearest subsection (d) hospital; and
•Have fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data as determined by CMS.

Lines 40 - 44--Reserved for future use.

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

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

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

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

Lines 49 - 55--Reserved for future use.

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

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

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

Line 58--As a teaching hospital, did you elect cost reimbursement for teaching physicians as defined in CMS Pub. 15-1, chapter 21, §2148? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-5.

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

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

Requirements During Five Year Period Following Implementation of Increases to Hospitals' FTE Resident Caps Under Section 5503 of the ACA, Lines 61 and Subscripts--Section 5503 of the ACA states that a hospital that receives an increase to its FTE resident cap under section 5503 shall ensure, during the 5-year period beginning on July 1, 2011, that:

> (I) The number of FTE primary care residents is not less than the average number of FTE primary care residents during the three most recent cost reporting periods ending prior to the date of enactment of section 5503; and
>
> (II) Not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency.

Failure to comply with either of these two requirements, known as the 3-year primary care average requirement (I) and the 75 percent test (II) means permanent removal of all section 5503 slots from the earliest applicable cost reporting period under the regulations at 42 CFR 413.79(n)(2).

Line 61--Did your hospital receive FTE slots under section 5503 of the ACA? Enter "Y" for yes or "N" for no in column 1. If "Y", enter the number of IME section 5503 slots awarded in column 4 and direct GME section 5503 slots awarded in column 5. The number of IME and/or direct GME slots entered here should be the amounts on the award letter from CMS. Complete the subscripts of line 61. If "N" for no, do not complete columns 4 or 5 and subscripts of line 61.

NOTE: Effective for portions of cost reporting periods occurring on or after July 1, 2011, do not complete line 61, columns 2 and 3. This information is now reported on line 61.01, columns 2 and 3.

Line 61.01--Effective for portions of cost reporting periods occurring on or after July 1, 2011, enter the average unweighted number of primary care FTE residents from the hospital's three most recent cost reports ending and submitted to the contractor before March 23, 2010. See 42 CFR 413.75(b) for the definition of "primary care resident". Enter the 3-year primary care average for IME in column 2. The source of the primary care IME FTE residents is the rotation schedules submitted by the provider to support its cost reports for the three most recent cost reports ending and submitted to the contractors prior to March 23, 2010. Any audit adjustments to these IME primary care FTE residents must be taken into account in computing the three year average. Exclude OB/GYN and general surgery FTE residents. This primary care average is based on the hospital's total primary care FTE count that would otherwise be allowable if not for the FTE resident cap for each year in the 3-year period. If any of the three cost reports is not a 12-month cost report, enter the 12-month equivalent FTE count.

Enter the average unweighted number of primary care FTE residents for direct GME in column 3. This primary care average is based on the hospital's total unweighted primary care FTE count that would otherwise be allowable if not for the FTE resident cap for each year in the 3-year period. If

the hospital did not train any OB/GYN residents in its three most recent cost reports ending and submitted prior to March 23, 2010, convert the weighted primary care FTE counts from line 3.19 of Worksheet E-3, Part IV of Form CMS-2552-96, to unweighted FTE counts, compute a 3-year average, and report the average in column 3. If the hospital did train OB/GYN FTE residents in its three most recent cost reports ending and submitted prior to March 23, 2010, subtract the OB/GYN FTE counts from line 3.19 of Worksheet E-3, Part IV of Form CMS-2552-96, convert the remaining primary care FTE counts to unweighted FTE counts, compute a three year average, and report the average in column 3. Exclude general surgery FTE residents. If any of the three cost reports is not a 12-month cost report, enter the 12-month equivalent FTE count.

Line 61.02--Enter the current cost reporting period total unweighted primary care FTE count (excluding obstetrics and gynecology and general surgery), which is used to determine compliance with the 3-year primary care average requirement. In accordance with section 5503 of the ACA, which states that the 3-year primary care average requirement must be met by "excluding any additional positions" added as a result of the section 5503 FTE cap increase, also exclude from this unweighted primary care FTE count any primary care FTEs added in the current cost reporting period specific to new or expanded programs under section 5503 (see 75 FR 72198-9 dated November 24, 2010). Enter the unweighted IME FTE count in column 2 and the direct GME FTE count in column 3. If the current cost report is not a 12-month cost report, enter the 12-month equivalent FTE count. These current cost reporting period unweighted primary care FTE counts are compared to the 3-year primary care average amounts in line 61.01.

Line 61.03--Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75 percent requirement. These primary care and/or general surgery FTEs would be a part of the unweighted allopathic and osteopathic FTE count from the hospital's 12-month (or prorated equivalent) cost report that immediately precedes the cost report that includes July 1, 2011. Report the IME primary care and/or general surgery baseline FTE count in column 2 and the direct GME baseline primary care and/or general surgery FTE count in column 3. (For example, the baseline cost report for June 30 providers would be July 1, 2010 through June 30, 2011; for December 31 providers, this would be January 1, 2010 through December 31, 2010; for September 30 providers, this would be October 1, 2009 through September 30, 2010). (On the Form CMS-2552-96, the baseline FTE primary care and/or general surgery count is included and commingled in the allopathic and osteopathic FTEs reported on line 3.08 of Worksheet E, Part A, and on line 3.05 of Worksheet E-3, Part IV. On the Form CMS-2552-10, the baseline primary care and/or general surgery FTE count is included and commingled in the allopathic and osteopathic FTEs reported on line 10 of Worksheet E, Part A, and on line 6 of Worksheet E-4). Use the rotation schedules from the hospital's 12-month (or prorated equivalent) cost report that immediately precedes the cost report that includes July 1, 2011, as the source for the primary care and/or general surgery FTEs.

Line 61.04--Enter the total number of unweighted primary care and/or general surgery allopathic and/or osteopathic FTEs in the current cost reporting period. If the cost report is not a 12-month cost report, enter the 12-month equivalent FTE count. Exclude OB/GYN FTEs. (These FTEs are part of the current year FTE count, and are included on Form CMS-2552-10, line 10 of Worksheet E, Part A, and line 6 of Worksheet E-4). Report the unweighted IME FTE count in column 2 and the direct GME FTE count in column 3.

Line 61.05--Determination of Compliance with 75 Percent Requirement--Enter the difference between the baseline primary care and/or general surgery FTE counts and the current year primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). Report the IME FTE count difference in column 2 and the direct GME FTE count difference in column 3. (If the difference is less than or equal to zero, enter a zero).

The section 5503 FTE cap slots reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (direct GME) are dependent upon this difference on line 61.05, because of the requirement that 75 percent of the section 5503 FTE cap award be **used** for primary care and/or general surgery FTEs in new or expanded programs. If the difference on line 61.05 is

greater than zero, then it must be at least 75 percent of the section 5503 FTE cap award to be reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME). For example, if a hospital was awarded a total of 10 slots, but the difference reported on line 61.05 is 5, then the section 5503 FTE slots reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME) **cannot be more than** 6.67 (that is, 5 divided by 75 percent). Therefore, determine that the difference on line 61.05 is at least 75 percent of the section 5503 award amount that is reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME).

Line 61.06--Enter the amount of the ACA section 5503 award FTEs that are being used for cap relief, if any, and/or that are nonprimary care or non-general surgery FTEs. Report the IME amount in column 2 and the direct GME amount in column 3. The amount reported on this line can be no more than 25 percent of the section 5503 FTE cap slots reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME). If the amount on line 61.05, column 2 and 3 is greater than or equal to the section 5503 cap award reported on line 61, columns 4 and 5, respectively, report zero on this line.

If the amount on line 61.05 is less than the section 5503 cap award, and the hospital either is training FTE residents over its existing FTE cap or has added nonprimary care and non-general surgery FTEs in the current cost reporting period, report on this line the difference of the section 5503 cap slots on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME) and the amount reported on line 61.05. For example, if a hospital was awarded a total of 10 slots, and 5 is reported on line 61.05, and the section 5503 FTE slots reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME) is 6.67 FTEs, then the amount reported on line 61.06 cannot exceed 1.67 FTEs which is the difference between the amount on line 61.05 and the amount reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME). If 10 is reported on line 61.05, then report 0 (zero) on line 61.06. If 8 is reported on line 61.05 and the hospital added 2 or more nonprimary care FTEs in the current cost reporting period, then report 2 on this line.

Lines 61.07 - 61.09--Reserved for future use.

Line 61.10--Of the FTEs in line 61.05, specify each new primary care or general surgery program specialty, if any, and the number of FTE residents for each new program. Use subscripted lines 61.11 through 61.19 for each additional new program. Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 the direct GME FTE unweighted count.

Line 61.20--Of the additional FTEs in line 61.05, specify each expanded primary care or general surgery program specialty, if any, and the number of FTE residents for each program expansion. Use subscripted lines 61.21 through 61.29 for each additional program expansion. Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 the direct GME FTE unweighted count.

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

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

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

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

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

Line 64--If line 63 is yes or your facility trained residents in the base year period, enter in column 1, for cost reporting periods that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that

occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimarycare FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.

Line 65--If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. (See 42 CFR 413.75(b) for the definition of "primary care resident.") Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.

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

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

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

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

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

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

Lines 68 - 69--Reserved for future use.

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

Line 71--If this facility is an IPF or contains an IPF subprovider (response to line 70, column 1 is "Y" for yes), were residents training in this facility **in the most recent cost report filed on or before November 15, 2004?** Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in new teaching programs in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter in column 2 "Y" for yes or "N" for no. (Note: questions 1 and 2 must have opposite answers, i.e., if column 1 is "Y", then column 2 must be "N" and vice versa; columns 1 and 2 cannot be "Y" simultaneously, columns 1 and 2 can be "N" simultaneously.) If yes, enter a "1", "2", or "3", respectively, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that begins during the current cost reporting period. If the current cost reporting period covers the beginning of the fourth academic year of the first new teaching program's existence, enter the number "4" in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program's existence, enter the number "5" in column 3.

Lines 72 - 74--Reserved for future use.

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

Line 76--If this facility is an IRF or contains an IRF subprovider (response to line 75, column 1 is "Y" for yes), did the facility train residents in teaching programs **in the most recent cost reporting period ending on or before November 15, 2004?** Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in new teaching programs in accordance with FR, Vol. 70, No. 156, page 47929 dated August 15, 2005? Enter in column 2 "Y" for yes or "N" for no. (Note: questions 1 and 2 must have opposite answers, i.e., if column 1 is "Y", then column 2 must be "N" and vice versa; columns 1 and 2 cannot be "Y" simultaneously, columns 1 and 2 can be "N" simultaneously.) If yes, enter a "1", "2", or "3", respectively, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that begins during the current cost reporting period. If the current cost reporting period covers the beginning of the fourth academic year of the first new teaching program's existence, enter the number "4" in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program's existence, enter the number "5" in column 3.

Lines 77 - 79--Reserved for future use.

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

Lines 81 - 84--Reserved for future use.

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

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

Line 121--Did this facility incur and report costs *(direct or indirect)* in the "Implantable Devices Charged to Patients" (line 72) cost center as indicated in the Federal Register, Vol. 73, number 161, dated August 19, 2008, page 48462 *bearing* the revenue codes *established by the National Uniform Billing Committee (NUBC) for high cost implantable devices.* Enter "Y" for yes or "N" for no in column 1.

Lines 122 - 124--Reserved for future use.

Line 125--Does your facility operate a transplant center(s)? Enter "Y" for yes or "N" for no in column 1. If yes, enter the applicable certification dates and termination dates on lines 126 through 133.

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

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

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

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

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

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

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

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

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

Lines 135 - 139--Reserved for future use.

Line 140--Are there any related organization or home office costs claimed as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, complete Worksheet

A-8-1. If this facility is part of a chain and you are claiming home office costs, enter in column 2 the home office chain number and complete lines 141 through 143. See CMS Pub. 15-1, chapter 21, §2150 for a definition of a chain organization.

Line 141--Enter the name of the chain home office in column 1, the home office contractor name in column 2, and the home office contractor number in column 3.

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

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

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

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

Line 146--Have you changed your cost allocation methodology from the previously filed cost report? Enter "Y" for yes or "N" for no. If yes, enter the approval date in column 2.

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

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

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

Lines 150 - 154--Reserved for future use.

Lines 155 - 161--If you are a hospital (public or non public) that qualifies for an exemption from the application of the lower of cost or charges as provided in 42 CFR 413.13, indicate the component and/or services for titles V, XVIII and XIX that qualify for the exemption by entering in the corresponding box a "Y" for yes, if you qualify for the exemption or an "N" for no if you do not qualify for the exemption. Subscript as needed for additional components. For title XVIII providers, a response of "Y" does not subject the provider to LCC.

Lines 162 - 164--Reserved for future use.

Line 165--Is the hospital part of a multi-campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. (For purposes of this question, only answer yes if the main campus and the off-site campus(es) are classified as section 1886(d) hospitals, or they are located in Puerto Rico).

Line 166--If you responded "Y" for yes to question 165, enter information for each campus (including the main campus) as follows: name in column 0, county in column 1, State in column 2, ZIP code in column 3, geographic CBSA in column 4, and the FTE count for this campus in column 5. If additional campuses exist, subscript this line as necessary. Enter the information in columns 0 through 5 for the main campus first, and then enter the information in each column for the subordinate campuses, in any order. For example, for the main campus, enter on line 166 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus. For the first subordinate campus, enter on line 166.01 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus.

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

Line 32--Effective for cost reporting periods beginning on or after October 1, 2012, enter in column 2, the total number of available beds located in the distinct ancillary labor and delivery rooms. In accordance with 42 CFR 412.105(b) and Vol. 77, No. 170 of the FR dated August 31, 2012, pages 53411 through 53413, distinct ancillary labor and delivery room beds, when occupied by an inpatient receiving IPPS-level acute care hospital services or when unoccupied, are considered to be part of a hospital's inpatient available bed count. These beds are not included in the inpatient routine beds reported on line 1. Note that the available bed days reported in column 3 are reduced on Worksheet E, Part A by the equivalent of outpatient labor and delivery days from line 32.01.

Effective for cost reporting periods beginning on or after October 1, 2013, enter in column 6 the number of labor/delivery inpatient days for title XVIII. (See Vol. 78, No. 160 of the FR dated August 19, 2013, pages 50730 through 50733.)

Effective for cost reporting periods beginning on or after October 1, 2009, enter in column 7 the number of labor/delivery inpatient days for title XIX and in column 8 the total number of labor/delivery inpatient days for the entire hospital. (See Vol. 74, No. 165 of the FR dated August 27, 2009, pages 43899 through 43901.)

For the purposes of reporting on this line, labor and delivery days are defined as days during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking, and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission (see CMS Pub. 15-1, chapter 22, §2205.2). Maternity patients must be admitted to the hospital as an inpatient for their labor and delivery days to be included on line 32. These days must not be reported on Worksheet S-3, Part I, line 1 or line 14.In the case where the maternity patient is in a single multipurpose labor/delivery/postpartum (LDP) room (also referred to as a birthing room), hospitals must determine the proportion of each inpatient stay that is associated with ancillary services (labor and delivery) versus routine adult and pediatric services (post partum) and report the days associated with the labor and delivery portion of the stay on this line. An example of this would be for a hospital to determine the percentage of each stay associated with labor/delivery services and apply that percentage to the stay to determine the number of labor and delivery days of the stay. Alternatively, a hospital could calculate an average percentage of time maternity patients receive ancillary services in an LDP room during a typical month, and apply that percentage through the rest of the year to determine the number of labor and delivery days to report on line 32.

Line 32.01--Effective for cost reporting periods beginning on or after October 1, 2012, enter in column 8 the equivalent days for the entire hospital that are attributable to outpatient services provided in the distinct ancillary labor and delivery room. Calculate the number of days by dividing the total number of hours attributable to the outpatient services by 24, and round to the nearest whole day. These total outpatient hours include the hours for outpatients occupying the distinct ancillary labor and delivery room until they are admitted as inpatients or are discharged from the hospital. For example, one patient is admitted as an inpatient after first occupying the distinct ancillary labor and delivery room bed for 8 hours. Therefore, for this patient, 8 hours would be included in the sum of the total hours used to compute equivalent days to be entered on line 32.01. Another patient is admitted to the distinct ancillary labor and delivery room for monitoring of possible labor or for a sonogram, etc. After spending 6 hours in this department (room), this patient is discharged from the hospital without being admitted as an inpatient. Therefore, for this patient, 6 hours would be included in the sum of the total hours used to compute the equivalent days to be entered on line 32.01. These outpatient labor and delivery days are used on Worksheet E, Part A to reduce the available bed days reported on line 32 so that only those distinct ancillary labor and delivery room beds which are occupied by inpatients or are unoccupied are ultimately counted as "beds."

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

4005.2 Part II - Hospital Wage Index Information.--This worksheet provides for the collection of hospital wage data which is needed to update the hospital wage index applied to the labor-related portion of the national average standardized amounts of the prospective payment system. It is important for hospitals to ensure that the data reported on Worksheet S-3, Parts II, III and IV are accurate. Beginning October 1, 1993, the wage index must be updated annually. (See §1886(d)(3)(E) of the Act.) Congress also indicated that any revised wage index must exclude data for wages incurred in furnishing SNF services. Complete Worksheet S-3, Parts II, III and IV for IPPS hospitals (see §1886(d)), any hospital with an IPPS subprovider, or any hospital that would be subject to IPPS if not granted a waiver.

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

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

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

Column 2

General instructions for completing column 2:

1. For each line item (except for wage-related costs on lines 17 through 25 or as otherwise indicated), report in column 2 the direct salaries and wages, including amounts for related paid vacation, holiday, sick leave, other paid-time-off (PTO), severance pay, and bonus pay for personnel associated with the line item.
2. Paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay must be reported in column 2 with related direct salaries and wages to be considered an allowable cost for the wage index.
3. Paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay must be reported in the same cost center as the related direct salaries and wages. For example, do NOT report the direct salaries and wages of an employee in one cost center and report the employee's paid vacation in a different cost center.
4. To be considered an allowable salary cost (i.e., direct salaries and wages plus paid vacation, holiday, sick leave, other PTO, and severance pay), the associated hours must also be reported in column 5. (See exceptions in column 5 instructions for bonus pay and overtime pay. Also, for wage-related costs, there are no associated hours.)
5. Bonus pay includes award pay and vacation, holiday, and sick pay conversion (pay in lieu of time off).

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

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

NOTE: Hospitals and contractors are not required to remove from domestic claims costs the personnel costs that are associated with hospital staff who deliver the services to employees.

Health-Related Services: inpatient and outpatient health services that are not covered under the hospital's health insurance plan, but are provided to employees at no cost or at a discount; for example, employee physicals and flu shots. Health-related services are to be included on Worksheet S-3, Parts II and IV as Core Wage-Related costs:

- Costs the hospital incurs in providing services to its employees. (Domestic claim charges must be reduced to cost. Costs must also exclude any copayments and deductibles paid by employees.)

NOTE: Hospitals and contractors are not required to remove from domestic claims costs the personnel costs that are associated with hospital staff who deliver the services to employees.

Line 18--Enter the wage-related costs that are considered an exception to the core list. (See note below for costs that are not to be included on line 18.) In order for a wage-related cost to be considered an exception, it must meet all of the following tests:

a. The cost is not listed on Worksheet S-3, Part IV,

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

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

d. The total cost of the particular wage-related cost for employees whose services are paid under IPPS exceeds 1 percent of total salaries after the direct excluded salaries are removed (Worksheet S-3, Part III, column 4, line 3). Wage-related cost exceptions to the core list are not to include those wage-related costs that are required to be reported to the Internal Revenue Service as salary or wages (i.e., loan forgiveness, sick pay accruals). Include these costs in total salaries reported on line 1 of this worksheet.

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 9 and 10. Instead, these costs are reported on line 19. Also, do not include the wage-related costs for physician Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel.

Line 19--Enter the total (core and other) wage-related costs applicable to the excluded areas reported on lines 9 and 10.

Lines 20 - 25--Enter from your records the wage-related costs for each category of employee listed. The costs are the core wage related costs plus the other wage-related costs. Do not include wage-related costs for excluded areas reported on line 19. Subscript line 22 and report the wage related costs for Part A teaching physicians reported on line 4.01, on line 22.01. On line 23, do not include wage-related costs related to non-physician salaries reported for Hospital-based RHCs and FQHCs services included on Worksheet A, column 1, lines 88 and/or 89, as applicable. These wage-related costs are reported separately on line 24.

Lines 26 - 43--Enter the direct salary and wages with related salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay from Worksheet A column 1 for the appropriate cost center identified on lines 26 through 43, column 2.

These lines provide for the collection of hospital wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded

units. These lines are completed by all hospitals if the ratio of Part II, column 5, sum of lines 9 and 10 divided by the result of column 5, line 1 minus the sum of lines 2, 3, 4.01, 5, 6, 7, 7.01 and 8 equals or exceeds a threshold of 15 percent. However, all hospitals with a ratio greater than 5 percent must complete line 7 of Part III for all columns. Calculate the percent to two decimal places for purposes of rounding.

Line 26--Salaries and hours reported on this line correlate to the salaries reported on line 4, column 1 of Worksheet A, for the *personnel working in the* Employee Benefit Department, or *the* Human Resources Department. *Do not report costs or hours associated with other hospital employees on this line.*

Lines 28, 33, and 35--Enter the amount paid for services performed **under contract**, rather than by employees, for administrative and general, housekeeping, and dietary services, respectively. DO NOT include costs for equipment, supplies, travel expenses, and other miscellaneous or overhead items. Report only personnel costs associated with these contracts. Continue to report on the standard lines (line 27, 32, and 34), the amounts paid for services rendered by employees not under contract.

Line 28--A&G costs are expenses a hospital incurs in carrying out its administrative and/or general management functions. Include on line 28 the contract services that are included on Worksheet A, line 5 and subscripts, column 2 ("Administrative and General"). Contract information and data processing services, legal, tax preparation, cost report preparation, and purchasing services are examples of contract labor costs that would be included on this line and must not be reported on lines 11 or 12. Do not include on line 28 the costs for top level management contracts (these costs are reported on line 11).

Column 3--Enter on each line, as appropriate, the **salary and wages** portion (as defined in column 2 instructions) of any reclassifications made on Worksheet A-6.

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

Column 5--Enter on each line the number of **paid** hours corresponding to the amounts reported in column 4. Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave hours, paid time-off hours, and hours associated with severance pay. For Part II, lines 1 through 15 (including subscripts), lines 26 through 43 (including subscripts), and Part III, line 7, if the hours cannot be determined, then the associated salaries must not be included in columns 2 through 4.

NOTE: The hours must reflect any change reported in column 3; For employees who work a regular work schedule, on call hours are not to be included in the total paid hours (on call hours should only relate to hours associated to a regular work schedule; overtime hours are calculated as one hour when an employee is paid time and a half. No hours are required for bonus pay. The intern and resident hours associated with the salaries reported on line 7 must be based on 2080 hours per year for each full time intern and resident employee. The hours reported for salaried employees who are paid a fixed rate are recorded as 40 hours per week or the number of hours in your standard work week.

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

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

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

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

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

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

Definitions:

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

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

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

4006. WORKSHEET S-4 - HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

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

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

Line 2--Enter the unduplicated count of all individual patients and title XVIII patients receiving home visits or other care provided by employees of the agency or under contracted services during the reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count (column 5, line 2) may not equal the sum of columns 1 through 4, line 2. For purposes of calculating the unduplicated census, if a beneficiary has received healthcare in more than one CBSA, you must prorate the count of that beneficiary so as not to exceed a total of (1). A provider is to also query the beneficiary to determine if he or she has received healthcare from another provider during the year, e.g., Maine versus Florida for beneficiaries with seasonal residence.

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

Enter the number of hours in your normal work week.

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

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

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

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

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

Line 20--Identify each CBSA where the reported HHA visits are performed by entering the 5 digit CBSA code and Non-CBSA (rural) code as applicable. Subscript the lines to accommodate the number of CBSAs you service. Rural CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the State of Maryland the rural CBSA code is 99921.

PPS Activity Data--Applicable for Medicare Services.

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

Line 4--Enter *in column 1, the direct salaries and salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay incurred only for employees in the* employee benefits department *and/or* the human resources department. *In accordance with CMS Pub. 15-1, chapter 23, §2307, if your accounting system directly allocates employee benefits to individual cost centers, enter in column 2 the employee benefits cost of employees in the employee benefits and/or human resources department. If your accounting system does not directly allocate all or a portion of the employee benefits to all the individual cost centers, then enter in column 2 the total employee benefits cost and/or residual employee benefits costs of all hospital employees.*

Line 5--Enter administrative and general (A & G) costs on this line. A&G includes a wide variety of provider administrative costs such as but not limited to cost of executive staff, legal and accounting services, facility administrative services (not already included in other general services cost centers), etcetera. If this line is componentized into more than one cost center, eliminate line 5. Componentized A & G lines must begin with subscripted line 5.01 and continue in sequential and consecutive order except where this manual specifies otherwise.

Line 6--Maintenance and repairs are any activity to maintain the facility and grounds such as, but not limited to, costs of routine painting, plumbing and electrical repairs, mowing and snow removal.

Line 7--Operation of plant includes the cost such as, but not limited to, the internal hospital environment including air conditioning (both heating and cooling systems and ventilation) and other mechanical systems.

Line 8--Laundry and linen services includes the cost of routine laundry and linen services whether performed in-house or by outside contractors.

Line 9--Housekeeping includes the cost of routine housekeeping activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 10--Dietary includes the cost of preparing meals for patients.

Line 11--Cafeteria includes the cost of preparing food for provider personnel, physicians working at the provider, visitors to the provider.

Line 12--Maintenance of personnel includes the cost of room and board furnished to employees. (See Pub. 15-1, chapter 7, §704.3.)

Line 13--Nursing administration normally includes only the cost of nursing administration. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks.

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

Line 14--Central services and supply includes the costs of supplies and services which are requested by departments throughout the provider, including medical supplies charged to patients.

Line 15--Pharmacy includes the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients.

Line 16--Medical records and medical records library includes the direct costs of the medical records cost center including the medical records library. The general library and the medical library are not included in this cost center but are reported in the A & G cost center.

Line 17--Social service includes the cost of explaining health care resources and policies to patients, family and professional staff; assistance in planning for post-hospital patient needs; assisting patients and families receive needed follow-up care by referral to health care resources and providing advocacy through appropriate organizations.

Line 19--The services of a nonphysician anesthetist generally are paid for by the Part B contractor based on a fee schedule rather than on reasonable cost basis through the cost report. As such, the salary and fringe benefit costs included on line 19 generally are not reimbursed through the cost report.

NOTE: Any costs are included on this line are limited to salary and employee benefit costs.

However, payment for the nonphysician anesthetists on a fee basis may not apply to a qualified rural hospital or CAH if the facility employed or contracted with not more than one FTE (2080 hours) nonphysician anesthetist and, if (1) the hospital had 800 or fewer surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services and (2) each nonphysician employed by or under contract with the hospital has agreed not to bill under Part B of title XVIII for professional services furnished. 42 CFR 412.113(c)(2)(i)

Payment under the fee schedule applies to qualified hospitals and CAHs unless the hospital establishes, before the beginning of each calendar year, that it did not exceed 800 surgical procedures requiring anesthesia in the previous year. 42 CFR 412.113(c)(2)(ii)

Hospitals which do not qualify for the exception and are therefore subject to the fee schedule payment method must remove the salary and fringe benefit costs from line 19. The total amount is reported on Worksheet A-8, line 28 and in column 6, line 19 of this worksheet. This removes these costs from the cost reported in column 7.

Line 46--Use this cost center to accumulate the direct costs incurred in maintaining long term care services not specifically required to be included in other cost centers. A long term care unit refers to a unit where the average length of stay for all patients is greater than 25 days. The beds in this unit are not certified for title XVIII.

Lines 47-49--Reserved for future use.

Lines 50 - 76--Use for ancillary service cost centers.

Line 57--Use this line to record direct costs associated with computed tomography (CT) services.

Line 58--Use this line to record direct costs associated with magnetic resonance imaging (MRI) services.

Line 59--Use this line to record direct costs associated with cardiac catheterization services.

Line 60--Use this line to record direct costs associated with laboratory services.

Line 61--Use this line to record costs when a pathologist continues to bill non-program patients for clinical laboratory tests and is compensated by you for services related to such tests for program beneficiaries. When you pay the pathologist an amount for administrative and supervisory duties for the clinical laboratory for program beneficiaries only, include the cost in this cost center.

NOTE: No overhead expenses are allocated to this cost center since it relates to services for program beneficiaries only. The cost reporting treatment is similar to that of services furnished under arrangement to program beneficiaries only. (See CMS Pub. 15-1, *chapter 23,* §2314.) These costs are apportioned among the various programs on the basis of program charges for provider clinical laboratory tests for all programs for which you reimburse the pathologist.

Line 62--Include the direct expenses incurred in obtaining blood directly from donors as well as obtaining whole blood and packed red blood cells from suppliers. Do not include in this cost center the processing fee charged by suppliers. The processing charge is included in the blood storing, processing, and transfusion cost center. Identify this line with the appropriate cost center code (06250) (Table 5 - electronic reporting specifications) for the cost of administering blood clotting factors to hemophiliacs. (See §4452 of BBA 1997, OBRA 1989 & 1993.)

Line 63--Include the direct expenses incurred for processing, storing, and transfusing whole blood, packed red blood cells, and blood derivatives. Also include the processing fee charged by suppliers.

Line 71--*Include on this line medical supplies charged to patients other than the high cost implantable devices reported on line 72. Obtain the expense amounts from your records as follows depending on how you accumulate these expenses in your general ledger (GL). (1) If the expenses for chargeable medical supplies are accumulated together with non-chargeable medical supplies in the "Central Services" GL account and are reported in that cost center (line 14 on Worksheet A), do not include the chargeable medical supplies expenses on Worksheet A, line 71. Rather, allocate the costs in column 14 of Worksheet B to line 71 (and other lines) using the recommended "costed requisitions" statistics. (2) If the expenses for chargeable medical supplies are reported in a separate GL account, include these expenses on Worksheet A, line 71, column 2. (3) If the expenses for chargeable medical supplies are reported in a specific subaccount(s) under the GL accounts for various routine and ancillary departments (i.e., operating room, adults and pediatrics, or clinic), report the sum of the balances in that subaccount(s) on Worksheet A, line 71, column 2. If you reported the total balance (i.e., including the amounts for chargeable medical supplies) of the various GL accounts (i.e., operating room, adults and pediatrics, or clinic), in those respective cost centers in column 2 of Worksheet A, reclassify the cost of the chargeable medical supplies from those cost centers to the "medical supplies charged to patients" cost center (line 71).* (See CMS Pub. 15-1, chapter 23, *§2308.2 and 42 CFR 413.53(a)(1).)*

Line 72--*Include on this line high cost implantable devices charged to patients bearing the revenue codes established by the NUBC as indicated in the FR, Vol. 73, No. 161, dated August 19, 2008, page 48,462, and not reported on line 71. Obtain the expense amounts from your records as follows depending on how you accumulate these expenses in your general ledger (GL). (1) If the expenses for chargeable implantable devices are accumulated together with non-chargeable implantable devices in the "Central Services" GL account and are reported in that cost center (line 14 on Worksheet A), do not include the high cost chargeable implantable devices expenses on Worksheet A, line 72. Rather, allocate the costs in column 14 of Worksheet B to line 72 (and other lines) using the recommended "costed requisitions" statistics. (2) If the expenses for high cost chargeable implantable devices are reported in a separate GL account, include these expenses on Worksheet A, line 72, column 2. (3) If the expenses for high cost chargeable implantable devices are reported in a specific subaccount(s) under the GL accounts for various routine and ancillary departments (i.e., operating room, adults and pediatrics, or clinic), report the sum of the balances in that subaccount(s) on Worksheet A, line 72, column 2. If you reported the total balance (i.e., including the amounts for high cost chargeable implantable devices) of the various GL accounts (i.e., operating room, adults and pediatrics, or clinic), in those respective cost centers in column 2 of Worksheet A, reclassify the cost of the high cost chargeable implantable devices from those cost centers to the "implantable devices charged to patients" cost center (line 72).* (See CMS Pub. 15-1, chapter 23, *§2308.2 and 42 CFR 413.53(a)(1).)*

Line 74--If you furnish renal dialysis treatments, account for such costs by establishing this separate ancillary service cost center. In accumulating costs applicable to the cost center, include no other ancillary services even though they are routinely administered during the course of the dialysis treatment. However, if you physically perform a few minor routine laboratory services associated with dialysis in the renal dialysis department, such costs remain in the renal dialysis cost center. Outpatient maintenance dialysis services are reimbursed under the composite rate reimbursement system. For purposes of determining overhead attributable to ESAs, include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

Effective for services rendered on or after January 1, 2011, ESRD services are paid under the ESRD PPS.

NOTE: ESRD physician supervisory services are not included as your costs under the composite rate reimbursement system or ESRD PPS. Supervisory services are included in the physician's monthly capitation rate.

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

Lines 77 - 87--Reserved for future use.

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

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

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

In accordance with the *Medicare Claims Processing Manual (CMS Pub. 100-04)*, chapter 9, §*40*A, compensation paid to a physician for RHC services rendered in a hospital-based RHC is cost-reimbursed. Where the physician agreement compensates for RHC services as well as non-RHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

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

In accordance with CMS Pub. 100-0*4*, chapter 9, §*40*, compensation paid to a physician for FQHC services rendered in a hospital-based FQHC is cost-reimbursed. Where the physician agreement compensates for FQHC services as well as non-FQHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

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

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

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

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

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

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

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

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

Effective for services rendered on or after January 1, 2011, ESRD services are paid under the ESRD PPS.

Transfer the total cost in column 26, line 100 (intern/resident services not in approved teaching program) to Worksheet D-2, Part I, column 2, line 1.

The total outpatient rehabilitation costs in column 26, line 93 and subscripts, must agree with Worksheet J-1, Part I, column 26, line 22, for each provider type.

Do not transfer ASC costs from column 26, line 115. Do not transfer the nonreimbursable cost center totals (lines 190 through 193).

NOTE: Do not transfer negative numbers.

Column Descriptions

Column 1--Include only capital costs for building and fixtures. See the instructions for Worksheet A, line 1, for a discussion capital-related costs for building and fixtures.

Column 2--Include only capital costs for movable equipment. See the instructions for Worksheet A, line 2, for a discussion capital-related costs for movable equipment.

Worksheet B, Part I, Column 25--*Hospitals other than CAHs*--Accumulate in this column the costs for interns and residents. Except as provided in 42 CFR 413.77(e)(1), the costs of interns and residents (direct graduate medical education costs for inpatient and outpatient in approved programs) *for PPS and TEFRA hospitals* are paid on a per resident amount *(PRA)* through Worksheet E-4. In order to avoid duplicate payments *of interns and residents costs*, enter the sum of the amounts reported on each line in columns 21 and 22 in the appropriate line of column 25. *When an adjustment to expenses is required after cost allocation, enter on the appropriate lines in this column the amounts from Worksheet B-2.* The total of columns 21 and 22 and the appropriate lines on Worksheet B-2 must equal the total of column 25.

NOTE: *In accordance with* 42 CFR 413.77(e), *if a hospital did not have any approved medical residency programs or did not participate in Medicare during the base period but either condition changes in a cost reporting period beginning on or after October 1, 2006 and the* residents are not on duty during the first month of the cost reporting period in which the hospital first begins to train residents, the contractor establishes a *per-resident amount* (*PRA)* using information from the first cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital. *Any interns and residents costs incurred during the cost reporting period, prior to the base period used to calculate the PRA, are reimbursed as pass-throughs based on reasonable costs* on Worksheets D, Parts III and IV *and D-2, Part II if applicable*. *If Worksheet S-2, Part I, line 57, column 1 is "Y" and column 2 is "N",* do not include in column 25 the intern*s* and resident*s* costs from columns 21 and 22.

If Worksheet S-2, Part I, Line 57, column 1 contains an "N" or column 2 contains a "Y", include in column 25 the interns and residents in approved programs costs from columns 21 and 22 because these costs will be reimbursed on a per-resident amount basis through Worksheet E-4.

CAHs--If you are CAH and responded "Y" to Worksheet S-2, Part I, question 107, (indicating that you have an I&R training program) the GME elimination is not performed. Consequently, do not include in column 25 the intern and resident costs from columns 21 and 22.

Worksheet B-1, Column 5A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, Part I, column 4A, line 202 and the accumulated cost reported on Worksheet B-1, column 5, line 5. Enter any amounts reported on Worksheet B, Part I, column 4A 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 5 the administrative and general costs reported on Worksheet B, Part I, column 5, line 5 since these costs are not included on Worksheet B-1, column 5 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 5.03 (Other A&G), the reconciliation column designation must be 5A.03.

Worksheet B-1, Column 5--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-l, column 5, line 5, is the difference between the amounts entered on Worksheet B, Part I, column 4A and Worksheet B-1, column 5A. 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 23--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.

4030. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

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

Worksheet E consists of the following two parts:

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

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

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

4030.1 Part A - Inpatient Hospital Services Under IPPS--

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

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

For IPPS hospitals participating in Model 4 of the Bundled Payments for Care Improvement (BPCI) initiative, Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model, as will outlier payments and hospital capital payments (see Change Request 8196, dated February 15, 2013). Enter on lines 1.03 and 2.02, in column 1 the applicable payment data for the cost reporting period.

Line Descriptions

Line 1--The amount entered on this line is the sum of the federal *specific* operating portion (DRG payments) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. *For cost reporting periods overlapping October 1, 2013, do not complete line 1, but complete lines 1.01 and 1.02. For cost reporting periods beginning on or after October 1, 2013, use this line and do not complete lines 1.01 and 1.02.*

Line 1.01--For cost reporting periods that overlap October 1, 2013, enter the amount of the federal specific operating portion (DRG payments) paid for PPS discharges and transfers occurring prior to October 1, 2013. For example, a calendar year provider would include DRG payments for discharges occurring during the period of (January 1 through September 30). ***Do not complete for cost reporting periods beginning on or after October 1, 2013.***

Line 1.02--For cost reporting periods that overlap October 1, 2013, enter the amount of the federal specific operating portion (DRG payments) paid for PPS discharges and transfers occurring on or after October 1, 2013. For example, a calendar year provider would include DRG payments for discharges occurring during the period of (October 1 through December 31).
Do not complete for cost reporting periods beginning on or after October 1, 2013.

Line 1.03--Enter the amount of the federal specific operating portion (DRG payments) for Model 4 bundled payments for care improvement (BPCI) initiative, effective for discharges occurring on or after October 1, 2013.

Line 2--Enter the amount of outlier payments made for PPS discharges during the period. See 42 CFR 412, Subpart F for a discussion of these items.

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

Line 2.02--Effective for discharges occurring on or after October 1, 2013, enter the amount of outlier payments made for Model 4 BPCI discharges during the cost reporting period.

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

Line 4--Enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 3, line 14) by the number of days in the cost reporting period (365 or 366 in case of leap year). Effective for cost reporting periods beginning on or after October 1, 2012, enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 3, line 14 plus line 32) by the number of days in the cost reporting period (365 or 366 in case of leap year).

NOTE: Reduce the bed days available by swing bed days (Worksheet S-3, Part I, column 8, sum of lines 5 and 6), and the number of observation days (Worksheet S-3, Part I, column 8, line 28). In addition, effective for cost reporting periods beginning on or after October 1, 2011, reduce the bed days available by the number of non-distinct part hospice days (Worksheet S-3, Part I, column 8, line 24.10) and effective for cost reporting periods beginning on or after October 1, 2012, the number of outpatient ancillary labor and delivery days (Worksheet S-3, Part I, column 8, line 32.01).

Indirect Medical Educational Adjustment Calculation for Hospitals--Calculate the IME adjustment only if you answered "yes" to line 56 on Worksheet S-2 and complete lines 5 to 29 as applicable. In addition, a hospital may be entitled to the IME adjustment if Worksheet S-2, line 56 is "no" and lines 13 and/or 14 are greater than zero. (See 42 CFR 412.105.) Hospitals that incur indirect costs for graduate medical education programs are eligible for an additional payment as defined in 42 CFR 412.105(d). This section calculates the additional payment by applying the applicable multiplier of the adjustment factor for such hospitals.

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

Line 5--Enter the FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. (42 CFR 412.105(f)(1)(iv).) Adjust this count for the 30 percent increase for qualified rural hospitals and also adjust for any increases due to primary care residents that were on approved leaves of absence. (42 CFR 412.105(f)(1)(iv) and (xi) respectively.) Temporarily reduce the FTE count of a hospital that closed a program(s), if the regulations at 42 CFR 412.105(f)(1)(ix) are applicable. (Effective 10/1/2001, see 42 CFR 413.79(h)(3)(ii)).

Line 6--Enter the FTE count for allopathic and osteopathic programs which meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1) or (e)(3), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995, but before October 1, 2012. For hospitals that began training residents in a new program for the first time on or after October 1, 2012, the cap is effective beginning with the sixth program year (see 77 FR August 31, 2012, 53417). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited or begun on or after January 1, 1995, and before August 6, 1997, is reported on this line and is effective in the fourth program year of each of those new programs (see 66 FR, August 1, 2001, page 39881). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 5. Do not report new program FTEs during the time frame prior to the effective date of the hospital's FTE cap adjustment on this line. New program FTEs during the time frame prior to the effective date of the hospital's FTE cap adjustment are reported on line 16. For urban hospitals that already have an FTE cap adjustment on line 5 but start a rural track program in accordance with 42 CFR 413.79(k), enter here the allopathic or osteopathic FTE count for residents in all years of a rural track program that meet the criteria for an add-on to the cap under 42 CFR 412.105(f)(1)(x). (If the rural track program is a new program under 42 CFR 413.79 and the urban hospital qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (3), do not report FTE residents in the rural track program on this line during the time frame prior to the effective date of the hospital's FTE cap.

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

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

Line 8--Enter the adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.

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

no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting period.

If the amount reported on Worksheet S-2, Part I, line 61.02, column 2, is less than the amount on line 61.01, column 2, then report 0 on this line.

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

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

Calculation of the allowable current year FTEs:

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

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

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

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

Line 14--Enter the total allowable FTE count for the penultimate year, either from Form 2552-96 line 3.14, or Form 2552-10 line 12, as applicable. If you were not training any residents in approved programs in the penultimate year, make no entry. Do not include residents in the initial years of the program that are exempt from the rolling average under 42 CFR 412.105(f)(1)(v). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 412.105(f)(1)(v)), enter on this line the allowable FTE count from line 12 plus the count of previously new FTE residents in that specific program that were added to line 16 of the penultimate year's cost report. (Line 3.17 if the prior year cost report was the 2552-96).

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

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

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

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

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

Line 20--In general, enter from the prior year cost report the intern and resident to bed ratio by dividing line 12 by line 4 (divide line 3.14 by line 3 if the prior year cost report was the 2552-96). However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e), add to the numerator of the prior year intern and resident to bed ratio the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program (i.e., the period of years is the minimum accredited length of the program). If the provider is participating in a Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap and current year FTE count due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator and the prior year numerator, and b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior year's numerator (see FR Vol. 66, No. 148 dated August 1, 2001, page 39880). Effective for cost reporting periods beginning on or after 10/1/02, if the hospital is training FTE residents in the current year that were displaced by the closure of another hospital or program, also adjust the numerator of the prior year ratio for the number of current year FTE residents that were displaced by hospital or program closure (42 CFR 412.105(a)(1)(iii)). The amount added to the prior year's numerator is the displaced resident FTE amount that you would not be able to count without a temporary cap adjustment. This is the same amount of displaced resident FTEs entered on line 17.

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

Line 22--Calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 21) to the .405 power) - 1} times {the sum of lines 1*, 1.01, 1.02, 1.03 and* 3}.

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

Line 23--Section 422 IME FTE Cap--Enter the number of allopathic and osteopathic IME FTE residents cap slots the hospital received under 42 CFR §412.105(f)(1)(iv)(C)(1), section 422 of the MMA.

Line 24--IME FTE Resident Count Over the Cap--Subtract line 9 from line 10 and enter the result here. If the result is zero or negative, the hospital does not need to use the 422 IME cap. Therefore, do not complete lines 23 through 28.

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

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

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

Line 28--IME Add On Adjustment--Enter the sum of lines 1*, 1.01, 1.02, 1.03* and 3, multiplied by the factor on line 27.

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

Disproportionate Share Adjustment--Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on lines 30 through 34. Complete lines 33 and 34 only if you are an IPPS hospital and answered yes to line 22, column 1 of Worksheet S-2, Part I.

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

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

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

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

Line 34--Multiply line 33 by line 1 *for cost reporting periods ending on or before September 30, 2013. Effective for cost reporting periods that overlap October 1, 2013, enter the sum of {(line 33 times line 1.01), plus ((line 33 times the sum of lines 1.02 and 1.03) times 25 percent)}. For cost reporting periods beginning on or after October 1, 2013, multiply (line 33 times the sum of lines 1 and 1.03) times 25 percent.*

Section 3133 of the ACA provides that for services occurring on or after October 1, 2013 a subsection (d) (i.e., IPPS hospital) hospital which is entitled to a receive a DSH payment will receive two separately calculated payments. The "empirically justified Medicare DSH payment" which represents 25 percent of the amount the hospital would have received under 42 CFR 412.106(d) is calculated on line 34. The "additional payment for uncompensated care" payment is calculated on lines 35 through 36.

Uncompensated Care Adjustment--Section 3133 of the ACA: (1) provides that for discharges occurring on or after October 1, 2013, subsection (d) hospitals' Medicare DSH payments are reduced by 75 percent (to the empirically justified Medicare DSH payment); and (2) established an uncompensated care payment amount which represents the remaining 75 percent of the DSH payments and distributes a portion of this amount to each qualifying DSH hospital based on its share of uncompensated care. Effective for cost reporting periods overlapping or beginning on or after October 1, 2013, complete lines 35 through 36, columns 1 and 2, as applicable only if you are a subsection (d) hospital and answered yes to Worksheet S-2, Part I, line 22, column 1.

If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, columns 1 and 2 are "Y", do not complete lines 35 and 35.01. If Worksheet S-2, Part I, line 22.01, either column 1 or 2 is "N", complete only the column with the "N" response for lines 35 and 35.01. A response of "Y" for both questions indicates that a hospital uncompensated care payment has been pre-determined for your hospital for the applicable FFY.

NOTE: *For cost reporting periods that overlap October 1, 2013, column 1 should be left blank and only column 2 should be completed.*

Line 35--If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "N", enter in the corresponding column the full amount (for all eligible IPPS hospitals) available for uncompensated care payments for the appropriate FFY. For example, for a cost reporting period ending December 31, 2013, enter zero in column 1 for the portion of the cost reporting period that began prior to October 1, 2013, and enter the FFY14 uncompensated care payment amount of $9,046,380,143 in column 2.

Line 35.01--If Worksheet S-2, Part I, line 22.01, column 1 or 2, is "N", enter the applicable factor 3 value determined by CMS for uncompensated care payments for the appropriate FFY in columns 1 and 2, respectively. If you are a new hospital, Worksheet S-2, Part I, line 47, column 2 is "Y", factor 3 must be calculated. In determining factor 3 the numerator is the current year cost report Medicaid days (Worksheet S-2, Part I, line 24, sum of columns 1 through 6) plus the SSI days published for the applicable FFY divided by the denominator which is a fixed amount obtained from the applicable FFY IPPS rule. For FFY14 the denominator is 36,429,747 (this represents the total IPPS hospitals Medicaid days and SSI days for FFY14). Round this factor 3 to 9 decimal places.

Line 35.02-- If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "Y", enter the hospital uncompensated care payment amount determined by CMS for the appropriate FFY in columns 1 and 2. If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "N", then CMS did not determine the hospital uncompensated care payment amount for that FFY. Compute this amount by multiplying line 35 times line 35.01, for columns 1 and 2, respectively. If Worksheet S-2, Part I, line 22, column 1 is "N" and/or line 34 above is zero, enter zero on this line.

Line 35.03--Enter the pro rata share of the hospital's uncompensated care payment in columns 1 and 2. Enter in column 1 (line 35.02 times the number of days in the cost reporting period prior to October 1 divided by the total days in the cost reporting period). Enter in column 2 (line 35.02 times the number of days in the cost reporting period on or after October 1 divided by the total days in the cost reporting period).

For example, a calendar year cost reporting period January 1, 2013 through December 31, 2013, enter zero in column 1, for the period of (January 1, 2013 through September 30, 2013) this period is prior to FFY 14; enter in column 2, for the period of (October 1, 2013 through December 31, 2013 (FFY 14)), (92 days/365 days) times line 35.02, column 2.

Another example, a calendar year cost reporting period of January 1, 2014 through December 31, 2014, enter in column 1, for the period (January 1, 2014 through September 30, 2014 (FFY 14)), (273 days/365 days) times lines 35.02, column 1; enter in column 2, for the period of (October 1, 2014 through December 31, 2014 (FFY 15)), (92 days/365days times line 35.02, column 2).

Line 36--Enter the hospital's uncompensated care adjustment amount, (the sum of columns 1 and 2, line 35.03.)

Lines *37* - 39--Reserved for future use.

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

Line 40--Enter total Medicare discharges excluding discharges for MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48447 and 48520).). Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see FR 160, Vol. 76, dated August 18, 2011, page 51693) for all Medicare beneficiaries entitled to Medicare Part A. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under section 1876 of the Act (HMOs), and competitive medical plans (CMPs). These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the denominator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals.

Line 41--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see Vol. 69, FR 154, dated August 11, 2004, page 49087) excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48520 and 48447). Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see FR 160, Vol. 76, dated August 18, 2011, page 51693) for all ESRD Medicare beneficiaries entitled to Medicare Part A who receive inpatient dialysis. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under section 1876 of the Act (HMOs), and CMPs. These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the numerator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals.

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

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

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

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

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

Line 47--Enter the sum of lines 1, *1.01, 1.02,* 2, 2.01, *2.02,* 29, 34, *36* and 46.

Line 48--Sole community hospitals are paid the highest of the federal payment rate, the hospital-specific rate (HSR) determined based on a federal fiscal year 1982 base period (see 42 CFR 412.73), the hospital-specific rate determined based on a federal fiscal year 1987 base period (See 42 CFR 412.75), for cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate determined based on a federal fiscal year 1996 base period (See 42 CFR 412.77), or for cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate determined based on a federal fiscal year 2006 base period (See 42 CFR 412.78). 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 (See 42 CFR 412.79), base period hospital specific rate. For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments.

For sole community hospitals only, the hospital-specific payment amount entered on this line is supplied by your contractor. Calculate it by multiplying the sum of the DRG weights for the period (per the PS&R) by the final per discharge hospital-specific rate for the period. For new hospital providers established after 1987, do not complete this line. Use the hospital specific rate based on the higher of the cost reporting periods beginning in FFY 1982, 1987, or 1996.

Additionally, for sole community hospitals only (effective for cost reporting periods beginning on or after January 1, 2009), use the highest of the determined hospital specific rate based on federal fiscal year 1982, 1987, 1996, or 2006.

For MDH discharges occurring on or after October 1, 2006, and before October 1, 2013, an MDH can use a FFY 2002 hospital specific rate. The MDH program ends on September 30, 2013.

Line 49--For SCHs, enter the greater of line 47 or 48. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2013, if line 47 is greater than line 48, enter the amount on line 47. Where line 48 is greater than line 47, enter the amount on line 47, plus 75 percent of the amount that line 48 exceeds line 47. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 47.

For hospitals subscripting column 1 of line 47 due to a change in geographic location, this computation will be computed separately for each column, and the sum of the calculations will be entered in column 1 of this line.

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

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

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

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

Line 53--Enter the amount of Nursing and Allied Health Managed Care payments if applicable.

Line 54--Enter the special add-on payment for new technologies (see 42 CFR §§412.87 and 412.88).

Line 55--Enter the net organ acquisition cost from Worksheet(s) D-4, Part III, column 1, line 69.

Line 56--Enter the cost of teaching physicians from Worksheet D-5, Part II, column 3, line 20.

Line 57--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, lines 30 through 35 for the hospital.

Line 58--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 59--Enter the sum of lines 49 through 58.

Line 60--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, treat the services as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted by you in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 60. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 60 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductible and coinsurance on line 60.

Enter the primary payer amounts applicable to organ transplants. However, do not enter the primary payer amounts applicable to organ acquisitions. Report these amounts on Worksheet D-4, Part III, line 66.

If you are subject to PPS, include the covered days and charges in the program days and charges, and include the total days and charges in the total days and charges for inpatient and pass through cost apportionment. Furthermore, include the DRG amounts applicable to the patient stay on line 1. Enter the primary payer payment on line 60 to the extent that the primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductibles.

Line 61--Enter the result of line 59 minus line 60.

Line 62--Enter from the PS&R or your records the deductibles billed to program patients *excluding deductibles and coinsurance associated with Model 4 BPCI payments*.

Line 63--Enter from the PS&R or your records the coinsurance billed to program patients *excluding deductibles and coinsurance associated with Model 4 BPCI payments*.

Line 64--Enter the program allowable bad debts, reduced by the bad debt recoveries. If recoveries exceed the current year's bad debts, line 64 and 65 will be negative.

Line 65--Enter the result of line 64 (including negative amounts) times 70 percent for cost reporting periods that begin prior to October 1, 2012. For cost reporting periods that begin on or after October 1, 2012, enter the result of line 64 times 65 percent.

Line 66--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 64.

Line 67--Enter the sum of lines 61 and 65 minus the sum of lines 62 and 63.

Line 68--Enter from the PS&R, the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in the IPPS final rule for the applicable cost reporting period. See CMS Pub. 100-04, chapter 3, *§*100.8.

Line 69--Enter the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses by entering the sum of lines 93, 95 and 96.

For SCHs, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.

Line 70--Enter any other adjustments. Specify the adjustment in the space provided. Hardcoded subscripts of this line are identified as such.

Line 70.92--Enter the discount amount for the bundled payments for care improvement initiative (also referred to as Model 1) in accordance with ACA 2010, §3023 effective for discharges occurring on or after October 1, 2013. This demonstration actually began April 1, 2013, however the discounted payments begin October 1, 2013. Obtain this amount from the PS&R.

Line 70.93--Enter the payment adjustment amount for the hospital value-based purchasing (HVBP) program in accordance with ACA 2010, §3001 effective for discharges occurring on or after October 1, 2012. Obtain this amount from the PS&R.

Line 70.94--Enter the adjustment amount resulting from the hospital readmissions reduction program in accordance with ACA 2010, §3025 effective for discharges occurring on or after October 1, 2012. Obtain this amount from the PS&R.

Line 70.95--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).)

Line 70.96 through 70.98 (lines 70.96 and 70.97 are hardcoded)--Effective for discharges occurring during federal fiscal years 2011 and 2012 (October 1, 2010, through September 30, 2011, and October 1, 2011, through September 30, 2012, respectively), temporary improved/changed payments are mandated by §§3125 and 10314 ACA of 2010, as addressed in 42 CFR 412.101. Section 605 of the American Taxpayer Relief Act of 2012 extends these provisions through federal fiscal year 2013 (October 1, 2012 through September 30, 2013). For cost reporting periods that are concurrent with the federal fiscal year (10/1 through 9/30), use line 70.97 only. For cost reporting periods that overlap October 1 for years 2010, 2011, 2012, and 2013, enter on lines 70.96 (Low Volume Adjustment (enter the corresponding federal year for the period prior to 10/1)) and line 70.97 (Low Volume Adjustment (enter the corresponding federal year for the period ending on or after 10/1)), and if necessary line 70.98 (low volume adjustments for additional portions of the cost reporting period, if necessary), the Medicare inpatient payment adjustment for low volume hospitals as applicable in accordance with Exhibit 4 (low volume adjustment calculation schedule and corresponding instructions).

Line 71--Enter the result of line 67 plus or minus lines 69, 70.93, 70.94, 70.96, 70.97, 70.98, and line 70 and its subscripts not previously identified, minus lines 68, 70.92 and 70.95.

Line 71.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 71].

Line 72--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For contractor final settlements, enter the amount reported on Worksheet E-1, column 2, line 5.99 on line 73. Include*d* in *the* interim payment*s are* the amount*s* received as the estimated nursing and allied health managed care payments *and capital, IME, DSH and outlier payments associated with Model 4 BPCI.*

Line 74--Enter line 71 minus the sum of lines 71.01, 72 and 73. Transfer to Worksheet S, Part III.

Line 75--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

Lines 76 through 89 were intentionally skipped to accommodate future revisions to this worksheet.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART A. LINES 90 THROUGH 96 ARE FOR CONTRACTOR USE ONLY.

Line 90--Enter the original operating outlier amount from line 2 sum of all columns of this Worksheet E, Part A prior to the inclusion of lines 92, 93, 95, and 96 of Worksheet E, Part A.

Line 91--Enter the original capital outlier amount from Worksheet L, part I, line 2.

Line 92--Enter the operating outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, chapter 3, §§20.1.2.5 - 20.1.2.7.

Line 93--Enter the capital outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, chapter 3, §§20.1.2.5 - 20.1.2.7.

Line 94--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §20.1.2.5 - §20.1.2.7.)

Line 95--Enter the operating time value of money for operating related expenses.

Line 96--Enter the capital time value of money for capital related expenses.

NOTE: If a cost report is reopened more than one time, subscript lines 90 through 96, respectively, one time for each time the cost report is reopened.

Instructions For Completing Exhibit 4--

Low Volume Adjustment Calculation Schedule:

Sections 3125 and 10314 of ACA 2010 and §605 of the American Taxpayer Relief Act of 2012 amended the low-volume hospital adjustment in section 1886(d)(12) of the Social Security Act by revising, for FFFYs 2011, 2012 and 2013 the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. CMS implemented these changes to the low-volume payment adjustment in the regulations at section 42 CFR 412.101 in the FFY 2011 IPPS final rule (75 FR 50238 through 50275).

The legislative amendments referenced in the preceding paragraph provide for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2011, 2012 and 2013 as follows:

- Those hospitals with 200 or fewer Medicare discharges will receive an adjustment of an additional 25 percent for each discharge; and
- Those with more than 200 and fewer than 1,600 Medicare discharges will receive an adjustment of an additional percentage for each discharge. This adjustment is calculated using the formula [(4/14) - (Medicare discharges/5600)].

And to qualify as a low-volume hospital, the hospital must meet both of the following criteria:

- Be more than 15 road miles from the nearest subsection (d) hospital; and
- Have fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data.

CMS provided a table listing the IPPS hospitals with fewer than 1,600 Medicare discharges and their low-volume percentage add-on if applicable, for FFYs 2011, 2012 and 2013. However, this list is not a list of all hospitals that qualify for the low-volume adjustment since it does not reflect whether or not the hospital meets the mileage criteria. Hospitals were required to request low-volume status in writing to their contractor and provide documentation that they met the mileage criteria.

The low-volume payment adjustment for eligible hospitals is based on their total per discharge payments made under section 1886 of the Act, including capital IPPS payments, DSH payments, IME payments, and outlier payments. For SCHs and MDHs, the low-volume payment adjustment for eligible hospitals is based on either the federal rate or the hospital-specific payment (HSP) rate, whichever results in a greater operating IPPS payment. The low-volume payment amount calculated by the IPPS Pricer is an interim payment amount and is subject to adjustment during year end cost report settlement if any of the payment amounts upon which the low-volume payment amount is based are also recalculated at cost report settlement (for example, payments for DSH and IME or federal rate versus HSP rate payments for SCHs and MDHs).

For SNFs with cost reporting periods beginning prior to October 1, 2012, enter the amount on line 34. For cost reporting periods beginning on or after October 1, 2012, calculate this line as follows: [((line 34 - line 36) * 65 percent) + (line 36 * 88 percent)]. For cost reporting periods beginning on or after October 1, 2013, calculate this line as follows: [((line 34 - line 36) * 65 percent) + (line 36 * 76 percent)]. For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 34 times 65 percent.

Line 36--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only except for the calculation of dual eligible bad debts for SNFs cost reporting periods beginning on or after October 1, 2012. This amount must also be reported on line 34.

Line 37--Enter the sum of lines 32, 33 and 34 or 35 (hospitals and subproviders only). For cost reporting periods beginning on or after October 1, 2012, enter the sum of lines 32, 33 and 35. (hospital, CAH, subproviders and SNFs).

Line 38--Enter the MSP-LCC reconciliation amount. Obtain this amount from the PS&R.

Line 39--Enter any other adjustments. Specify the adjustment in the space provided.

Line 39.98--Enter from the PS&R, the partial or full credits received from manufacturers for replaced devices. See CMS Pub. 100-04, chapter 4, §61.3.

Line 39.99--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).)

Line 40--Enter the result of line 37, plus or minus line 39 *and its* subscripts not previously identified, minus lines 38, *39.98* and 39.99.

Line 40.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 40].

Line 41--Enter interim payments from Worksheet E-1, column 4, line 4. For contractor final settlements, enter the amount reported on line 5.99 on line 42. For contractor purposes it will be necessary to make a reclassification of the bi-weekly pass through payments from Part A to Part B and report that Part B portion on line 42. Maintain the necessary documentation to support the amount of the reclassification.

Line 43--Enter line 40 minus the sum of lines 40.01, 41 and 42. Transfer this amount to Worksheet S, Part III, column 3, line as appropriate.

Line 44--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by a 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 CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

Lines 45 through 89 were intentionally skipped to accommodate future revisions to this worksheet.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART B. LINES 90 THROUGH 94 ARE FOR CONTRACTOR USE ONLY.

Line 90--Enter the original outlier amount from line 4 (sum of all columns) prior to the inclusion of line 94 of Worksheet E, Part B.

Line 91--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 4, §10.7.2.2 - §10.7.2.4.

Line 92--Enter the rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 4, §10.7.2.2 - §10.7.2.4.)

Line 93--Enter the time value of money.

Line 94--Enter sum of lines 91 and 93.

NOTE: If a cost report is reopened more than one time, subscript lines 90 through 93, respectively, one time for each time the cost report is reopened.

4031. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

4031.1 Part I - Analysis of Payments to Providers for Services Rendered--

Complete this worksheet for each component of the health care complex which has a separate provider or subprovider number as shown on Worksheet S-2, Part I. If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. When the worksheet is completed for a component, show both the hospital provider number and the component number. Complete this worksheet only for Medicare interim payments paid by the contractor. Do not complete it for purposes of reporting interim payments for titles V or XIX or for reporting payments made under the composite rate for ESRD services. Providers paid on an interim basis on periodic interim payment (PIP) adjust the interim payments for MSP/LCC claims.

The following components use the indicated worksheet instead of Worksheet E-1:

- Hospital-based HHAs use Worksheet H-5.
- Hospital-based outpatient rehabilitation facilities use Worksheet J-4.
- RHCs/FQHCs use Worksheet M-5.

The column headings designate two categories of payments:

Columns 1 and 2 - Inpatient Part A
Columns 3 and 4 - Part B

Complete lines 1 through 4. The remainder of the worksheet is completed by your contractor. All amounts reported on this worksheet must be for services, the costs of which are included in this cost report.

NOTE: When completing the heading, enter the provider number and the component number which corresponds to the provider, subprovider, SNF, or swing bed-SNF which you indicated.

DO NOT reduce any interim payments by recoveries as a result of medical review adjustments where the recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not also adjusted.

DO NOT include fee-schedule payments for ambulance services rendered.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to you (excluding payments made under the composite rate for ESRD services), including amounts paid under PPS and pass through payments. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must also include amounts withheld from your interim payments due to an offset against overpayments applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2--Enter the total Medicare interim payments (excluding payments made under the ESRD composite rate) payable on individual bills.

Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period but not paid as of the end of the cost reporting period.

Also, include in column 4 the total Medicare payments payable for servicing home program renal dialysis equipment when the provider elected 100 percent cost reimbursement.

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

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer as follows:

Reimbursement Method	From Column	Transfer To
Part B Payments	4	Wkst. E, Part B, line 41
Part A Payments		
IPPS	2	Wkst. E, Part A, line 72
TEFRA	2	Wkst. E-3, Part I, line 19
IPF PPS	2	Wkst. E-3, Part II, line 32
IRF PPS	2	Wkst. E-3, Part III, line 33
LTC PPS	2	Wkst. E-3, Part IV, line 23
Cost	2	Wkst. E-3, Part V, line 31
SNF PPS Title XVIII	2	Wkst. E-3, Part VI, line 16

NOTE: For a swing bed-SNF, transfer the column 2, line 4, and column 4, line 4, amounts to Worksheet E-2, columns 1 and 2, line 20, respectively.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 8 ARE FOR CONTRACTOR USE ONLY. ***(EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)***

Line 5--List separately each settlement payment after the cost report is received together with the date of payment. If the cost report is reopened after the NPR has been issued, continue to report all settlement payments after the cost report is received separately on this line.

Line 6--Enter the net settlement amount (balance due the provider or balance due the program). Obtain the amounts as follows:

Worksheet E-1, Column as Indicated	From Settlement Worksheet
2	Wkst. E, Part A, line 74
4	Wkst. E, Part B, line 43
2	Wkst. E-3, Part I, line 21
2	Wkst. E-3, Part II, line 34
2	Wkst. E-3, Part III, line 35
2	Wkst. E-3, Part IV, line 25
2	Wkst. E-3, Part V, line 33
2	Wkst. E-3, Part VI, line 18

For swing bed-SNF services, column 2 must equal Worksheet E-2, column 1, line 22. Column 4 must equal Worksheet E-2, column 2, line 22.

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

Line 7--Enter in columns 2 and 4 the sum of lines 4 through 6. Enter amounts due the program as a negative number. These amounts must agree with amount due provider reported on Worksheet E, Part A, line 71; Worksheet E, Part B, line 40; Worksheet E-2, line 19; Worksheet E-3, Part I, line 18; Worksheet E-3, Part II, line 31; Worksheet E-3, Part III, line 32; Worksheet E-3, Part IV, line 22; Worksheet E-3, Part V, line 30; and Worksheet E-3, Part VI, line 15.

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

4031.2 Part II - Calculation of Reimbursement Settlement for Health Information Technology-

THIS PART IS COMPLETED BY THE CONTRACTOR FOR STANDARD COST REPORTING PERIODS AND BY THE CONTRACTOR FOR NONSTANDARD COST REPORTING PERIODS.

In accordance with the American Recovery and Reinvestment Act (ARRA) of 2009, section 4102, inpatient acute care services under IPPS (providers subject to section 1886(d) of the Act) and CAHs are eligible for health information technology (HIT) payments.

This part captures relevant data used to compute the HIT payment and records the single HIT initial payment paid by the contractor to the provider and any corresponding adjustments to this initial payment.

Data Collection Required for the Health Information Technology Calculation--

NOTE: Lines 1 through 7 must transfer data as indicated below for reporting periods which cover exactly 12 months (referred to as standard cost reporting periods and covers a range of 360 through 371 days). For cost reporting periods which cover other than exactly 12 months (less than or greater than 12 months (referred to as nonstandard cost reporting periods and covers a range of less than 360 days or greater than 371 days) lines 1 through 8 must be directly input by the contractor**.**

NOTE: For standard cost reporting periods, the provider will complete lines 30 and 31 in the "as filed" cost report and the amount computed on line 32 will be transferred to Worksheet S, Part III, column 4. For non-standard cost reporting periods, the "as filed" cost report will display zeros on all lines and a zero will be transferred from line 32 to Worksheet S, Part III, column 4. The contractor must complete this worksheet for nonstandard cost reporting periods.

Line 29--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 30--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc., enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 30.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 31--Enter the sum of lines 26 through 28 plus or minus lines 29 and 30.

Line 31.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 31].

Line 32--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 33 the amount on line 5.99.

Line 34--Enter line 31 minus the sum of lines 31.01, 32 and 33. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 35--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-1, chapter 1, §115.2.) Attach a schedule showing the details and computations.

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

Line 50--Enter the original outlier amount from Worksheet E-3, Part II, line 2.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 3, §190.7.2.3 - §190.7.2.5.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, chapter 3, §190.7.2.3 - §190.7.2.5.)

Line 53--Enter the time value of money.

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

4033.3 Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS--Use Worksheet E-3, Part III to calculate Medicare reimbursement settlement under IRF PPS for hospitals and subproviders. (See 42 CFR 412, subpart P.)

Use a separate copy of Worksheet E-3, Part III for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part III to indicate the component for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

Line 1--Enter the net federal IRF PPS payment. The federal payment includes short stay outlier amounts. Exclude low income patient (LIP) and outlier payments. Obtain this information from the PS&R and/or your records.

In accordance with the FR, Vol. 78, No. 151, dated August 6, 2013, page 47869, effective for IRF discharges rendered on or after October 1, 2013, the IRF LIP adjustment factor is updated. Subscript column 1 for lines 1 and 3 for cost reporting periods that overlap October 1, 2013. Enter the net federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2013 in column 1 and the net federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2013 in column 1.01 to facilitate the calculation of the LIP adjustment on line 3, columns 1 and 1.01, respectively. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013.

Line 2--Enter the Medicare SSI ratio from your contractor as applicable for a freestanding IRF (IRF hospital or facility) or a hospital based IRF (subprovider or subunit).

Line 3--*Effective for cost reporting periods ending prior to October 1, 2013, enter the* IRF LIP payment *as* the result of {(1 + (line 2) + (L1/L2)) to the .4613 power - 1} times (line 1). L1 = IRF Medicaid Days from Worksheet S-2, Part I, columns 1 through *6*, line 25. L2 = IRF total days from Worksheet S-3, Part I, column 8, lines 1 or 17 as applicable plus employee discount days (S-3, Part I, column 8, line 30 (line 31 for IRF subproviders)).

For cost reporting periods that overlap October 1, 2013, subscript column 1. To calculate the IRF LIP payment for discharges prior to October 1, 2013, enter in column 1 the result of {(1 + (line 2) + (L1/L2)) to the .4613 power - 1} times (line 1, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2013, enter in column 1.01 the result of {(1 + (line 2) + (L1/L2)) to the .3177 power - 1} times (line 1, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013. To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2013, enter in column 1 the result of {(1 + (line 2) +(L1/L2)) to the .3177 power - 1} times line 1.

Line 4--Enter the IRF outlier payment. Obtain this from the PS&R and/or your records.

NOTE: Complete only line 5 or line 6, but not both.

Line 5--For providers that trained residents in the most recent **cost reporting period ending on or before November 15, 2004** (response to Worksheet S-2, Part I, line 76, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period ending on or before November 15, 2004.

Line 5.01--For IRFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment in accordance with FR, volume 76, No. 151, dated August 5, 2011, page 47846.

Line 6--If the response to Worksheet S-2, Part I, line 76, column 2 is "Y" and your facility did not train residents in the most recent cost reporting period ending on or before November 15, 2004, and qualifies to receive a cap adjustment (see FR Vol. 70, No. 156, page 47929, dated August 15, 2005) enter the new cap adjustment on this line. Do not complete this line until the new program growth period has ended using the method described in 42 CFR 413.79(e)(1)(i) and (ii). If your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the cap adjustment accordingly.

Line 7--Enter the current year unweighted FTE resident count excluding **FTEs** in the new program growth period. FTEs in the new program growth period are reported on line 8. If your fiscal year end does not correspond to the program year end and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly.

Line 8--Enter the current year unweighted FTE count for residents in the new program growth period. Complete this line only during the new program growth period of the first new program's existence. If your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly.

Line 9--For providers that completed line 5, enter the lower of the FTE count on line 7 or the sum of the cap amounts on lines 5 and 5.01.

For providers that qualify to receive a cap adjustment (see FR Vol. 70, No. 156, page 47929, dated August 15, 2005), during the new program growth period of the first new program's existence enter the FTE count from line 8.

Beginning with the program year following the new program growth period of the first new program's existence, enter the lower of the FTE count on line 7 or the FTE count on line 6. Add to this count the FTEs on line 8 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program.

Line 10--Enter the total IRF patient days divided by the number of days in the cost reporting period (Worksheet S-3, column 8, line 1 (independent/freestanding) or 17 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

NOTE: *For cost reporting periods overlapping October 1, 2013, subscript column 1 (add column 1.01) for lines 11 and 12. For cost reporting periods beginning on or after October 1, 2013, do not script column 1.*

Line 11--*For cost reporting periods ending prior to October 1, 2013, calculate in column 1* the teaching adjustment factor by adding 1 to the ratio of line 9 *divided by* line 10. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the teaching adjustment factor. This is expressed mathematically as {(1 + (line 9 / line 10)) to the .6876 power - 1}.

In accordance with the FR, Vol. 78, No. 151, dated August 6, 2013, page 47869, effective for IRF discharges rendered on or after October 1, 2013, the teaching adjustment factor is updated. For cost reporting periods that overlap October 1, 2013, subscript column 1.

To calculate the teaching adjustment factor for discharges prior to October 1, 2013, enter in column 1 the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of .6876 and then subtract 1 from this amount. This is expressed mathematically as {(1 + (line 9 / line 10)) to the .6876 power - 1}. To calculate the teaching adjustment factor for discharges on or after October 1, 2013, enter in column 1.01 the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of 1.0163 and then subtract 1 from this amount. This is expressed mathematically as {(1 + (line 9 / line 10)) to the 1.0163 power - 1}. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013.

To calculate the teaching adjustment factor for cost reporting periods beginning on or after October 1, 2013, enter in column 1 the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of 1.0163 and then subtract 1 from this amount. This is expressed mathematically as {(1 + (line 9 / line 10)) to the 1.0163 power - 1}.

Line 12--*For cost reporting periods ending prior to October 1, 2013, calculate* the teaching adjustment by multiplying line 1, by line 11. *For cost reporting periods that overlap October 1, 2013, subscript column 1. Calculate the teaching adjustment for discharges prior to October 1, 2013 in column 1 by multiplying line 1, column 1 by line 11, column 1. Calculate the teaching adjustment for discharges on or after October 1, 2013, in column 1.01 by multiplying line 1, column 1.01 by line 11, column 1.01. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013. For cost reporting periods beginning on or after October 1, 2013, calculate the teaching adjustment by multiplying line 1, by line 11.*

Line 13--Enter the sum of line 1, *columns 1 and 1.01; line* 3, *columns 1 and 1.01; line* 4 and *line* 12, *columns 1 and 1.01*.

Line 14--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable. Only complete this line if your facility is a freestanding/independent non-IPPS hospital that does not complete Worksheet E, Part A.

Line 15--DO NOT USE THIS LINE.

Line 16--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter the amount from Worksheet D-5, Part II, column 3, line 20.

Line 17--Enter the sum of lines 13, 14, 15 and 16.

Line 18--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 18. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 18 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 18 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 19--Enter line 17 minus line 18.

Line 20--Enter the Part A deductibles.

Line 21--Enter line 19 less line 20.

Line 22--Enter the Part A coinsurance.

Line 23--Enter the result of subtracting line 22 from line 21.

Line 24--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 24 and 25 will be negative.

Line 25--Multiply the amount (including negative amounts) from line 24 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 26--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 24.

Line 27--Enter the sum of lines 23 and 25.

Line 28--Enter the amount from Worksheet E-4, line 49 for the hospital component (freestanding IRF) only. Do not complete this line for an IRF unit.

Line 29--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility or line 41 for IRF the subproviders. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 30--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 31--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 31.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 32--Enter the sum of lines 27, 28, and 29 plus or minus lines 30 and 31.

Line 32.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 32].

Line 33--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 34 the amount on line 5.99.

Line 35--Enter line 32 minus the sum of lines 32.01, 33 and 34. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 36--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

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

Line 50--Enter the original outlier amount from Worksheet E-3, Part III, line 4.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 3, §140.2.8 - §140.2.10.

Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §140.2.8 - §140.2.10)

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.

This page is reserved for future use.

4033.4 Part IV - Calculation of Medicare Reimbursement Settlement Under LTCH PPS--Use Worksheet E-3, Part IV to calculate Medicare reimbursement settlement under LTCH PPS for hospitals. (See 42 CFR 412, subpart O.)

Line Descriptions

Line 1--Enter the net federal LTCH PPS payment including short stay outlier payments. Obtain this information from the PS&R and/or your records.

Line 2--Enter the high cost outlier payments. Obtain this from the PS&R and/or your records.

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

Line 4--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable.

Line 5--DO NOT USE THIS LINE.

Line 6--For hospitals that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter the amount from Worksheet D-5, Part II, column 3, line 20.

Line 7--Enter the sum of lines 3, 4, 5 and 6.

Line 8--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 8. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

specific nonprimary care program included in Form 2552-96, Worksheet E-3, Part IV, line 3.16 or Form 2552-10, Worksheet E-4, sum of lines 15 and 16 of the prior year's cost report. If subject to the cap in the prior year Form 2552-96 cost report, report the result of Worksheet E-3, Part IV, line 3.08 times (line 3.04/line 3.05) plus line 3.11. If subject to the cap in the prior year Form 2552-10 cost report, report the result of Worksheet E-4, column 2, line 8 times (line 5/line 6) plus line 10.

Line 13--Enter in column 1, the weighted FTE count for primary care residents for the cost reporting year before last, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific primary care program included in Form 2552-96, line 3.22 or for 2552-10, sum of lines 15 and 16 of that year's cost report. If subject to the cap in the year before last Form 2552-96 cost report, report the result of line 3.07 times (line 3.04/line 3.05). If subject to the cap in that year Form 2552-10 cost report, report the result of column 1, line 8 times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the cost reporting year before last, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific nonprimary care program included in Form 2552-96, line 3.16 or Form 2552-10, sum of lines 15 and 16 of that year's cost report. If subject to the cap in the cost reporting year before last, Form 2552-96 cost report, report the result of line 3.08 times (line 3.04/line 3.05) plus line 3.11. If subject to the cap in that year Form 2552-10 cost report, report the result of column 2, line 8 times (line 5/line 6) plus line 10.

Line 14--Enter the rolling average FTE count in each column, by adding lines 11 through 13 and dividing by 3.

Line 15--Enter the weighted number of FTE residents in the initial years of a program that meets the exception to the rolling average rules in column 1 for primary care and in column 2 for nonprimary care FTEs.

Line 16--Enter the temporary weighted FTE residents that were displaced by program or a hospital closure in column 1 for primary care and in column 2 for nonprimary care FTEs, which you would not be able to count without a temporary cap adjustment. (42 CFR 413.79(h).)

Line 17--Enter the sum of lines 14 through 16.

Line 18-- Enter in column 1, the primary care and OB/GYN per resident amount. Enter in column 2, the nonprimary care per resident amount.

Line 19--Enter the result of multiplying lines 17 times line 18. Enter in column 3, the sum of columns 1 and 2.

Line 20--Section 422 Direct GME FTE Cap--Enter the number of unweighted allopathic and osteopathic direct GME FTE resident cap slots the hospital received under 42 CFR §413.79(c)(4).

Line 21--Direct GME FTE Resident Unweighted Count Over/Under the Cap--Subtract line 7 from line 6 and enter the result here. If the result is zero or negative, the hospital does not need to use the direct GME section 422 additional cap and lines 22 through 24 will not be completed.

Line 22--Section 422 Allowable Direct GME FTE Resident Count--If the count on line 21 is less than or equal to the count on line 20, then divide line 8 by line 6, and multiply the resulting ratio by the amount on line 21. If the count on line 21 is greater than the count on line 20, then divide line 8 by line 6, and multiply the resulting ratio by the amount on line 20.

Line 23--Enter the locality adjusted national average per resident amount as specified at 42 CFR section 413.77(g), inflated to the hospital's cost reporting period.

Line 24--Enter the product of lines 22 and 23. This is the allowable section 422 GME cost.

Line 25--Enter the sum of lines 19 and 24. This is the total Part A direct GME cost.

Computation of Program Patient Load--This section computes the ratio of program inpatient days to the total inpatient days. For this calculation, total inpatient days include inpatient days of the hospital along with its subproviders, including distinct part units excluded from the prospective payment system. Record hospital inpatient days of Medicare beneficiaries whose stays are paid by risk basis HMOs and organ acquisition days as non-Medicare days. Do not count inpatient days applicable to nursery, hospital-based SNFs and other nursing facilities, and other non-hospital level of care units for the purpose of determining the Medicare patient load.

Line Descriptions

Line 26--*Effective for cost reporting periods beginning prior to October 1, 2013, e*nter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 8 through 12, and 16 through 18, and subscripts, as applicable. *Effective for cost reporting periods beginning on or after October 1, 2013, enter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1; 8 through 12 and subscripts; 16 through 18 and subscripts; and 32.* For titles V or XIX, enter the amounts from columns 5 or 7, respectively, sum of lines 1, 8 through 12, and 16 through 18, and subscripts, as applicable *plus column 7, line 32 for title XIX*.

For title XVIII, enter in column 2, Medicare managed care days from Worksheet S-3, Part I, column 6, lines 2, 3 and 4. For title XIX, enter in column 2, Medicaid managed care days from Worksheet S-3, Part I, column 7, lines 2, 3 and 4.

Line 27--*Effective for cost reporting periods beginning prior to October 1, 2013, t*ransfer to columns 1 and 2, respectively, the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, and 16 through 18 and subscripts, as applicable.

Effective for cost reporting periods beginning on or after October 1, 2013, transfer to columns 1 and 2, the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, and 16 through 18 and subscripts, as applicable, plus line 32.

Line 28--In each column, divide line 26 by line 27 and enter the result (expressed as a decimal). Column 1 is the *t*itle XVIII Part A inpatient utilization and column 2 is the Medicare managed care inpatient utilization.

Line 29--Multiply the amount on line 25, column 1, by the amount reported in each column of line 28.

Line 30--In column 2, enter the amount on line 29, column 2 multiplied by the reduction factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. This is the reduction for direct GME payments for *Medicare Advantage*.

Line 31--Enter the sum of columns 1 and 2, line 29, less the amount in column 2, line 30.

Direct Medical Education Costs for ESRD Composite Rate Title XVIII Only--This section computes the title XVIII nursing school and paramedical education costs applicable to the ESRD composite rate. These costs are reimbursable based on the reasonable cost principles under 42 CFR 413.85 separate from the ESRD composite rate.

Line Descriptions

Line 32--Enter the amount from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94.

Line 33--Enter the amount from Worksheet C, Part I, column 8, sum of lines 74 and 94. This amount represents the total charges for renal and home dialysis.

Line 34--Divide line 32 by line 33, and enter the result. This amount represents the ratio of ESRD direct medical education costs to total ESRD charges.

Line 35--Enter from your records the Medicare outpatient ESRD charges.

Line 36--Enter the result of multiplying line 34 by line 35. This represents the Medicare outpatient ESRD costs. Transfer this amount to Worksheet E, Part B, line 29.

Apportionment of Medicare Reasonable Cost of GME--This section determines the ratio of Medicare reasonable costs applicable to Part A and Part B. The allowable costs of GME on which the per resident amounts are established include GME costs attributable to the entire hospital complex (including non-hospital portions of a health care complex). Therefore, the reasonable costs used in the apportionment between Part A and Part B include the hospital, hospital-based providers, and distinct part units. Do not complete this section for titles V and XIX.

Line Descriptions

Line 37--Include the Part A reasonable cost for the entire hospital complex computed by adding the following amounts:

- Hospital and Subprovider(s) - Sum of each Worksheet D-1, Part II, line 49;
- Hospital-Based HHAs - Worksheet H-4, Part I, column 1, line 1;
- Swing Bed-SNF - Worksheet E-2, line 1, column 1;
- Hospital-Based PPS SNF - Sum of Worksheet D-1, Part III, line 74 and Worksheet E-3, Part VI, column 1, line 4.

Line 38--Enter the organ acquisition costs from Worksheet(s) D-4, Part III, column 1, line 69.

Line 39--Enter the cost of teaching physicians from Worksheet(s) D-5, Part II, column 3, line 20.

Line 40--Enter the total Medicare Part A primary payer amounts for the hospital complex from the applicable worksheets.

- PPS hospital and/or subproviders - Worksheet E, Part A, line 60;
- TEFRA hospital and/or subproviders - Worksheet E-3, Part I, line 5;
- IPF PPS hospital and/or subproviders - Worksheet E-3, Part II, line 17;
- IRF PPS hospital and/or subproviders - Worksheet E-3, Part III, line 18;

- LTC PPS hospital - Worksheet E-3, Part IV, line 8;
- Cost reimbursed hospital and/or subproviders - Worksheet E-3, Part V, line 5;
- Hospital-based HHAs - Each Worksheet H-4, Part I, column 1, line 9;
- Swing Bed SNF and/or NF - Worksheet E-2, column 1, line 9; and
- Hospital-based PPS SNF - Worksheet E-3, Part VI, column 1, line 13.

Line 41--Enter the sum of lines 37 through 39 minus line 40.

Line 42--Enter the Part B Medicare reasonable cost. Enter the sum of the amounts on each title XVIII Worksheet E, Part B, columns 1 and 1.01, sum of lines 1, 2, 9, 10, 22, and 23; Worksheet E-2, column 2, line 8; Worksheet H-4, Part I, sum of columns 2 and 3, line 1; Worksheet J-3, column 1, line 1; and Worksheet M-3, line 16.

Line 43--Enter the Part B primary payer amounts. Enter the sum of the amounts on each Worksheet E, Part B, line 31; Worksheet E-2, column 2, line 9; Worksheet H-4, Part I, sum of columns 2 and 3, line 9; Worksheet J-3, line 4; Worksheet M-3, sum of columns 1 and 2, line 17.

Line 44--Enter line 42 minus line 43

Line 45--Enter the sum of lines 41 and 44.

Line 46--Divide line 41 by line 45, and enter the result.

Line 47--Divide line 44 by line 45, and enter the result.

Allocation of Medicare Direct GME Costs Between Part A and Part B--Use this section to compute the GME payments for title XVIII, Part A and Part B, and to compute the total GME payments applicable to titles V and XIX.

Line Descriptions

Line 48--Enter the amount from line 31.

Line 49--Complete for title XVIII only. Multiply line 46 by line 48, and enter the result. If you are a hospital subject to IPPS, transfer this amount to Worksheet E, Part A, line 52. Although this amount includes the Part A GME payments for subproviders, for ease of computation, transfer this amount to the primary hospital component worksheet only. If you are freestanding facility subject to TEFRA, transfer this amount to Worksheet E-3, Part I, line 15. If you are a freestanding IPF PPS, transfer this amount to Worksheet E-3, Part II, line 27. If you are a freestanding IRF PPS, transfer this amount to Worksheet E-3, Part III, line 28. If you are a freestanding LTCH PPS, transfer this amount to Worksheet E-3, Part IV, line 18.

Line 50--Complete for title XVIII only. Multiply line 47 by line 48, and enter the result. Transfer this amount to Worksheet E, Part B, line 28. Although this amount includes the Part B GME payments for subproviders, for ease of computation, transfer this amount to the hospital component only.

SECTIONS 4035 THROUGH 4039 ARE RESERVED FOR FUTURE USE.

4045.2 Part II - Computation of HHA Reimbursement Settlement.--

Line 10--Enter in column 1 the amount in Part I, column 1, line 1 less the amount in column 1, line 9. Enter in column 2 the sum of the amounts from Part I, columns 2 and 3, line 1 less the sum of the amounts in columns 2 and 3 on line 9. This line will only include pneumococcal, influenza, hepatitis B and injectable osteoporosis drugs reduced by primary payor amounts.

Lines 11 through 24--Enter in column 1 only for lines 11 through 14, as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 only on lines 15 and 16, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter on lines 18 through 20 the total DME, oxygen, prosthetics and orthotics payments, respectively, associated with home health PPS services (bill types 32 and 33). For lines 18 through 20 do not include any payments associated with services paid under bill type 34X. Obtain these amounts from your PS&R report.

Line 21--Enter in column 2 the Part B deductibles billed to program patients. Include any amounts of deductibles satisfied by primary payer payments.

Line 23--If there is an excess of reasonable cost over customary charges in any column on line 8, enter the amount of the excess in the appropriate column.

Line 25--Enter in column 2 all coinsurance billable to program beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of the costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 21 and primary payment amounts in column 3, line 9 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 27--Enter the allowable bad debts in the appropriate columns. If recoveries exceed the current year's bad debts, line 27 will be negative. This line is shaded as HHAs cannot generate bad debts.

Line 28--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 27. This line is shaded as HHAs cannot generate bad debts.

Line 29--Enter the result of line 26 plus 27.

Line 30--Enter any other adjustments. For example, enter an adjustment from changing the recording of vacation pay from the cash basis to accrual basis. (See CMS Pub. 15-1, chapter 21, §2146.4.)

Line 31--Enter the result of line 29 plus or minus line 30.

Line 31.01--Enter the sequestration adjustment amount from the PS&R report.

Line 32--Enter the interim payment amount from Worksheet H-5, line 4. For contractor final settlement, report on line 33 the amount from Worksheet H-5, line 5.99. For titles V and XIX, enter the interim payments from your records.

Line 34--The amounts show the balance due the provider or the program by entering the result of line 31 minus the sum of lines 31.01, 32 and 33. Transfer to Worksheet S, Part III, line 9 as applicable.

Line 35--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) A schedule showing the supporting details and computations for this line must be attached.

4046. WORKSHEET H-5 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.)

The column headings designate two categories of payments: Part A and Part B.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor. Do not include on this worksheet any payments made for DME or medical supplies charged to patients that are paid on the basis of a fee schedule.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA for cost and HHA PPS reimbursed services. The amount entered reflects payments for all episodes concluded in this fiscal year. **Do not include any payments received for fee scheduled services.** The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from your interim payments due to an offset against overpayments applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

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

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

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to the appropriate column on Worksheet H-4, Part II, line 32.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET H-5. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR CONTRACTOR. ***(EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)***

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

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening. Enter in column 2 the amount on Worksheet H-4, Part II, column 1, line 34. Enter in column 4 the amount on Worksheet H-4, Part II, column 2, line 34.

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

Line 7--Enter the total of the amounts on lines 4, 5.99, and 6. Enter in column 2 the amount on Worksheet H-4, Part II, column 1, line 31. Enter in column 4 the amount on Worksheet H-4, Part II, column 2, line 31.

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

4047. ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

This worksheet provides for the analysis of the direct and indirect expenses related to the renal dialysis cost centers, allocation of cost between inpatient and outpatient renal dialysis services where separate cost centers are not maintained, and the allocation of the cost to the various modes of outpatient dialysis treatment. The ancillary renal dialysis cost center is serviced by the general cost centers and includes all reimbursable cost centers within the provider organization which provide services to the renal dialysis department. The cost used in the analysis for the renal dialysis department is obtained, in part, from Worksheets A; B, Part I; and C. Complete a separate Worksheet I series for lines 74 and 94 of Worksheet A. In other words, complete one Worksheet I series for line 74 and one for line 94, if appropriate.

4048. WORKSHEET I-1 - ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

This part provides for recording the direct salaries and other direct expenses applicable to the total inpatient and outpatient renal dialysis cost center or outpatient renal dialysis cost center where you maintain a separate and distinct outpatient renal dialysis cost center. If you have more than one renal dialysis department, and/or more than one home dialysis department, submit one Worksheet I series combining the renal dialysis departments and a separate Worksheet I series combining the home dialysis departments. You must also have on file, as supporting documentation, a Worksheet I series for each renal dialysis department and for each home dialysis department along with the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-1, §2720. Do not combine the cost of the renal dialysis with home program dialysis reported separately on Worksheet A, lines 74 and 94.

This worksheet also provides for recording the indirect expenses applicable to the total renal or outpatient renal dialysis department obtained from Worksheet B, Part I, columns 1 through 23, line 74 as adjusted for post stepdown adjustments, if any. When completing a separate Worksheet I for home program dialysis, transfer the direct expenses from Worksheet B, Part I, columns 1 through 23, line 94. Do not combine the cost of the renal department with home program dialysis. These costs are listed separately on Worksheet A, lines 74 and 94, respectively.

Column Descriptions

Column 1--Enter on lines 1 through 8 the amounts included from Worksheet A, column 7 for salaries only. Enter on lines 10 through 16 and 18 through 26 the amounts from Worksheet B, Part I, all columns for lines 74 and 94. The subtotal on Worksheet I-1, line 27 agrees with the sum of Worksheet B, Part I, column 26, line 74 or line 94 if a home dialysis cost center was established and used on Worksheet A.

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

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

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

Line Descriptions

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

Line 4.01--Enter in column 1 the amount shown in your records for coinsurance billed to Medicare (Part B) patients. Include only coinsurance amounts that are related to the payments listed on line 2.01, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2 the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment.

Line 4.02--Enter in column 1 the amount shown in your records for coinsurance billed to Medicare (Part B) patients. Include only coinsurance amounts that are related to the payments listed on line 2.02, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2 the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment.

Line 4.03--Enter the sum of lines 4, 4.01 and 4.02, columns 1 and 2 respectively.

Line 5--Enter the uncollectible portion of the amounts entered on lines 3 and 4 reduced by any amount recovered during the cost reporting period. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 1 the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered prior to January 1, 2011. Transfer this amount to column 2.

Line 5.01--Enter in column 1 the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2011, but before January 1, 2012. Enter in column 2, 75 percent of the amount in column 1, plus 25 percent of the amount in column 1 times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, do not complete this line, but complete line 5.04.

Line 5.02--Enter in column 1 the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2012, but before January 1, 2013. Enter in column 2, 50 percent of the amount in column 1, plus 50 percent of the amount in column 1 times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, do not complete this line, but complete line 5.04.

Line 5.03--Enter in column 1 the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2013, but before January 1, 2014. Enter in column 2, 25 percent of the amount in column 1, plus 75 percent of the amount in column 1 times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, do not complete this line, but complete line 5.04.

Line 5.04--Enter in column 1 the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2014. Enter in column 2, 100 percent of the amount in column 1, times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, DO NOT complete lines 5.01, 5.02 or 5.03, but enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries for all services rendered on or after January 1, 2011. Enter in column 2, 100 percent of the amount in column 1, times the facility specific composite cost ratio on line 14.

Line 5.05--Enter in column 1 the sum of lines 5 through 5.04, column 1. This amount must reconcile to the provider's bad debt listing(s). Enter in column 2, the sum of lines 5 through 5.04, column 2.

Line 6--Enter the result of line 5.05, column 2 (including negative amounts) times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 7--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be included in the amount on line 5.05, column 1, i.e., line 7 is a subset of line 5.05, column 1.

Line 8--Enter the sum of lines 3 and 4, less line 5, in column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 2, the sum of lines 3.03, column 2 and 4.03 column 2, less line 5.05, column 2.

Line 9--Subtract line 3 from line 2, and enter 80 percent of the difference in column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, subtract line 3.03, column 2 from line 2.03, column 2, and enter 80 percent of the difference in column 2.

Line 10--Enter the result of line 1 minus the sum of lines 8 and 9, in column 1. If the result is negative, enter zero and do not complete line 11. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 2, the result of line 1 minus the sum of lines 8 and 9, column 2. For cost reporting periods beginning on or after January 1, 2013, do not complete this line.

Line 11--Enter in column 1, the lesser of line 5 or line 10, column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 1, the lesser of line 5.05, column 2 or line 10, column 2. For cost reporting periods that begin on or after October 1, 2012, enter in column 1, the lesser of line 6, column *1*, or line 10, column 2. For cost reporting periods beginning on or after January 1, 2013, enter in column 1, the result of line 6, column *1*. Transfer the amount on this line to Worksheet E, Part B, line 33.

Part II - Calculation of Facility Specific Composite Cost Percentage.--A facility specific composite cost percentage is applied to the facility's total bad debt amounts and associated cost data necessary to compute the ESRD facility bad debt payments. This percentage is computed by dividing your facility's basic composite rate costs by your total allowable expenses.

Line 12--For cost reporting periods that overlap or begin on or after January 1, 2011, enter the total allowable expenses from Worksheet I-4, column 2, line 11, plus Worksheet B-2, sum of the absolute values of lines 1 through 6, column 4.

Line 13--Enter total base composite rate costs from Worksheet I-4, column 2, line 11.

Line 14--Compute the facility specific composite cost percentage (line 13 divided by line 12).

Line 19--Enter the actual coinsurance billed to program patients (from your records).

Line 20--For title XVIII, enter the difference of line 17 minus line 19. For titles V and XIX, enter the difference of line 18 minus line 19.

Line 21--Enter allowable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records). If recoveries exceed the current year's bad debts, line 21 will be negative.

Line 22--Enter the result of line 21 (including negative amounts) times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 23--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 21.

Line 24--Enter the result of line 20 plus line 21. For cost reporting periods beginning on or after October 1, 2012, enter the result of line 20 plus line 22.

Line 25--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see CMS Pub. 15-1 chapter 21, §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 26--Enter the result of line 24 plus or minus line 25.

Line 26.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 26].

Line 27--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4.

Line 28--For contractor final settlement, report on this line the amount from Worksheet J-4, line 5.99.

Line 29--Enter the balance due provider/program (line 26 minus lines 26.01, 27 and 28), and transfer this amount to Worksheet S, Part III, columns as appropriate, lines as appropriate.

Line 30--Enter the program reimbursement effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with CMS Pub. 15-2, chapter 1, §115.2. Attach a schedule showing the supporting details and computation.

4056. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

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

Line Descriptions

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

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

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

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

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY. ***(EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)***

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

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

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

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

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

4064. WORKSHEET L - CALCULATION OF CAPITAL PAYMENT

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

Worksheet L consists of the following three parts:

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

COMPLETE EITHER PART I OR PART II, OR PARTS I AND III.

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

4064.1 Part I - Fully Prospective Method.--This part computes settlement under the fully prospective method only, as defined in 42 CFR 412.340. Use the fully prospective method for IPPS capital settlement when the hospital's base year hospital-specific rate is below the adjusted federal rate and for IPPS hospitals with cost reporting periods beginning after the capital PPS transition.

Line Descriptions

Line 1--Enter the amount of the federal rate portion of the capital DRG payments for other than outlier during the period.

Line 1.01--Enter the amount of the federal rate portion of the capital DRG payments for other than outlier during the period associated with Model 4 BPCI.

Line 2--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during the period. (See 42 CFR 412.312(c).)

Line 2.01--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during the period associated with Model 4 BPCI. (See 42 CFR 412.312(c).)

Indirect Medical Education Adjustment

Lines 3 - 6

Line 3--Enter the result of dividing the sum of total patient days (Worksheet S-3, Part I, column 8, lines 14 and 30) by the number of days in the cost reporting period (365 or 366 in case of leap year). Do not include statistics associated with an excluded unit (subprovider).

NOTE: Reduce total patient days by nursery days (Worksheet S-3, Part I, column 8, line 13), and swing bed days (Worksheet S-3, Part I, column 8, lines 5 and 6).

Line 4--Obtain the intern and resident amount from Worksheet E, Part A, line 18 plus line 25.

Line 5--Enter the result of the following calculation: $\{e^{.2822 \text{ x line } 4/\text{line } 3}\}-1$ where e = 2.71828. (See 42 CFR 412.322(a)(3) for limitation of the percentage of I&Rs to average daily census. Line 4 divided by line 3 cannot exceed 1.5.

Line 6--Multiply line 5 by *the sum of* lines 1 *and 1.01*.

Capital Disproportionate Share Adjustment

Lines 7 - 11

Enter the amount of the federal rate portion of the additional capital payment amounts relating to the disproportionate share adjustment. Complete these lines if you answered yes to line 45 on Worksheet S-2, Part I. (See 42 CFR 412.312(b)(3).) For hospitals qualifying for disproportionate share in accordance with 42 CFR 412.106(c)(2) (Pickle amendment hospitals), do not complete lines 7 through 9, and enter 11.89 percent on line 10.

Line 7--Enter the percentage of SSI recipient patient days (from your contractor or your records) to Medicare Part A patient days. This amount agrees with the amount reported on Worksheet E, Part A, line 30.

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

Line 9--Add lines 7 and 8, and enter the result.

Line 10--Enter the percentage that results from the following calculation: $(e^{.2025 \times \text{line } 9})-1$ where e equals 2.71828. If Worksheet S-2, Part I, line 22, column 2 is "Y" (Pickle amendment hospital), enter 11.89 percent.

Line 11--Multiply line 10 by *the sum of* line*s* 1 *and 1.01* and enter the result.

Line 12--Enter the sum of lines 1, *1.01*, 2, *2.01,* 6 and 11. For title XVIII, transfer this amount to Worksheet E, Part A, line 50.

4064.2 Part II - Payment Under Reasonable Cost.--This part computes capital settlement under reasonable cost principles subject to the reduction pursuant to 42 CFR 412.324(b). Use the reasonable cost method for capital settlement determinations for new providers under 42 CFR 412.324(b) for the first two years or for titles V or XIX determinations, if applicable. This part may also be completed for cost reporting periods beginning on or after October 1, 2002, for the first two years for new providers under 42 CFR 412.304(c)(2)(i) (response to Worksheet S-2, Part I, line 47, column 1 is "Y" and column 2 is "N").

Line Descriptions

Line 1--Enter the amount of program inpatient routine service capital costs. This amount is the sum of the program inpatient routine capital costs from the appropriate Worksheet D, Part I, column 7, sum of the amounts on lines 30 through 35 and 43 for the hospital (lines 40 through 42 as applicable for the subprovider).

Line 2--Enter the amount of program inpatient ancillary capital costs. This amount is the sum of the amounts of program inpatient ancillary capital costs from the appropriate Worksheet D, Part II, column 5, line 200.

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

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

Line 5--Multiply line 3 by line 4. For title XVIII, transfer the amount to Worksheet E, Part A, line 50.

Transfer this amount to Worksheet M-3, line 2.

Line 16--Enter the Medicare cost of pneumococcal and influenza vaccines and their administration costs. This is equal to the sum of the amount in column 1, line 14 plus column 2 (and applicable subscripts), line 14.

Transfer the result to Worksheet M-3, line 21.

4070. WORKSHEET M-5 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

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

Line Descriptions

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

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

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

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

DO NOT COMPLETE THE REMAINDER OF WORKSHEET M-5. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY. ***(EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)***

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

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

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

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

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

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