

Medicare

Provider Reimbursement Manual -

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

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

Transmittal 21

Date: January 2010

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
3600.2 - 3600.3	36-9 - 36-10 (2 pp.)	36-9 - 36-10 (2 pp.)
3604 (Cont.) - 3604 (Cont.)	36-25 - 36-28.4 (8 pp.)	36-25 - 36-28.4 (8 pp.)
3605.1 - 3605.2	36-29 - 36-32.1 (5 pp.)	36-29 - 36-32 (4 pp.)
3608.2 - 3608.2 (Cont.)	36-39 - 36-40 (2 pp.)	36-39 - 36-40 (2 pp.)
3610 (Cont.) - 3610 (Cont.)	36-51 - 36-52 (2 pp.)	36-51 - 36-52 (2 pp.)
3617 - 3617 (Cont.)	36-75 - 36-76 (2 pp.)	36-75 - 36-76 (2 pp.)
3621.5 (Cont.) - 3621.5 (Cont.)	36-101 - 36-102 (2 pp.)	36-101 - 36-102 (2 pp.)
3622.2 (Cont.) - 3622.2 (Cont.)	36-115 - 36-116 (2 pp.)	36-115 - 36-116 (2 pp.)
3630.1 (Cont.) - 3630.1 (Cont.)	36-136.1 - 36-138 (8 pp.)	36-136.1 - 36-138 (8 pp.)
3630.1 (Cont.) - 3630.1 (Cont.)	36-140.1 - 36-140.2 (2 pp.)	36-140.1 - 36-140.2 (2 pp.)
3630.2 (Cont.) - 3630.3	36-145 - 36-146 (2 pp.)	36-145 - 36-146 (2 pp.)
3631.1 - 3633.2 (Cont.)	36-155 - 36-158.6 (10 pp.)	36-155 - 36-158.5 (9 pp.)
3651 - 3651 (Cont.)	36-195 - 36-196 (2 pp.)	36-195 - 36-195 (2 pp.)
3660 - 3660.2 (Cont.)	36-211 - 36-212.2 (4 pp.)	36-211 - 36-212.2 (4 pp.)
3664 - 3666	36-223 - 36-226.1(5 pp.)	36-223 - 36-226.1(5 pp.)
3690 (Cont.)	36-503 - 36-506.2 (7 pp.)	36-503 - 36-506.2 (7 pp.)
	36-533 - 36-534 (2 pp.)	36-533 - 36-534 (2 pp.)
	36-537 - 36-540 (4 pp.)	36-537 - 36-540 (4 pp.)
	36-593 - 36-594 (2 pp.)	36-593 - 36-594 (2 pp.)
3695 (Cont.)	36-705 - 36-706 (2 pp.)	36-705 - 36-706 (2 pp.)
	36-723 - 36-728 (9 pp.)	36-723 - 36-728 (8 pp.)
	36-749 - 36-752 (4 pp.)	36-749 - 36-752 (4 pp.)
	36-759 - 36-762.2 (6 pp.)	36-759 - 36-762 (4 pp.)
	36-765 - 36-766.5 (7 pp.)	36-765 - 36-766.5 (7 pp.)
	36-770.1 - 36-770.2 (2 pp.)	36-770.1 - 36-770.2 (2 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE:

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

Significant Revisions:

- Worksheet S-2 - Line 21.01 is amended to ascertain if providers that qualify for disproportionate share (DSH) payments are also subject to the "Pickle Amendment."
 - Line 21.08 is added to identify the method of accumulating the day count (including labor/delivery days) for Title XIX and total days to refine the calculation for DSH payments in accordance with the Federal Register, volume 74, number 165, date August 27, 2009, page 43899, effective for cost reporting periods beginning on or after October 1, 2009.
 - Line 30.03 is eliminated effective for cost reporting periods beginning on or after October 1, 2009, as critical access hospitals (CAHs) will complete Worksheet D, Part V, line 65 only for ambulance services that were billed as exempt from the ambulance fee schedule as indicated in the provider's accounting books and records or the Provider Statistical and Reimbursement (PS&R) report type 85C.

- Worksheet S-3, Part I - Line 26, columns 5 and 6 are revised to reflect the exclusion of observation patient days from the computation of the disproportionate patient percentage (DPP) and from the computation of bed days available for the purpose of computing indirect medical education (IME) in accordance with the Federal Register, volume 74, number 165, date August 27, 2009, page 43905, effective for cost reporting periods beginning on or after October 1, 2009.
 - Line 29 is added to capture the day count of including labor/delivery days for Title XIX and total days to refine the calculation for DSH payments in accordance with the Federal Register, volume 74, number 165, date August 27, 2009, page 43899, effective for cost reporting periods beginning on or after October 1, 2009.
- Worksheet A - As a provider invoked option, nonstandard cost centers for Cardiac Rehabilitation, Hyperbaric Oxygen Therapy, and Lithotripsy are established for use on Worksheet A as identified in Table 5 of the electronic cost reporting (ECR) specifications.
 - Line 55.01, the “Implantable Devices Charged to Patients” cost center established in T20, is re-designated to line 55.30.
- Worksheet E, Part A - The calculation of line 3 is revised to reflect the subtraction of total observation days from the computation of bed days available for the purpose of IME and the calculation of line 4.01 is revised to reflect the exclusion of subsequently admitted observation days from the computation of the DPP in accordance with the Federal Register, volume 74, number 165, date August 27, 2009, page 43905, effective for cost reporting periods beginning on or after October 1, 2009.
 - Line 5.05 is revised to reflect the update of the cost per renal dialysis treatment for the calendar year 2010 (\$135.15) as indicated in change request (CR) 6679, transmittal 113, dated October 30, 2009.
 - Lines 55 and 56 are revised to reflect the outlier reconciliation time value of money as input amounts.
- Worksheet E, Part B - Line 53 is revised to reflect the outlier reconciliation time value of money as an input amount.
- Worksheet E-3, Part I - Instructions revised for inpatient rehabilitation facilities (IRF) to reflect the update for the low income patient (LIP) adjustment factor and the medical education adjustment factor both effective for discharges on or after October 1, 2009 in accordance with the Federal Register, volume 74, number 151, dated August 7, 2009, page 39774.
- Worksheet L, Part I - Section is revised to reinstate the full capital IME teaching adjustment factor (previously addressed in T20) applied for fiscal year 2009 and subsequent in accordance with the Federal Register, volume 74, number 165, dated August 27, 2009, page 43929, giving providers the full capital IME teaching amount for discharges occurring on or after October 1, 2008.
- Worksheet M-3 - Line 14 is revised to implement section 102 of Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 for rural health clinics (RHCs) and Federally qualified health centers (FQHCs), to phase out the outpatient mental health treatment limitation over the 5 year period from 2010 through 2014.
- Worksheet M-4 - Columns 2.01 and 2.02 are added to capture relevant data and calculate the costs of H1N1 influenza vaccines; and the simultaneous administration of H1N1 influenza and seasonal influenza vaccines and administration under the authority of section 1861(s)(10)(A) of the Social Security Act.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after October 1, 2009.

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

4. Round to 5 decimal places:
 - a. Sequestration (e.g., 2.092 percent is expressed as .02092)
 - b. Payment reduction (e.g., capital reduction, outpatient cost reduction)
5. Round to 6 decimal places:
 - a. Ratios (e.g., unit cost multipliers, cost/charge ratios, days to days)

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

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

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

LIP	-	Low Income Patient
LOS	-	Length of Stay
LCC	-	Lesser of Reasonable Cost or Customary Charges
LTCH	-	Long Term Care Hospital
MA	-	Medicare Advantage (previously known as M+C)
M+C	-	Medicare + Choice (also known as Medicare Part C)
MCP	-	Monthly Capitation Payment
MDH	-	Medicare Dependent Hospital (10/97)
MED-ED	-	Medical Education
MIPPA	-	Medicare Improvements for Patients and Providers Act of 2008
MMA	-	Medicare Prescription Drug Improvement and Modernization Act of 2003
MSA	-	Metropolitan Statistical Area (10/97)
MS-DRG	-	Medicare Severity Diagnosis-Related Group
MSP	-	Medicare Secondary Payer
NF	-	Nursing Facility
NHCMQ	-	Nursing Home Case Mix and Quality Demonstration
NPI	-	National Provider Identifier
OBRA	-	Omnibus Budget Reconciliation Act
OLTC	-	Other Long Term Care
OOT	-	Outpatient Occupational Therapy
OPD	-	Outpatient Department
OPO	-	Organ Procurement Organization
OPPS	-	Outpatient Prospective Payment System
OPT	-	Outpatient Physical Therapy
OSP	-	Outpatient Speech Pathology
ORF	-	Outpatient Rehabilitation Facility
PBP	-	Provider-Based Physician
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PRO	-	Professional Review Organization
PS&R	-	Provider Statistical and Reimbursement System
PT	-	Physical Therapy
RCE	-	Reasonable Compensation Equivalent
RHC	-	Rural Health Clinic
RPCH	-	Rural Primary Care Hospitals
RT	-	Respiratory Therapy
RUG	-	Resource Utilization Group
SCH	-	Sole Community Hospitals
SCHIP	-	State Children Health Insurance Program
SNF	-	Skilled Nursing Facility
SSI	-	Supplemental Security Income
TEFRA	-	Tax Equity and Fiscal Responsibility Act of 1982
TOPS	-	Transitional Outpatient Payment System
UPIN	-	Unique Physician Identification Number
WKST	-	Worksheet

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

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

Where applicable, at the end of select paragraphs and/or sentences the effective date (s) is indicated in parentheses () for cost reporting periods ending on or after that date, i.e., (12/31/01).

If the facility operates an Intermediate Care Facility/Mental Retarded (ICF/MR) subscript line 7 to 7.01 and enter the data on that line. Note: Subscribing is allowed only for the purpose of reporting an ICF/MR. FIs will reject a cost report attempting to report more than one nursing facility (9/96).

Line 8--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 9--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. Do not use this line 10.

Line 11--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 12--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 4, 5, and 6. (10/00) Do not use this line 13.

Line 14--This line is used by rural health clinics (RHC) and/or Federally qualified health clinics (FQHC) 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 on lines 14 through 14.09. For FQHCs, report on lines 14.10 through 14.19. Report the required information in the appropriate column for each. (See Exhibit 2, Table 4, Part IV, page 36-755.) RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-4, chapter 9, §30.8. Do not subscript this line if you elect to file under the consolidated cost reporting method. See section 3608.2 for further instructions.

Line 15--This line is used by hospital-based comprehensive outpatient rehabilitation facilities, community mental health centers, outpatient physical therapy, outpatient occupation therapy, and/or outpatient speech pathology clinics. Report these provider types on lines 15 through 15.09; 15.10 through 15.19; 15.20 through 15.29, 15.30 through 15.39; and 15.40 through 15.49, respectively. (See Exhibit 2, Table 4, Part III, page 36-755.)

Line 16--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 17--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-II, §§102.1-102.3 for situations where you may file a short period cost report.)

Line 18--Indicate the type of control or auspices under which the hospital is conducted as indicated.

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

Lines 19 and 20--Indicate in column 1, as applicable, the number listed below which best corresponds with the type of services provided. Subscript for lines as needed, i.e., line 20.01 for subprovider 2, etc.

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

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 lengths of stay greater than 25 days. These hospitals may be identified in 2 ways:

o Those hospitals properly identified by a distinct type of facility code in the third digit of the Medicare provider number; or

o Those hospitals that are certified as other than long term care hospitals, but which have 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 21--Indicate in column 1 if your hospital is either urban or rural at the end of the cost reporting period. Enter 1 for urban or 2 for rural. Indicate in column 2 if your facility is geographically classified or located in a rural area and contains 100 or fewer beds (see Worksheet E, Part A, line 3). Enter yes or "N" for no. (Effective after 8/1/2000s and before 2/29/04 FYE)

Line 21.01--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)?(Effective for FYB 10/1/09) Enter in column 2 "Y" for yes or "N" for no.*

Line 21.02--Has your facility received a geographic reclassification after the first day of the cost reporting period from rural to urban or *vice* versa? Enter "Y" for yes and "N" for no. If yes, report in column 2 the effective date. If the effective date is other than the beginning date of the provider's fiscal year, subscript Worksheet E, Part A. (4/30/03s) (on or before 2/29/04 FYE)

Line 21.03--Indicate in column 1 your hospital's actual geographic location by entering either 1 for Urban or 2 for Rural. If you answer Urban in column 1, indicate a "Y" for yes and "N" for no in column 2 if you have received either a Wage or Standard Geographic reclassification to a Rural location. If column 2 is "Y" enter in column 3 the effective date. Does this facility contain 100 (see Worksheet E, Part A, line 3) or fewer beds in accordance with 42 CFR 412.105? Enter in column 4 "Y" for yes or "N" for no. (2/29/04) Enter in column 5 the CBSA number of the provider. (12/31/2006)

Line 21.04--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. (2/29/04)

Line 21.05--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. (2/29/04)

Line 21.06--Effective for services rendered after December 31, 2005, does the hospital qualify

for the three year transition of hold harmless payments for small rural hospitals under the prospective payment system for hospital outpatient department services, under DRA, section 5105 or the extension of this provision under MIPPA, section 147 effective for services rendered from January 1, 2009, through December 31, 2009? Enter , "Y" for yes or "N" for no. Also see CR 4367, transmittal 877, dated February 24, 2006 and CR 6320, transmittal 1657, dated December 31, 2008, as applicable. (1/1/2006s) This response impacts the TOPs calculation on worksheet E, Part B, line 1.06.

Line 21.07--Effective for services rendered from January 1, 2009, through December 31, 2009, does the hospital qualify as a SCH with 100 or fewer beds reimbursed under the prospective payment system for hospital outpatient department services, under MIPPA 147? Enter "Y" for yes or "N" for no. Also see CR 6320, transmittal 1657, dated December 31, 2008. This response impacts the TOPs calculation on worksheet E, Part B, line 1.06. (1/1/2009s)

Line 21.08--Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on Worksheet S-3, Part I, line 29, column 5 during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no. (10/1/2009b)

Line 22--Are you classified as a referral center? Enter "Y" for yes and "N" for no. *See 42 CFR 412.96.*

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

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

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

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

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

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

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

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

Line 24--If this is an organ procurement organization (OPO), enter the OPO number in column 2, the termination date in column 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 28.02--Enter the updated hospital based SNF facility rate supplied by your fiscal intermediary if you have not transitioned to 100 percent SNF PPS payment. Enter in column 2

the classification of the SNF at the end of the cost reporting period, either (1) for urban or (2) for rural. Enter in column 3 the SNF's CBSA code. Where the cost reporting period overlaps October 1, 2005, enter in column 3 the SNF's CBSA code for services rendered prior to October 1, 2005, and enter in column 4 the SNF's CBSA code for services rendered on or after October 1, 2005. For cost reporting periods which begin on or after October 1, 2005, enter in column 4 the SNF's CBSA code. If you are located in a rural area enter your State code as your CBSA or CBSA code, as applicable.

Lines 28.03 through 28.20--A notice published in the August 4, 2003, **Federal Register**, Vol. 68, No. 149 provided for an increase in RUG payments to Hospital based Skilled Nursing Facilities (SNF) for payments on or after October 1, 2003, however, this data is required for cost reporting periods beginning on or after October 1, 2003. Congress expected this increase to be used for direct patient care and related expenses. Subscript line 28 into the following lines: 28.03 - Staffing, 28.04 - Recruitment, 28.05 - Retention of Employees, 28.06 - Training, and 28.07-28.20 - Other. Enter in column 1 the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. For each line, indicate in column 2 whether the increased RUG payments received for cost reporting periods beginning on or after October 1, 2003 reflects increases associated with direct patient care and related expenses by responding "Y" for yes. Indicate "N" for no if there was no increase in spending in any of these areas. If the increased spending is in an area not previously identified in areas one through four, identify on the "Other (Specify)" line(s), the cost center(s) description and the corresponding information as indicated above.

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

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

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

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

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

Line 30.03--If this facility qualifies as an CAH is it eligible for cost reimbursement for ambulance services (12/21/00s). Enter a "Y" for yes or a "N" for no. If yes, enter in column 2 the date eligibility determination was issued. (See 42 CFR 413.70(b)(5)) *For CAHs with cost reporting periods beginning on or after October 1, 2009, do not complete this question.*

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

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

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

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

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

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

Line 36--Do you elect the fully prospective payment methodology for capital costs? (See 42 CFR 412.340.) (This also includes providers that were previously hold harmless, but are now considered 100 percent fully prospective for purposes of completing Worksheet L, Part I in lieu of Worksheet L, Part II.) Enter "Y" for yes or "N" for no in the applicable columns. (For cost reporting periods beginning on or after October 1, 2001, the response is always "Y", except for new providers under 42 CFR 412.304(c)(2), with initial cost reporting periods beginning on or after October 1, 2002, for which the response maybe "N" for the provider's first 2 years.) Questions 36 and 37 are mutually exclusive.

Line 36.01--Does your facility qualify and receive payments for capital disproportionate share in accordance with 42 CFR 412.320? Enter "Y" for yes and "N" for no. If you are eligible as a result of the Pickle amendment, enter "P" instead of "Y."

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

Line 37--Do you elect the hold harmless payment methodology for capital costs? (See 42 CFR 412.344.) Enter "Y" for yes or "N" for no in the applicable columns. (Not applicable for cost reporting periods beginning on or after October 1, 2001, except for the third thru tenth cost reporting period of new providers under 42 CRF 412.324(b)(2) certified prior to October 1, 1999. If a new provider's response is "Y", complete Worksheet A, line 90 and Worksheet B, Parts II and III.)

Line 37.01--If you are a hold harmless provider, are you filing on the basis of 100 percent of the Federal rate even though payment on this basis may result in lower payment under the hold harmless blend? Enter "Y" for yes or "N" for no in the applicable columns. (Not applicable for cost reporting periods beginning on or after October 1, 2001, except for the third thru tenth cost reporting periods of new providers under 42 CRF 412.324(b)(2) certified prior to October 1, 1999.)

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

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

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

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

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

Line 39--Do not use this line.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This worksheet consists of three parts:

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

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

Column Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

Line Descriptions

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

Labor and delivery days (as defined in the instructions for line 29 of Worksheet S-3, Part I) must not be included on this line.

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

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

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

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

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

Line 12--Enter the sum of lines 5 - 11 for columns 1 - 6, and for columns 12 - 15, enter the amount from line 1. For columns 7 - 11, enter the total for each from your records.

Labor and delivery days (as defined in the instructions for line 29 of Worksheet S-3, Part I) must not be included on this line.

Line 13--Enter the number of outpatient visits for cost reporting periods beginning prior to October 1, 1997, for a rural primary care hospital by program and total. An outpatient RPCH visit is defined in 42 CFR 413.70(b)(3)(iii). Begin reporting visits for CAHs for cost reporting periods beginning on or after October 1, 2000.

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

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

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

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

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

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

Line 19--Do not use this line.

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

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

Line 22--Do not use this line.

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

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

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

Effective for cost reporting periods beginning on or after October 1, 2009, do not enter any information on line 26, columns 5.01, 5.02, 6.01, and 6.02 since all the observation bed days (both those for the patients that are subsequently admitted as inpatients and those who are discharged) will be excluded from the computation of the disproportionate patient percentage (DPP) on Worksheet E, Part A, line 4.01 and will be deducted from the computation of the beds on Worksheet E, Part A, line 3 for purpose of calculating the indirect medical education (IME) and disproportionate share hospital (DSH) payments. See Federal Register, volume 74, number 165, date August 27, 2009, page 43905, effective for cost reporting periods beginning on or after October 1, 2009.

Effective for cost reporting periods beginning on or after October 1, 2004 *and beginning before October 1, 2009*, for line 26 add (unshade) column 5 (total Medicaid observation bed days), subscript column 5 by adding column 5.01 (Medicaid observation bed days for patients who are subsequently admitted as inpatients but only the hours up to the time of admission), and column 5.02 (Medicaid observation bed days for patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge).

Additionally, *effective for cost reporting periods beginning on or after October 1, 2004, and beginning before October 1, 2009*, subscript column 6 by adding column 6.01 (Total observation bed days for patients who are subsequently admitted as inpatients but only the hours up to the time of admission) and column 6.02 (Total observation bed days for patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge).

The amount in column 5 must equal the sum of columns 5.01 and 5.02 and the amount in column 6 must equal the sum of columns 6.01 and 6.02. (10/1/2004b)

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

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

Line 29--*Effective for cost reporting periods beginning on or after October 1, 2009, indicate in column 5 the count of labor/delivery days for Title XIX and in column 6 the total count of labor/delivery days for the entire facility.*

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

LDP room during a typical month, and apply that percentage through the rest of the year to determine the number of labor and delivery days to report on line 29. Maternity patients must be admitted to the hospital as an inpatient for their labor and delivery days to be included on line 29. These days must not be reported on Worksheet S-3, Part I, line 1 or line 12.

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

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

Column 1

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

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

NOTE: Capital related salaries, hours, and wage-related costs associated with lines 1 through 4 of Worksheet A must be excluded from Worksheet S-3, Parts II and III.

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

PTO salary cost -- The required source for costs on Worksheet A is the general ledger (see Provider Reimbursement Manual, Part II, section 3610 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

3608. STATISTICAL DATA OUTPATIENT PROVIDERS

3608.1 Worksheet S-6 - Hospital-Based Outpatient Rehabilitation Provider Data.--In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to hospital-based outpatient rehabilitation providers. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility. For cost reporting periods beginning on or after April 1, 2001, if all services provided by the CORF and for cost reporting periods beginning on or after July 1, 2003, OPTs, OSPs, or OOTs, are paid 100 percent from fee scheduled payments, skip lines 1 through 18 and enter an affirmative response on line 19 of this worksheet and do not complete the corresponding J series worksheets.

This worksheet provides statistical data related to the human resources of the outpatient rehabilitation provider. The data maintained depends on the services provided by the outpatient rehabilitation provider. FTE data is required by employee staff, contracted staff, and total. The human resources statistics are required for each of the job categories specified on lines 1 through 17. Enter any additional categories needed on line 18.

Line 19- Is this component paid 100 percent under established fee schedules? Enter a "Y" and a "N" for no.

Enter the number of hours in your normal work week in the space provided.

Report in column 1 the full time equivalent (FTE) employees on the outpatient rehabilitation provider's payroll. These are staff for which an IRS Form W-2 was issued.

Report in column 2 the FTE contracted and consultant staff of the outpatient rehabilitation provider.

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

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

3608.2 Worksheet S-8 - Provider-Based Rural Health Clinic/Federally Qualified Health Center Provider Statistical Data (1/98).--Effective with services rendered on and after January 1, 1998, in accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain separate statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based Federally qualified health centers (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility. RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-4, chapter 9, §30.8.

Lines 1 and 1.01--Enter the full address of the RHC/FQHC.

Line 2--For FQHCs only, enter your appropriate designation (urban or rural). See §505.2 of the RHC/FQHC Manual for information regarding urban and rural designations. If you are uncertain of your designation, contact your intermediary. RHCs do not complete this line.

Lines 3 through 8--In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 9--Subscript line 9 as needed to list all physicians furnishing services at the RHC/FQHC. Enter the physician's name in column 1, and the physician's Medicare billing number in column 2. This line is not applicable for cost reporting periods ending on or after May 31, 2009.

Line 10--Subscript line 10 as needed to list all supervisory physicians. Enter the physician's name in column 1, and the number of hours the physician spent in supervision in column 2. This line is not applicable for cost reporting periods ending on or after May 31, 2009.

Line 11--If the facility provides other than RHC or FQHC services (e.g., laboratory or physician services), answer "Yes" and enter the type of operation on subscripts of line 12 otherwise enter "N" for no.

Line 12 --Enter in columns 1 through 14 the starting and ending hours in the applicable columns for the days that the facility is available to provide RHC/FQHC services. Enter the starting and ending hours in the applicable columns 1 through 14 for the days that the facility is available to provide other than RHC/FQHC services. When entering time do so as military time, e.g., 2:00 p.m. is 1400.

Line 13--Have you received an approval for an exception to the productivity standards? Enter a "Y" for yes and an "N" for no.

Line 14--Is this a consolidated cost report as defined in the Rural Health Clinic Manual? If yes, enter in column 2 the number of providers included in this report, complete line 15, and complete only one worksheet series M for the consolidated group. If no, complete a separate worksheet S-8 for each component accompanied by a corresponding worksheet M series.

Line 15--Identify provider's name and number filing the consolidated cost report.

Line 16--Are you claiming allowable GME costs for services rendered on and after January 1, 1999, as a result of your substantial payment for interns and residents. If yes, enter the number of program visits in the appropriate column performed by interns and residents (1/99).

Line 17--For cost reporting periods which overlap July 1, 2001, is this a *small* hospital with under 50 beds based on the calculation method in §3664? Enter a "Y" for yes *or* "N" for no. If yes, subscript the columns on M-3 to accommodate the application or exemption of the payment limits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 55--Include the expense of medical supplies charged to patients. These items are low cost medical supplies generally not traceable to individual patients. Do not include high cost implantable devices on this line. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 15 (central service and supply) based on the recommended statistic of *costed* requisitions.

Line 55.30--Include the expense of implantable devices charged to patients. The types of items includable on this line are high cost implantable devices chargeable and traceable to individual patients. Do not include low cost medical supplies on this line. When determining what costs are reported in this cost center, providers should use costs associated with implantable devices bearing revenue codes identified in the FR, Vol. 73, No. 161, page 48462, dated August 19, 2008. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 15 (central service and supply) based on the recommended statistic of *costed* requisitions. Identify this line with the appropriate cost center code according to Table 5 of the electronic reporting specifications. This cost center is effective for cost reporting periods beginning on or after May 1, 2009.

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

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

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

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

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

3617. WORKSHEET B, PART I - COST ALLOCATION - GENERAL SERVICE COSTS
AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

Base cost data on an approved method of cost finding and on the accrual basis of accounting except where government institutions operate on a cash basis of accounting. (See 42 CFR 413.24(a).) Cost data based on such basis of accounting is acceptable subject to appropriate treatment of capital expenditures. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by you to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs. The various cost finding methods recognized are outlined in 42 CFR 413.24. Worksheets B, Part I, and B-1 have been designed to accommodate the stepdown method of cost finding. Modify these worksheets to accommodate other methods of cost finding approved prior to October 1, 1991.

The provider can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the intermediary, in writing, 90 days prior to the end of that reporting period. The intermediary has 60 days to make a decision and notify the provider of that decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or should demonstrate simplification in maintaining the changed statistics. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used.

As an alternative approach to the cost finding methods identified in HCFA Pub. 15-I, §2306, the provider may request a simplified cost allocation methodology. This methodology reduces the number of statistical bases a provider maintains. It may result in reducing Medicare reimbursement. A comparison is recommended if the possible loss reimbursement is surpassed by the reduced costs of maintaining voluminous statistics. The following statistical bases must be used for purposes of allocating overhead cost centers. There can be no deviation of the prescribed statistics and it must be utilized for all the following cost centers.

Buildings and Fixtures	Square Footage
Movable Equipment	Square Footage
Maintenance and Repairs	Square Footage
Operation of Plant	Square Footage
Housekeeping	Square Footage
Employee Benefits	Salaries
Cafeteria*	Salaries
Administrative and General	Accumulated Costs
Laundry and Linen	Patient Days
Dietary**	Patient Days
Social Service	Patient Days
Maintenance of Personnel	Eliminated
Nursing Administration	Nursing Salaries
Central Services and Supply	Costed Requisitions
Pharmacy	Costed Requisitions
Medical Records and Library	Gross Patient Revenue
Nursing School*	Assigned Time
Interns and Residents	Assigned Time
Paramedical Education	Assigned Time
Nonphysician Anesthetists	100 percent to Anesthesiology

NOTE: If you are paid on a prospective payment basis, the capital consistency rules will apply. The election of the alternative method discussed above can not result in inappropriately shifting costs.

*Contract labor is not included and is not grossed up.

**If this is a meals on wheels program, a Worksheet A-8 adjustment is required.

Once the simplified method is elected, the provider must continue to use this method for no less than 3 years, unless a change of ownership occurs.

In addition, the following overhead cost center statistics can be substituted for the recommended statistics printed on Worksheet B-1. The 90-day and 60-day rule discussed above still applies, as well as capital consistency.

Housekeeping	Square Footage
Cafeteria	FTEs
Maintenance of Personnel	Eliminated and moved to A&G
Medical Records	Gross Patient Revenue

Worksheet B, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within your organization, other general service cost centers, inpatient routine service cost centers, ancillary service cost centers, outpatient service cost centers, other reimbursable cost centers, special purpose cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet A, column 7.

All direct graduate medical education costs (inpatient and outpatient in approved programs) are reimbursed based on a specific amount per resident as computed on Worksheet E-3, Part IV. Costs applicable to interns and residents must still be computed in columns 22 and 23. These costs are, however, eliminated from total costs in column 26, unless you qualify for the exception. See the instructions for column 26 for a more detailed explanation.

Worksheet B-1 provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B, Part I. To facilitate the allocation process, the general format of Worksheets B, Part I, and B-1 is identical. Each general service cost center has the same line number as its respective column number across the top. Also, the column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each routine service, ancillary outpatient service, other reimbursable, special purpose, and nonreimbursable cost center are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheet A. If you have subscribed any lines on Worksheet A, subscript the same lines on these worksheets.

NOTE: General service columns 1 through 24 and subscripts thereof must be consistent on Worksheets B, Parts I, II, and III; H-5, Part I, J-1, Part I; and L-1, Part I.

The statistical basis shown at the top of each column on Worksheet B-1 is the recommended basis of allocation of the cost center indicated. If a different basis of allocation is used, you must indicate the basis of allocation actually used at the top of the column *subject to the provisions of PRM-1, section 2313.*

Most cost centers are allocated on different statistical bases. However, for those cost centers with the same basis (e.g., square feet), the total statistical base over which the costs are allocated differs

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

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

For CAHs (BIPA §205), enter the charges for the period you are subject to the limit and/or blend and the subscripted line the charges for which you are exempt from the limit and/or blend (see Worksheet S-2, line 30.03). If you are exempt for the full cost reporting period only complete line 65, no subscripts are required. *For CAHs with cost reporting periods beginning on or after October 1, 2009, complete line 65 only for ambulance services that were billed as exempt from the ambulance fee schedule (from your records or PS&R report type 85C).*

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

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

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

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

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

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

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

Generally, CAHs follow the instructions for ambulance services subject to the limit (10/1/97b) and/or the blend (4/1/02s). However, CAHs eligible for cost reimbursement for ambulance (Worksheet S-2, line 30.03, column 1 = "Yes") multiply column 1 times column 5 and enter the result. (12/21/00s) *CAHs eligible for cost reimbursement for ambulance services (billed as exempt from the ambulance fee schedule) effective for cost reporting periods beginning on or after October 1, 2009, such ambulance services on line 65 are transferred from your records or PS&R report type 85C. Multiply column 1 times column 5 and enter the result.*

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

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

Line Descriptions

Line 44--Generally, for title XVIII, Medicare outpatient covered clinical laboratory services are paid on a fee basis, and should not be included on this line. Outpatient CAH clinical laboratory services rendered on or after November 29, 1999 will be paid on a reasonable cost basis not subject to deductibles and coinsurance. In addition, hospital outpatient laboratory testing by a hospital

Line 58.01--Starting with the first full cost reporting period and counting forward, enter from the third full cost reporting period the lesser of the hospital's inpatient operating cost per discharge (line 53/line 54) or line 55, updated and compounded by the market basket for each year through the current reporting year. If the third full cost reporting period ended during or before the Federal fiscal year 1996 use the amounts from fiscal year 1996. For hospitals where its third full cost reporting period ended in the Federal fiscal year 1997 or subsequent fiscal period enter the inpatient operating cost per discharge updated and compounded by the market basket for each year through the current reporting year.

Line 58.02--Enter from the prior year cost report, the lesser of the hospital's inpatient operating cost per discharge (line 53/line 54) or line 55, updated by the market basket.

Line 58.03--For cost reporting periods beginning on or after October 1, 1997, if (line 53/line 54) is less than the lower of lines 55, 58.01 or 58.02, enter the lesser of 50 percent of the amount by which operating costs (line 53) are less than expected costs (line 54 times line 58.02), or 1 percent of the target amount (line 56); otherwise enter zero. *See 42 CFR 413.40(d)(4)(i).*

For long-term care hospitals and psychiatric hospitals or psychiatric subproviders the 1 percent limitation is increased to 1.5 percent for cost reporting periods beginning on and after October 1, 2000 and before October 1, 2001 and to 2 percent for cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002. For cost reporting periods beginning on or after 10/1/2002, the instructions in the above paragraph are again applicable.

Line 58.04--If line 57 is a negative amount (actual inpatient operating cost is greater than the target amount) and line 53 is greater than 110 percent of line 56, enter on this line the lesser of (1) or (2): (1) 50 percent of the result of (line 53 minus 110 percent of line 56) or (2) 10 percent of line 56; otherwise enter zero. *See 42 CFR 413.40(d)(3).*

Line 59--For cost reporting periods beginning prior to October 1, 1997, enter the sum of lines 52 and 58 plus the lesser of line 53 or line 56. For cost reporting periods beginning on or after October 1, 1997, if line 57 is a positive amount, enter the sum of lines 52, 53, 58 and 58.03 (if applicable). If line 57 is a negative amount enter the sum of lines 52, 56, and 58.04. If line 57 is zero, enter the sum of lines 52 and 56. New providers enter the lesser of lines 53 or 56 plus line 52. TEFRA providers (42 CFR §413.40(j)), except cancer and children's hospitals, for services rendered on and after October 1, 1997 and on or before September 30, 2002, are required to reduce capital to 85 percent of reported costs. To recalculate line 52, for cost reporting periods that overlap the October 1, 1997 effective date, multiply the capital pass through costs included on lines 50 and 51 of Worksheet D-1, which are obtained from Worksheet D, Parts I and II, by the ratio of days on and after October 1, 1997, to total days for the period. Multiply that result by 85 percent and add to that 100 percent of the ratio of days prior to October 1, 1997, to total days applied to the capital pass through amount. For cost reporting periods beginning on or after October 1, 1997, multiply the capital amount reported on lines 50 and 51 by 85 percent. Add the result of the 85 percent of capital to the non capital pass through costs included on lines 50 and 51 (10/1/97s). To recalculate line 52, for cost reporting periods that overlap the September 30, 2002 expiration date, multiply the capital pass through costs included on lines 50 and 51 of Worksheet D-1, which are obtained from Worksheet D, Parts I and II, by the ratio of days on and before September 30, 2002, to total days for the period applied to the capital pass through amount. Multiply that result by 85 percent and add to that 100 percent of the ratio of days after September 30, 2002, to total days for the period. For cost reporting periods beginning on or after October 1, 2002, multiply the capital amount reported on lines 50 and 51 by 100 percent. Add the result of the 100 percent of capital to the non capital pass through costs included on lines 50 and 51 as the capital reduction is no longer applicable (9/30/02s).

Lines 59.01 through 59.08--Lines 59.01 through 59.08 will be completed for long-term care providers with cost reporting periods beginning on or after October 1, 2002 and before October 1, 2006, that have not elected to be reimbursed at 100 percent of the Federal rate.

Line 59.01--Enter the allowable inpatient cost per discharge, computed as line 59 divided by line 54.

Line 59.02--Enter the number of program discharges occurring from the beginning of the cost reporting period through June 30. For full year cost reporting periods ending June 30, this amount will agree with the discharges entered on line 54.

Line 59.03--Enter the number of program discharges occurring from July 1 through the end of the cost reporting period.

NOTE: Subscripted line 59.04 and 59.07 will be required for cost reporting periods greater than 12 months that overlap two July 1 dates.

Line 59.05 through 59.07--Compute the reduced inpatient cost per discharge for each period by applying the appropriate budget neutrality factor to the allowable inpatient cost per discharge reported on line 59.01. Budget neutrality factors have been identified in the Federal Register dated August 30, 2002, page 56034; June 6, 2003, page 34153; May 7, 2004, page 25703; *May 6, 2005, page 24202; May 12, 2006, page 27841; and May 11, 2007, page 26900* and are reflected as follows:

- 93.40 percent for discharges occurring from 10/1/2002 through 6/30/2003.
- 94.00 percent for discharges occurring from 7/1/2003 through 6/30/2004.
- 99.50 percent for discharges occurring from 7/1/2004 through 6/30/2005.
- 1.000 (a 0.0 percent reduction) for discharges occurring from 7/1/2005 through 6/30/2006.
- 1.000 (a 0.0 percent reduction) for discharges occurring from 7/1/2006 through 6/30/2007.
- *The budget neutrality factor is not computed for discharges occurring on or after 7/1/2007.*

Line 59.08--Enter the sum lines 59.02 times 59.05, 59.03 times 59.06, and 59.04 times 59.07 (if applicable). Transfer this amount to Worksheet E-3, Part I, line 1 for long-term care hospital providers with cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, that have not elected to be reimbursed at 100 percent of the Federal rate.

Line 60--Enter the amount of Medicare swing bed-SNF type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-SNF type inpatient days on line 10 by the rate used on line 17. For CAH multiply line 10 times the per diem calculated on line 38 (12/21/00b).

Line 61--Enter the amount of Medicare swing bed-SNF type inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-SNF type inpatient days on line 11 by the rate used on line 18. For CAH multiply line 11 times the per diem calculated on line 38 (12/21/00b).

Line 62--Enter the sum of lines 60 and 61. Transfer this amount to the appropriate Worksheet E-2, column 1, line 1 for cost reporting periods beginning prior to July 1, 2002. However, CAHs continue to transfer this amount to worksheet E-2.

Line 63--Enter the amount of titles V or XIX swing bed-NF type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-NF type inpatient days on line 12 by the rate used on line 19.

Line 64--Enter the amount of titles V or XIX swing bed-NF type inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-NF type inpatient days on line 13 by the rate used on line 20.

Line 65--Enter the sum of lines 63 and 64. Transfer this amount to the appropriate Worksheet E-2, column 1, line 2. If your state recognizes only one level of care obtain the amount from line 62.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Complete line 1.08 for cost reports with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004.

Line 1.06--If you answered "yes" to line 55 of Worksheet S-2, and you did not receive the add-on payment during the year, report the additional amount eligible in accordance with CFR 412.107 on line 1.06 by multiplying the sum of lines 1 through 2.01 by .5 percent for services beginning in the government's fiscal year 1998 and .3 percent for 1999. If lines 1 through 2.01 reflect payment and you are no longer eligible, multiply that amount by .995025 for 1998 and .997024 for 1999 and subtract that result from the sum of lines 1 through 2.01 and enter the result as a negative.

Line 1.07--Enter the payment for discharges occurring on or after April 1, 2001 and before October 1, 2001 or April 1, 2004 through September 30, 2004.

Line 1.08--Enter the total managed care "simulated payments" from the PS&R on or after April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004.

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. Report only the outlier payments attributable to discharges occurring prior to October 1, 1997. Report on line 2.01 the outlier payments received for discharges occurring on and after October 1, 1997.

Line 3--Enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 2, line 12) by the number of days in the cost reporting period (365 or 366 in case of leap year). Do not include statistics associated with an excluded unit (subprovider).

NOTE: Reduce the bed days available by nursery days (Worksheet S-3, Part I, column 2, line 11), swing bed days (Worksheet S-3, Part I, column 6, sum of lines 3 and 4), and the number of observation days (Worksheet S-3, Part I, column 6, line 26 for cost reporting periods beginning before October 1, 2004 *and beginning on or after October 1, 2009*, or Worksheet S-3, Part I, column 6.02, line 26 for cost reporting periods beginning on or after October 1, 2004, *and beginning before October 1, 2009*).

Indirect Medical Educational Adjustment--Calculate the amount of the additional payment relating to indirect medical education on lines 3 to 3.03. (See 42 CFR 412.105.) Calculate the IME adjustment only if you answered "yes" to line 25.01 on Worksheet S-2. For cost reporting periods ending on or before September 30, 1997, complete lines 3 to 3.03. For cost reporting periods which overlap October 1, 1997, and thereafter, skip lines 3.01 to 3.03 and complete lines 3.04 to 3.24.

Line 3.01--Enter the number of interns and residents from Worksheet S-3, Part I, column 9, line 12. (See 42 CFR 412.105(f) for counting FTE.)

Line 3.02--Enter the indirect medical education percentage ($1.89 \times \{(1 + \text{line 3.01}/\text{line 3}) \text{ to the } .405 \text{ power} - 1\}$).

Line 3.03--Multiply the percentage calculated on line 3.02 by the sum of lines 1 and 2 and subscripts.

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

Line 3.04--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) Effective for discharges occurring on or after April 1, 2000, adjust this count for the 30 percent increase for qualified rural hospitals. For cost reporting periods beginning on or after November 29, 1999, 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) Effective for discharges occurring on or after October 1, 2001, 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.

Line 3.05--Enter the FTE count for allopathic and osteopathic programs which meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995. For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited or begun on or after January 1, 1995 and before August 6, 1997, is effective in the fourth program year of each of those new programs (see 66 FR, August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTE's that were already included in the cap on line 3.04. Also enter here the allopathic or osteopathic FTE count for residents in all years of a rural track program that meet the criteria for an add-on to the cap under 42 CFR 412.105(f)(1)(x). (If the rural track program is a new program under 42 CFR 413.79(l) and qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (3), do not report FTE residents in the rural track program on this line until the fourth program year. Report these FTEs on line 3.17). Also include here any temporary adjustment to the cap due to a hospital closing for cost reporting periods beginning before October 1, 2001.

Line 3.06--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**, page 26336, May 12, 1998.

Line 3.07--Enter the sum of lines 3.04 through 3.06 for all cost reporting periods ending prior to July 1, 2005 and for cost reporting periods ending on or after July 1, 2005, only if worksheet S-2, line 25.05 column 2 is "N". If the IME FTE cap was reduced under 42 CFR 412.105(f)(1)(iv)(B) due to unused residency slots, (Worksheet S-2, line 25.05, column 2 is "Y"), for cost reporting periods ending on or after July 1, 2005, enter the sum of the amounts from line 3.06 plus the amount on Worksheet E-3, Part VI, line 15.

Calculation of the allowable current year FTEs:

Line 3.08--Enter the FTE count for allopathic and osteopathic programs in the current year from your records for cost reporting periods beginning on or after October 1, 1997. Residents in new programs who were included in the cap (line 3.04) should be included on lines 3.08, 3.09, 3.11, 3.12, and prior years' counts on lines 3.15 and 3.16. These residents are not included after the rolling average. Do not include residents in the initial years of the new program. (42 CFR 412.105(f)(1)(iv) and/or (f)(1)(v).)

Lines 3.09 through 3.12 apply only to providers with cost reporting periods that overlap the October 1, 1997 effective date. Complete these lines in lieu of line 3.08. Do not include residents in the initial years of the program. **For cost reporting periods beginning on or after October 1, 1997, do not complete these lines.**

Line 3.09--For cost reporting periods beginning before October 1, enter the percentage of discharges to total discharges occurring prior to October 1. (10/97)

Line 3.10--For cost reporting periods beginning before October 1, 1997, enter the percentage of discharges to total discharges occurring on and after October 1. (10/97)

Line 3.11--Enter the FTE count net of dental and podiatry for the period identified in line 3.09. Use the actual count as if counting for the entire year, or what would have been reported on line 3.08. Do not include intern and residents in the initial years of the program 42 CFR 413.79(d).

Line 3.12--Enter the FTE count net of dental and podiatry for the period identified in line 3.10. Use the actual count as if counting for the entire year, or what would have been reported on line 3.08. Do not include intern and residents in the initial years of the program 42 CFR 413.79(d).

Line 3.13--Enter the FTE count for residents in dental and podiatric programs.

Line 3.14--Enter the result of the lesser of lines 3.07 or 3.08 added to line 3.13. If lines 3.09 through 3.12 are completed, enter the sum of (line 3.09 times line 3.11) plus the lesser of (line 3.10 times line 3.12) or (line 3.10 times line 3.07). Add that result to the amount on line 3.13. Calculate the rolling average count for cost reporting periods beginning on or after October 1, 1997.

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

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

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

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

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

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

Line 3.19--In general, for cost reporting periods beginning on or after October 1, 1997, enter from the prior year cost report the intern and resident to bed ratio by dividing line 3.14 by line 3. However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e), add to the numerator of the prior year intern and resident to bed ratio the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program (i.e., the period of years is the minimum accredited length of the program). If the provider is participating in a Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap and current year FTE count due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator and the prior year numerator, and b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior year's numerator (see FR Vol. 66, No. 148 dated August 1, 2001, page 39880). Effective for cost reporting periods beginning on or after October 1, 2002, if the current year is the first cost reporting period in which a receiving hospital trains FTE residents displaced by the closure of another hospital or program, then also adjust the numerator of the prior year ratio for the number of current year FTE residents that were displaced by hospital or program closure (42 CFR 412.105(a)(1)(iii)). Also, in the cost reporting period following the last year the receiving hospital's FTE cap is temporarily adjusted for the displaced residents, adjust the numerator of the prior year ratio by subtracting the displaced FTE residents reported on line 3.17 of the prior year's cost report.(42 CFR 412.105 (a)(1)(iv). If no intern and resident to bed ratio was reported in the prior year, calculate the ratio using the FTE count for residents in the initial years of the new program. For prior year cost reporting periods ending prior to October 1, 1997, compute the ratio by dividing line 3.01 by line 3.

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

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

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

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

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

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

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

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

Disproportionate Share Adjustment--Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on lines 4 through 4.04. Complete this portion only if you answered yes to line 21.01 of Worksheet S-2. For cost reporting periods which overlap January 20, 2000, do not complete lines 4 through 4.03 and enter on line 4.04 the manually calculated DSH payment adjusted by the appropriate reduction. (See intermediary PM A-99-62 for proper determination of DSH adjustment.) For those hospitals experiencing a change in the DSH percentage as a result of the application of the BIPA provisions effective for services on and after April 1, 2001, or as a result

of the application of the MMA provisions effective for discharges on and after April 1, 2004, (i.e., geographic reclassification) subscript column 1 (add column 1.01) for lines 1, 1.01, 1.02, 1.07, 4.03 and 4.04 and apply the appropriate percentage for the DSH payment and reduction in accordance with the payment dates prescribed above. Review the payment chart on page 137 and lines 1, 1.01, 1.02 and 1.07 for proper reporting of payments. Do not subscript the column for lines 4.03 and 4.04, except as applicable for SCH\MDH and geographic reclassification.

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

Line 4.01--*For cost reporting periods beginning prior to October 1, 2004, and on or after October 1, 2009, enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, (plus Worksheet S-3, Part I, line 29, column 5 for cost reporting periods beginning on or after October 1, 2009), minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12 (plus Worksheet S-3, Part I, line 29, column 6 for cost reporting periods beginning on or after October 1, 2009) minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.*

For cost reporting periods beginning on or after October 1, 2004, *and beginning before October 1, 2009*, enter the percentage resulting from the calculation of the total Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, plus column 5.01, line 26, minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12, plus column 6.01, line 26, minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

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

Line 4.03--Compare the percentage on line 4.02 with the criteria described in 42 CFR 412.106(c) and (d). Enter the percentage identified in the CFR to be applied against PPS payments. *Hospitals qualifying for DSH in accordance with 42 CFR 412.106(c)(2) (Pickle Amendment hospitals), if Worksheet S-2, line 21.01, column 2 is "Y" for yes, enter 35.00 percent on line 4.03.*

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

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

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

1, 2000 through March 31, 2001; 1 percent for April 1, 2001 through September 30, 2001; 3 percent for October 1, 2001 through September 30, 2002; and 0 (zero) percent thereafter. Review the payment chart on page 137 for the proper splitting of payments before and on or after October 1 and April 1 for those cost reports that overlap these dates in order to properly calculate the reduction.

High Percentage of ESRD Beneficiary Discharges Adjustment--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104. When the average weekly cost per dialysis treatment changes within a cost reporting period, create a subscripted column 1.01 for lines 5.01 and 5.05.

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

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

Line 5.02--Divide line 5.01, *sum of columns 1 and 1.01* by line 5, *sum of columns 1 and 1.01*. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

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

Line 5.04--Enter the average length of stay expressed as a ratio to 7 days. Divide line 5.03 by line 5.01, *sum of columns 1 and 1.01*, and divide the result by 7 days.

Line 5.05--Enter the average weekly cost per dialysis treatment of \$401.43 (\$133.81 times the average *weekly* number of treatments (3)). See CR 6216, Transmittal 98, dated December 12, 2008. See CR 6679, Transmittal 113, dated October 30, 2009, for the calendar year 2010 average weekly cost per dialysis treatment of \$405.45 (3 times rate per treatment of \$135.15). This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.

Line 5.06--Enter the ESRD payment adjustment (line 5.04, column 1 times line 5.05, column 1 times line 5.01, column 1 plus, if applicable, line 5.04, column 1 times line 5.05, column *1.01* times line 5.01, column *1.01*).

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

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

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

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

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

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

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

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

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

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

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

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

Line 24--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. Effective for discharges occurring on or after October 1, 2008, enter on line 24.98 the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in Change Request 5860, transmittal 1509, dated May 9, 2008. Only FI/contractors complete line 24.99 by entering the sum of lines 52, 53, 55, and 56.

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

in accordance with CMS Pub. 15-1, §§132-134.4. For gains or losses on new capital, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. (See 42 CFR 413.134(f)(1).)

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

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

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

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

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

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

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

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

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART A. LINES 50 THROUGH 56 ARE FOR CONTRACTOR USE ONLY.

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

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

Line 52--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5-§20.1.2.7

Line 53--Enter the capital outlier reconciliation amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7

Line 54--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7.)

Line 55--*Enter the time value of money for operating related expenses.*

Line 56--*Enter the time value of money for capital related expenses.*

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

payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered charges in program charges, and include the charges in charges for cost apportionment purposes. Enter the primary payer payment on line 26 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 26.

Line 25--Enter line 23 minus line 24.

Line 26--Enter the amount of reimbursable bad debts for deductibles and coinsurance for ESRD services reimbursed under the composite rate system from Worksheet I-5, line 9.

Line 27--Enter from your records reimbursable bad debts for deductibles and coinsurance net of recoveries for other services, excluding professional services. Do not include ESRD bad debts. These are reported on line 26. Bad debts associated with ambulance services rendered on or after April 1, 2002 (implementation of the cost/fee blend) are not allowable. If recoveries exceed the current year's bad debts, line 27 and 27.01 will be negative.

Line 27.01--Multiply the amount (including negative amounts) on line 27 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; and 55 percent for October 1, 1999; 70 percent for October 1, 2000 and thereafter (hospitals and subproviders only). The reduction does not apply to Critical Access Hospitals.

Line 27.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 27. (4/1/2004b)

Line 28--Enter the sum of lines 25, 26 and 27 or 27.01(hospitals and subproviders only).

Line 29--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 30--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. For cost reporting periods ending on or after June 30, 2006, enter on line 30.99 the MSP-LCC reconciliation amount. Obtain this amount from the PS&R.

Line 31--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.) Enter the amount of any excess depreciation taken as a negative amount in parentheses ().

Line 32--Enter the result of line 28, plus or minus lines 30 and 31 minus lines 29 and 30.99. Line 30.99 would only be included for cost reporting periods ending on or after June 30, 2006.

Line 33--Enter the sequestration adjustment amount, if applicable.

Line 34--Enter interim payments from Worksheet E-1, column 4, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 34.01. For intermediary 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 34.01. Maintain the necessary documentation to support the amount of the reclassification.

Line 35--Enter line 32 minus the sum of lines 33 and 34. Transfer this amount to Worksheet S, Part II, column 3, line as appropriate.

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

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART B. LINES 50 THROUGH 54 ARE FOR CONTRACTOR USE ONLY. (Effective for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009.)

Line 50--Enter the original outlier amount from line *1.02* sum of all columns of this worksheet.

Line 51--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-4, Chapter 4, §10.7.2.2 - §10.7.2.4.

Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-4, Chapter 4, §10.7.2.2 - §10.7.2.4.)

Line 53--*Enter the time value of money.*

Line 54--Enter sum of lines 51 and 53.

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.

3630.3 Part C - Outpatient Ambulatory Surgical Center--Use this worksheet to calculate reimbursement settlement for outpatient ambulatory surgery for titles V, XVIII, and XIX for the hospital and/or subprovider for services rendered prior to August 1, 2000; otherwise do not complete.

NOTE: Rural primary care hospitals that have elected the all-inclusive method for payment of outpatient services (see Worksheet S-2, lines 30 through 30.02), and CAHs do not complete this worksheet.

As required by §§1833(a)(4), 1832(a)(2)(F), and 1833(I) of the Act, payment for facility services furnished in connection with covered ASC procedures furnished by hospitals on an outpatient basis is based on the lesser of the outpatient cost or charges (in the aggregate) net of cost sharing or a blend of hospital cost and ASC rates at 42/58. (See CMS Pub. 15-I, §2830.3.) For cost reporting periods that end on or after October 1, 1997, and before September 30, 1998, it is necessary to subscript the column to accommodate the change in payment methodology regarding the application of deductibles and coinsurance. For all cost reporting periods that begin on or after October 1, 1997, continue to use the subscripted column and no longer complete column 1.

Line Descriptions

Line 1--Enter the standard overhead amounts from the PS&R report or from your records. Payments to ASCs for covered procedures are made on the basis of prospectively set rates known as standard overhead amounts (ASC fees). (See CMS Pub. 15-I, §2830.3.)

Line 2--Enter in column 1 the deductibles billed to the program for services prior to October 1, 1997. For column 1.01, do not complete this line.

3633. WORKSHEET E-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT

The five parts of Worksheet E-3 are used to calculate reimbursement settlement:

- Part I- Calculation of Medicare Reimbursement Settlement Under TEFRA, IRF PPS, LTCH PPS, and IPF PPS
- Part II- Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement (*CAHs*)
- Part III- Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services - Part A Services for Title XVIII PPS SNFs
- Part IV- Direct Graduate Medical Education and ESRD Outpatient Direct Medical Education Costs
- Part V- Calculation of NHC MQ Demonstration Reimbursement Settlement for Medicare Part A Services

3633.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA, IRF PPS, LTCH PPS, and IPF PPS.--Use Worksheet E-3, Part I to calculate Medicare reimbursement settlement under TEFRA for hospitals and subproviders.

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

Line Descriptions

Lines 1.01, 1.02, 1.05, and 1.06 pertain only to inpatient rehabilitation facilities (IRF) for cost reporting periods beginning on or after January 1, 2002 and long term care hospitals (LTCH) for cost reporting periods beginning on or after October 1, 2002. Line 1.03 and 1.04 pertain only to IRFs with cost reporting periods beginning on or after January 1, 2002. (See §1886(j) of the Act and PMs A-01-110 and A-01-131). Inpatient psychiatric facilities (IPF) complete lines 1, 1.01 and 1.08 through 1.23 for cost reporting periods beginning on or after January 1, 2005. Lines 1.08 through 1.23 are used exclusively for IPF services. (See Vol. 69, FR 219 dated November 15, 2004, page 66922 and CRs 3541 (December 1, 2004), 3678 (January 21, 2005), 3752 (March 4, 2005), and 3809 (April 29, 2005))

Line 1--Enter (for TEFRA hospitals, IRFs, and subprovider) the amount from Worksheet D-1, Part II, line 59. For IRFs, if Worksheet S-2, line 58, column 2 is yes, or for cost reporting period beginning on or after October 1, 2002, enter zero on this line. Enter for LTCHs with cost reporting periods beginning on or after October 1, 2002 and before October 1, 2006 the amount from Worksheet D-1, Part II, line 59.08. For LTCHs, if Worksheet S-2, line 59, column 2 is yes, or for cost reporting period beginning on or after October 1, 2006, enter zero on this line. Enter for IPFs with cost reporting periods beginning on or after January 1, 2005 and before January 1, 2008 the amount from Worksheet D-1, Part II, line 59. For IPFs, if Worksheet S-2, line 60, column 2 is yes, or for cost reporting period beginning on or after January 1, 2008, enter zero on this line.

Line 1.01--For IRFs enter hospital specific amount by multiplying line 1 times 33 1/3 percent. For LTCH enter the hospital specific amount by multiplying line 1 times the blended TEFRA rate percentage (see 42 CFR §412.533(a)(1)) for the appropriate cost reporting period. For IPF enter the hospital specific amount by multiplying line 1 times the blended TEFRA rate percentage (See 42 CFR §412.426(a)) for the appropriate cost reporting period.

Line 1.02--Enter the Net Federal IRF PPS for cost reporting periods beginning on or after January 1, 2002. 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. If line 1.01 is greater than zero, the PS&R will reflect 66 2/3 percent of the Federal IRF PPS payment amount (excluding LIP and outlier payments).

In accordance with The Federal Register, Vol. 70 FR 156 page 47933, dated August 15, 2005 and CR 4037 dated September 16, 2005, effective for IRF discharges rendered on or after October 1, 2005, it is necessary to subscript column 1 to identify the Net Federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2005 (column 1) and the Net Federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2005 (column 1.01) to appropriately prorate the LIP adjustment on line 1.04. Only subscript column 1 when the cost reporting period overlaps October 1, 2005, *except as otherwise indicated in the following paragraph*. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2005, *except as otherwise indicated in the following paragraph*.

In accordance with the Federal Register, volume. 74, number 151, page 39774, dated August 7, 2009, effective for IRF discharges rendered on or after October 1, 2009, subscript column 1 to identify the Net Federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2009 (column 1) and the Net Federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2009 (column 1.01) to appropriately prorate the LIP adjustment on line 1.04. Only subscript column 1 when the cost reporting period overlaps October 1, 2009. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2009.

Enter the Net Federal LTCH PPS payment for cost reporting periods beginning on or after October 1, 2002, including short stay outlier payments. Obtain this information from the PS&R and/or your records. If line 1.01 is greater than zero, the PS&R will reflect the applicable reduced percent of the Federal IRF PPS payment amount (excluding short stay outlier payments). (See Vol. 67 FR 169 dated August 30, 2002, page 55976 for rates.)

Line 1.03--Enter the Medicare SSI ratio from your intermediary as applicable for a freestanding IRF (IRF hospital or facility) or a hospital based IRF (subprovider or subunit). Not applicable for LTCH. (4/30/2003)

Line 1.04--IRF LIP payment, enter the result of $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .4838 \text{ power} - 1\}$ times (line 1.02). L1 = IRF total Medicare Days from Worksheet S-3, Part I, column 4, lines 1 or 14 and subscripts as applicable (L1 is not applicable for T10 & subsequent transmittals). L2 = IRF Medicaid Days from Worksheet S-3, Part I, column 5, lines 1 or 14 and subscripts as applicable plus Medicaid HMO days (S-3, Part I, column 5, line 2 (subscript line 2 for IRF subproviders)). L3 = IRF total days from Worksheet S-3, Part I, column 6, lines 1 or 14 and subscripts as applicable plus employee discount days (S-3, Part I, column 6, line 28 (subscript line 28 for IRF subproviders)). Not applicable for LTCH.

In accordance with Vol. 70 FR 156 page 47933 dated August 15, 2005 and CR 4037 dated September 16, 2005, effective for discharges on or after October 1, 2005, the IRF LIP payment formula has been updated. For cost reporting periods that overlap October 1, 2005, column 1 must be subscripted. To calculate the IRF LIP payment for discharges prior to October 1, 2005, enter in column 1 the result of $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .4838 \text{ power} - 1\}$ times (line 1.02, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2005, enter in column 1.01 the result of $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .6229 \text{ power} - 1\}$ times (line 1.02, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2005, *except as otherwise noted*. To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2005, enter in column 1 the result of $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .6229 \text{ power} - 1\}$ times line 1.02. Not applicable for LTCH.

In accordance with the Federal Register, volume 74, number 151, date August 7, 2009, page 39774, effective for discharges on or after October 1, 2009, the IRF LIP payment formula is updated. For cost reporting periods that overlap October 1, 2009, column 1 must be subscripted. To calculate the IRF LIP payment for discharges prior to October 1, 2009, enter in column 1 the result of $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .6229 \text{ power} - 1\}$ times (line 1.02, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2009, enter in column 1.01 the result of $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .4613 \text{ power} - 1\}$ times (line 1.02, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after

October 1, 2009. To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2009, enter in column 1 the result of $\{(1 + (\text{line } 1.03) + (\text{L2/L3})) \text{ to the } .4613 \text{ power} - 1\}$ times line 1.02. Not applicable for LTCH.

Line 1.05--Enter the IRF outlier payment. For LTCH enter the high cost outlier payments. Obtain this from the PS&R and/or your records.

Line 1.06--Enter the sum of lines 1.01; 1.02, columns 1 and 1.01, as applicable; 1.04, columns 1 and 1.01, as applicable; *1.42, columns 1 and 1.01 as applicable*, and 1.05.

Line 1.07--Enter the amount of Nursing and Allied Health Managed Care payments if applicable. Only complete this line if your facility is a freestanding/ independent non-PPS provider that does not complete Worksheet E, Part A.

Inpatient psychiatric facilities (IPF) complete lines 1, 1.01 and 1.08 through 1.23 for cost reporting periods beginning on or after January 1, 2005.

Inpatient Psychiatric Facility (IPF)-Lines 1.08 through 1.23

In accordance with the Federal Register (see Vol. 69, FR 219 dated November 15, 2004, page 66922) and Change Request 3541 (CMS Pub. 100-04, transmittal 384 dated December 1, 2004) and Change Request 3678 (CMS Pub. 100-04, transmittal 444 dated, January 21, 2005) complete these lines for IPFs effective for cost reporting periods beginning on or after January 1, 2005.

Line 1.08--Enter the net (blended) Federal IPF PPS payment for cost reporting periods beginning on or after January 1, 2005. This amount excludes payments for outliers, stop-loss, electroconvulsive therapy (ECT), and the teaching adjustment. Obtain this information from the PS&R and/or your records.

Line 1.09--Enter the net (blended) IPF outlier payment. Obtain this from the PS&R and/or your records.

Line 1.10--Enter the net (blended) IPF payments for ECT. Obtain this from the PS&R and/or your accounting books and records.

NOTE: Complete only line 1.11 or line 1.12, but not both.

Line 1.11--For providers that trained residents **in the most recent cost reporting period filed before November 15, 2004** (response on Worksheet S-2, line 60.01, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period filed on or before November 15, 2004. See the above referenced Federal Register for a detailed explanation.

Line 1.12--For providers that did not train residents in the most recent cost reporting period filed before November 15, 2004, but qualify to receive a cap adjustment under §412.424(d)(1)(iii)(2) for training residents in a newly accredited program(s) after that cost reporting period, enter the unweighted cap adjustment (response to Worksheet S-2, line 60.01, column 2 is "Y" for yes and column 3 contains a "4" or "5"). Do not complete this line until the fourth program year of the first new program. If your fiscal year end does not correspond to the program year end, and this current cost reporting period includes the beginning of the fourth program year of the first new program, then prorate the cap adjustment accordingly.

Line 1.13--Enter the current year unweighted FTE resident count for **other than the FTEs** in the first 3 program years of the first new program's existence. If your fiscal year end does not correspond to the program year end and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.14--Enter the current year unweighted FTE count for residents in new programs. Complete this line only during the first 3 program years of the first new program's existence. If your fiscal year end does not correspond with the program year end, and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.15--For providers that completed line 1.11, enter the lower of the FTE count on line 1.13 or the cap amount on line 1.11.

For providers that qualify to receive a cap adjustment under §412.424(d)(1)(iii)(2) during the first 3 program years of the first new program's existence, enter the FTE count from line 1.14.

Beginning with the 4th program year of the first new program's existence, enter the lower of the FTE count on line 1.13 or the FTE count on line 1.12. Add to this count the FTEs on line 1.14 if your fiscal year end does not correspond with the teaching program year end, and this current cost reporting period includes the beginning of the 4th program year of the first new program.

Line 1.16--Enter the total IPF patient days divided by number of days in the cost reporting period (Worksheet S-3, column 6, line 1 (independent/freestanding) or 14 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 1.17--Enter the medical education adjustment factor by adding 1 to the ratio of line 1.15 to line 1.16. Raise that result to the power of .5150. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as $\{(1 + (\text{line 1.15} / \text{line 1.16})) \text{ to the } .5150 \text{ power} - 1\}$.

Line 1.18--Enter the medical education adjustment by multiplying line 1.08 by line 1.17.

Line 1.19--Enter the adjusted net IPF PPS payments by entering the sum of lines 1.08, 1.09, 1.10, and 1.18.

Line 1.20--Enter the stop loss floor by entering the result of line 1 multiplied by 70 percent. For new IPFs (100 percent PPS) and for cost reporting periods beginning on or after January 1, 2008, enter zero (0) on this line.

Line 1.21--Enter the adjusted net payment floor by multiplying line 1.20 by the appropriate Federal blend payment percentage: (25 percent for cost reporting periods beginning on or after January 1, 2005 but prior to January 1, 2006, 50 percent for cost reporting periods beginning on or after January 1, 2006 but prior to January 1, 2007, or 75 percent for cost reporting periods beginning on or after January 1, 2007 but prior to January 1, 2008). Enter 100 percent if this is a new IPF (worksheet S-2, line 60, column 2 equals "Y") or for cost reporting periods beginning on or after January 1, 2008.

Line 1.22--If line 1.21 is greater than line 1.19 enter the amount on line 1.21 minus the amount on line 1.19; otherwise enter zero (0). This is the amount of the stop loss adjustment.

Line 1.23--Enter the IPF PPS payments by adding the amounts from lines 1.01, 1.19 and 1.22.

Inpatient Rehabilitation Facility (IRF)-Lines 1.35 through 1.42

In accordance with the Federal Register (see Vol. 70, No. 156, pages 47928-47932, dated August 15, 2005) and Change Request 4037 (CMS Pub. 100-04, transmittal 680 dated September 16, 2005), complete these lines for IRFs effective for discharges on or after October 1, 2005.

NOTE: Complete only line 1.35 or line 1.36, but not both.

Line 1.35--For providers that trained residents **in the most recent cost reporting period ending on or before November 15, 2004** (response to line 58.01, 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. See the above referenced Federal Register for a detailed explanation.

Line 1.36--For providers that did not train residents in the most recent cost reporting period ending on or before November 15, 2004, that qualify to receive a cap adjustment (see Vol. 70, FR 156, page 47929, dated August 15, 2005) for training residents in a newly accredited program(s) after that cost reporting period, enter the unweighted cap adjustment (response to line 58.01, column 2 is "Y" for yes and column 3 contains a "4" or "5"). Do not complete this line until the fourth program year of the first new program. If your fiscal year end does not correspond to the program year end, and this current cost reporting period includes the beginning of the fourth program year of the first new program, then prorate the cap adjustment accordingly.

Line 1.37--Enter the current year unweighted FTE resident count for **other than the FTEs** in the first 3 program years of the first new program's existence. If your fiscal year end does not correspond to the program year end and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.38--Enter the current year unweighted FTE count for residents in new programs. Complete this line only during the first 3 program years of the first new program's existence. If your fiscal year end does not correspond with the program year end, and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.39--For providers that completed line 1.35, enter the lower of the FTE count on line 1.37 or the cap amount on line 1.35.

For providers that qualify to receive a cap adjustment (see Vol. 70, FR 156, page 47929, dated August 15, 2005), during the first 3 program years of the first new program's existence enter the FTE count from line 1.38.

Beginning with the 4th program year of the first new program's existence, enter the lower of the FTE count on line 1.37 or the FTE count on line 1.36. Add to this count the FTEs on line 1.38 if your fiscal year end does not correspond with the teaching program year end, and this current cost reporting period includes the beginning of the 4th program year of the first new program.

Line 1.40--Enter the total IPF patient days divided by number of days in the cost reporting period (Worksheet S-3, column 6, line 1 (independent/freestanding) or 14 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 1.41--*For discharges prior to October 1, 2009, enter in column 1* the medical education adjustment factor by adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .9012. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as $\{(1 + (\text{line 1.39} / \text{line 1.40})) \text{ to the } .9012 \text{ power} - 1\}$.

In accordance with the Federal Register, volume 74, number 151, date August 7, 2009, page 39774, effective for discharges on or after October 1, 2009, the medical education adjustment factor has been updated making it necessary to subscript column 1 for lines 1.41 and 1.42 for cost reporting periods that overlap October 1, 2009.

Calculate the medical education adjustment factor for discharges prior to October 1, 2009, by entering in column 1 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .9012. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as $\{(1 + (\text{line 1.39} / \text{line 1.40})) \text{ to the } .9012$

power - 1}. To calculate the medical education adjustment factor for discharges on or after October 1, 2009, enter in column 1.01 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as $\{(1 + (\text{line 1.39} / \text{line 1.40}))\}$ to the .6876 power - 1}. Do not subscript column 1 for lines 1.41 and 1.42 for cost reporting periods beginning on or after October 1, 2009.

Calculate the medical education adjustment factor for cost reporting periods beginning on or after October 1, 2009, by entering in column 1 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as $\{(1 + (\text{line 1.39} / \text{line 1.40}))\}$ to the .6876 power - 1}.

Line 1.42--Enter in *column 1*, the medical education adjustment by multiplying line 1.02, *column 1* by line 1.41, *column 1*. If applicable, enter in *column 1.01*, the medical education adjustment by multiplying line 1.02, *column 1.01* by line 1.41, *column 1.01*. Add the *amounts in columns 1 and 1.01* to line 1.06.

Line 2--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-6, Part III, column 1, line 61 when Worksheet E-3, Part I, is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 2 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

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

Line 4--Enter the sum of lines 1, 1.07, 2 and 3. IRFs/LTCH enter the sum of lines 1.06, 1.07, 2 and 3. IPFs enter the sum of lines 1.23, 2, and 3.

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

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

Line 9--Enter the Part A coinsurance. Include any primary payer amounts applied to Medicare beneficiaries coinsurance in situations where the primary payer payment does not fully satisfy the obligation of the beneficiary to the provider. Do not include any primary payer payments applied to Medicare beneficiary coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to the provider.

Line 10--Enter the result of subtracting line 9 from line 8.

Line 11--Enter program reimbursable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 11 and 11.01 will be negative.

Line 11.01--Multiply the amount (including negative amounts) from Line 11 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999; and 70 percent for October 1, 2000 and all subsequent periods.

Line 11.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 11. (4/1/2004b)

Line 12--Enter the sum of lines 10 and 11.01.

Line 13--Enter the amount from Worksheet E-3, Part IV, line 24 for the hospital component only.

Line 13.01--For IRF cost reporting periods beginning on or after January 1, 2002, LTCH cost reporting periods beginning on or after October 1, 2002, and IPF cost reporting periods beginning on or after January 1, 2005, enter the routine service other pass through costs from Worksheet D, Part III, column 8, line 25 for a freestanding facility or line 31 for the subproviders. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101. For IRFs, LTCHs, or IPFs reimbursed on a blended TEFRA rate percentage (worksheet S-2, line 58, 59, or 60, respectively, column 2 equals "N") reduce the pass through amounts by the TEFRA blend percentage used on line 1.01 for IRFs, IPFs, and LTCHs, respectively. After the respective transition periods have elapsed do not reduce this line as these facilities are entitled to 100 percent of other pass through costs.

Line 14--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 15--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, sequestration, etc, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. FIs only complete line 15.99 by entering the sum of lines 51 and 53.

Line 16--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.)

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

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

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

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

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

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

Line 50--Enter the original outlier amount from worksheet E-3, Part I, line 1.05 (IRF) or 1.09 (IPF).

Line 51--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5-§20.1.2.7.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7.)

Line 53--Enter the time value of money.

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

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

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

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs:

Hospital (CAH) or Subprovider - Worksheet D-1, Part II, line 49

Skilled Nursing Facility - Worksheet D-1, Part III, line 82

RPCH - Worksheet C, Part IV, line 6 (Not applicable for cost reporting periods beginning after October 1, 1997)

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

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

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

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

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

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full.

This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but not in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system. However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--Enter the amount on line 4 minus the amount on line 5. For CAHs with cost reporting periods beginning on or after January 1, 2004, enter on this line 101 percent of the line 4 minus line 5. (1/1/2004b)

Computation of Lesser of Reasonable Cost or Customary Charges.--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e). An RPCH/CAH is not subject to this provision for inpatient services.

Line Descriptions

NOTE: An RPCH/CAH does not complete lines 7 through 17.

Lines 7 through 17--These lines provide for the accumulation of charges which relate to the reasonable cost on line 6.

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

Line 7--Enter the program inpatient routine service charges from your records for the applicable component. Include charges for both routine and special care units. The amounts entered include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

3650. ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

This worksheet provides for the analysis of the direct and indirect expenses related to the renal dialysis cost centers, allocation of cost between inpatient and outpatient renal dialysis services where separate cost centers are not maintained, and the allocation of the cost to the various modes of outpatient dialysis treatment. The ancillary renal dialysis cost center is serviced by the general cost centers and includes all reimbursable cost centers within the provider organization which provide services to the renal dialysis department. The cost used in the analysis for the renal dialysis department is obtained, in part, from Worksheets A; B, Part I; and C. Complete a separate Worksheet I series for lines 57 and 64 of Worksheet A. In other words, complete one Worksheet I series for line 57 and one for line 64, if appropriate.

3651. WORKSHEET I-1 - ANALYSIS OF RENAL COSTS

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

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

Column Descriptions

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

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

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

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

Line Descriptions

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

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

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

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

Line 17--Add lines 9 through 16. *This total in column 1 must agree with the total on Worksheet A, column 7, line 57 or line 64, as appropriate.*

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

NOTE: *Line 27 should exclude the costs of EPO and Aranesp administered to ESRD patients in the renal department and home program identified on Worksheet B-2, lines 1, 2, 3 or 4.*

Worksheet I-1, Part I, Column 1, <u>Line Number</u>	<u>General Service Cost Centers</u>	Worksheet B, Part I, Lines 57 or 64, <u>Columns</u>
18	Old Capital-Related Costs- Buildings and Fixtures	1
19	Old Capital-Related Costs- Moveable Equipment	2
20	New Capital-Related Costs- Buildings and Fixtures	3
21	New Capital-Related Costs- Moveable Equipment	4
22	Employee Benefits	5
23	Administrative and General	6

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

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

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

Line Descriptions

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

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

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

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

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

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

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

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

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

3660. WORKSHEET L - CALCULATION OF CAPITAL PAYMENT

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

Worksheet L consists of the following four parts:

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

COMPLETE ONLY PART I, II, OR III.

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

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

Line Descriptions

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

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

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

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

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

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

Lines 4.02 through 4.03--Reinstatement of IME Adjustment Factor--In accordance with the Federal Register, volume 74, number 165, page 43928, dated August 27, 2009, the full capital IME teaching adjustment is fully reinstated for discharges occurring on or after October 1, 2008. Consequently, line 2 (above) and lines 4.02 through 4.03 (below) shall be completed in accordance with the applicable instructions.

Line 4.02--Enter the result of the following calculation: $\{e^{.2822 \times \text{line 4.01}/\text{line 4}}\}-1$ where $e = 2.71828$. (See 42 CFR 412.322(a)(3) for limitation of the percentage of I&Rs to average daily census. Line 4.01 divided by line 4 cannot exceed 1.5.

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

Lines 5 - 5.04

NOTE: Enter the amount of the Federal rate portion of the additional capital payment amounts relating to the disproportionate share adjustment. Complete these lines if you answered yes to line 36.01 on Worksheet S-2. (See 42 CFR 412.312(b)(3).) For hospitals qualifying for disproportionate share in accordance with 42 CFR 412.106(c)(2) (Pickle Amendment hospitals), do not complete lines 5 through 5.02, and enter 11.89 percent on line 5.03.

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

Line 5.01--*For cost reporting periods beginning prior to October 1, 2004, and beginning on or after October 1, 2009, enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, (plus Worksheet S-3, Part I, line 29, column 5 for cost reporting periods beginning on or after October 1, 2009), minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12 (plus Worksheet S-3, Part I, line 29, column 6 for cost reporting periods beginning on or after October 1, 2009) minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28. This amount agrees with the amount reported on Worksheet E, Part A, line 4.01.*

For cost reporting periods beginning on or after October 1, 2004, *and beginning on or before September 30, 2009, enter the percentage resulting from the calculation of the total Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, minus the sum of lines 3 and 4, plus column 5.01, line 26) to total days reported on Worksheet S-3, column 6, line 12, minus the sum of lines 3 and 4, plus column 6.01, line 26. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28. This amount agrees with the amount reported on Worksheet E, Part A, line 4.01.*

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

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

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

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

3660.2 Part II - Hold Harmless Method.--This part computes settlement under the hold harmless method only as defined in 42 CFR 412.344. Use the hold harmless method for PPS capital settlement when the hospital's base year hospital-specific rate exceeds the established Federal rate. Do not complete this part for cost reporting periods beginning on and after October 1, 2001, except for new providers certified prior to October 1, 1999, that are paid in accordance with 42 CFR 412.324(b)(3). Formerly hold harmless providers (other than new providers) should consider themselves fully prospective and complete Part I of the Worksheet.

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

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

Line Descriptions

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

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

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

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

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

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

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

Line descriptions

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

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

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

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

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

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

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

For services rendered from January 1, 2010, through December 31, 2013, the maximum rate per visit entered on line 8 and the outpatient mental health treatment service limitation applied on line 14 both correspond to the same time period (partial calendar year). Consequently, both are entered in the same column and no further subscripting of the columns is necessary.

Lines 8 and 9--The limits are updated every January 1 (except calendar year 2003 updates that occurred January 1 and March 1 (see PM A-03-021)). Complete columns 1, 2 and 3, if applicable (add a column 3 for line 8-14 if the cost reporting overlaps 3 limit update periods) of lines 8 and 9 to identify costs and visits affected by different payment limits for a cost reporting period that overlaps January 1. If only one payment limit is applicable during the cost reporting period (calendar year reporting period), complete column 2 only.

Line 8--Enter the per visit payment limit. Obtain this amount from CMS Pub. 27, §505 or from your intermediary. If Worksheet S-8, line 17 was answered yes, subscript (add column 3) to accommodate the exclusion of the limit.

NOTE: If you are based in a small rural hospital with less than 50 beds (the bed count is based on the same calculation used on worksheet E, Part A, line 3), in accordance with 42 CFR §412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2. (* Substitute for the asterisk in the denominator for the number of days in the cost reporting period.)

NOTE: For services rendered on or after July 1, 2001, RHCs that are based in small urban hospital with less than 50 beds (as calculated above) will also be exempt from the per visit limit.

RHCs based in a small urban hospital with cost reporting periods overlapping July 1, 2001, will add a column 3 for lines 9 through 14 and complete according to the instructions. Enter in column 3, line 9 the amount from line 7. Column 3, line 10 through 14 will be completed in accordance with the instructions. For RHCs based in small urban hospitals with cost reporting periods beginning on or after July 1, 2001, transfer the adjusted cost per visit (line 7) to line 9, column 1 and/or 2.

Line 9--Enter the lesser of the amount on line 7 or line 8.

Calculation of Settlement--Complete lines 10 through 26 to determine the total program payment due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period. Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

Line descriptions

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

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

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

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

Line 14--Enter the limit adjustment. *In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: For services rendered through December 31, 2009, the limitation is 62.50 percent; services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; services from January 1, 2013 through December 31, 2013, the limitation is 81.25 percent; and services on or after January 1, 2014, the limitation is 100 percent.* This is computed by multiplying the amount on line 13 by the *corresponding* outpatient mental health treatment service limit *percentage*. This limit applies only to therapeutic services, not initial diagnostic services.

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

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

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

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

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

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

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

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

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

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

Line 23--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-I §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 24--This is the sum of lines 21 and 22 plus or minus line 23.

Line 25--Enter the total interim payments from Worksheet M-5 made to you for covered services furnished to program beneficiaries during the reporting period (from intermediary records). For final settlement, report on line 25.01 the amount on line 5.99 of Worksheet M-5.

Line 26--Enter the total amount due to/from the program (lines 24 minus line 25). Transfer this amount to Worksheet S, Part II, column 3, line 9.

Line 27--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal costfinding process. (See §115.2.) A schedule showing the supporting details and computations must be attached.

3665. WORKSHEET M-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of these vaccines for services rendered on and after August 1, 2000. Prior to that date all vaccines were reimbursed through the provider based hospital and could not be claimed by the RHC and FQHC. *Additionally, only use this worksheet for vaccines rendered to patients who, at the time of receiving the vaccine(s), were not inpatients or outpatients of the parent provider. If a patient simultaneously received vaccine(s) with any Medicare covered services as an inpatient or outpatient, those vaccine costs are reimbursed through the parent provider and cannot be claimed by the RHC and FQHC.*

Effective for services rendered on or after September 1, 2009, the administration of influenza H1N1 vaccines furnished by RHCs and FQHCs is cost reimbursed. However, no cost will be incurred for the influenza H1N1 vaccine as this is provided free of charge to providers/suppliers.

To account for the cost of administering seasonal influenza vaccines, influenza H1N1 vaccines, and/or both vaccines administered during the same patient visit, column 2 is subscripted adding column 2.01 (administration of only H1N1 vaccines) and 2.02 (administration of both the seasonal influenza and H1N1 vaccines during the same patient visit). The data entered in all columns (1, 2, and applicable subscripts) for lines 4, 11, and 13 are mutually exclusive. That is,

the vaccine costs, the total number of vaccines administered, and the total number of Medicare covered vaccines shall only be represented one time in the appropriate column. Columns 2.01 and 2.02 will not reflect the cost of H1N1 vaccines as it is furnished at no cost to the provider. However, the cost of seasonal influenza vaccines is required in columns 2 and 2.02, line 4.

Line 1--Enter the health care staff cost from Worksheet M-1, column 7, line 10.

Line 2--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4--Enter the cost of the pneumococcal and influenza vaccine medical supplies from your records.

Line 5--Enter the sum of line 3 and 4.

Line 6--Enter the amount from Worksheet M-1, column 7, line 22. This is your total direct cost of the facility.

Line 7--Enter the amount from Worksheet M-2, line 16.

Line 8--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9--Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10--Enter the sum of the amounts on lines 5 and 9.

Line 11--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12--Enter the cost per pneumococcal and influenza vaccine injections by dividing the amount on line 10 by the number on line 11.

Line 13--Enter the number of program pneumococcal and influenza vaccine injections from your records or the PS&R.

Line 14--Enter the program cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15--Enter the total cost of pneumococcal and influenza vaccine and its(their) administration *and the administration of H1N1 vaccines* by entering the sum of the amount in column 1, line 10 and the amount in column 2 (*and applicable subscripts*), line 10.

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

Line 16--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration *and the administration of H1N1 vaccines*. 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 20.

3666. 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 fiscal intermediary.

Line Descriptions

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

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

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

Line 4--Transfer the total interim payments to the title XVIII Worksheet M-3, line 25.

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

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

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

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

Line 7--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet M-3, line 24.