Medicare

Provider Reimbursement Manual - Part 1, Chapter 28, Prospective Payments

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2810 - 2810.3	28-97.40 - 28-98.17 (19 pp.)	28-97.40 - 28-98.17 (19 pp.)

CLARIFIED/UPDATED MATERIAL--*EFFECTIVE DATE:* N/A

Section 2810, Special Treatment of Sole Community Hospitals Under the Inpatient Prospective System, is revised to clarify guidance on the special treatment of sole community hospitals (SCHs) for cost reporting periods beginning prior to January 1, 2009, and for cost reporting periods beginning on or after January 1, 2009. The section is also revised to provide guidance on the special treatment of SCHs for cost reporting periods beginning on or after October 1, 2017.

DISCLAIMER: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged.

2805. COST APPORTIONMENT FOR HOSPITALS UNDER PROSPECTIVE PAYMENT SYSTEM (PPS)

Prior to PPS, all providers were required to use cost apportionment data (e.g., charges and days) for the actual services rendered during the cost reporting period. For Medicare inpatients, cut-off bills at the end of the cost reporting period were required to arrive at the Medicare days and charges for actual services rendered. That is, days and charges for patients remaining in the provider at the end of the cost reporting period were accrued through the last day of the period.

In hospitals subject to PPS, payment for Medicare inpatients is based on discharges. Therefore, beginning with the end of each hospital's first cost reporting year under PPS, cut-off bills are no longer required. Since only bills for discharged patients are required, the cost apportionment data available based on individual bills for Medicare inpatients includes only services rendered to patients discharged during the cost reporting period. Therefore, hospitals under PPS use utilization statistics for services (i.e., days and charges) related to discharges occurring during the cost reporting period as the Medicare apportionment statistics. During the initial year that discharge statistics are used, apportionment data includes all data for discharges occurring during the year, including those for any portions of stays occurring during the prior year, even though those data also were used to apportion costs during the prior year. Cost apportionment data for all other services rendered to Medicare patients (i.e., other than Medicare inpatient services subject to PPS) continue to include the actual volume of services rendered during the cost reporting period.

In order to provide for an orderly transition in data accumulation methods, for cost reporting periods which ended prior to January l, 1985, hospitals under PPS may still use accrued charges and patient days applicable to actual services rendered during the period for the apportionment process. Since the use of such accrued data is not related to cut-off bills, hospitals using this method must maintain auditable data.

The change described above does not affect Medicare policy for the accumulation of costs subject to apportionment in any provider, including PPS hospitals.

2806. CAPITAL-RELATED COSTS - GENERAL

Effective for cost reporting periods beginning on or after October 1, 1991, capital-related costs for inpatient hospital services are paid on a prospective basis. Effective for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1991, capital-related costs are excluded from the prospective payment system for operating costs and are paid on a retrospective reasonable cost basis. (See §§2801, 2802, and §2807.) This section defines capital-related costs for purposes of the pre-October 1991 exclusion.

NOTE: For cost reporting periods beginning on or after October 1, 1983, and before October 1, 1986, the capital-related costs for each hospital must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the hospital's prospective payment rate. (See §2802B1.)

2806.1 Costs Included In Capital-Related Costs.--This section sets forth the costs that may be included in capital-related costs.

A. Net depreciation expense as determined under §§100-104.22, 108-122 and 134-134.12, adjusted by gains and losses realized from the disposition or involuntary conversion of assets as determined under §§130-133.5 and by recovery of accelerated depreciation as determined under §136ff, are included in capital-related costs. If the adjustments for gains and losses and recovery of accelerated depreciation result in a negative amount (i.e., a net negative adjustment exceeds the allowable depreciation expense in the cost reporting year), the negative amount must be used to reduce all other allowable cost reimbursement due the provider. If a negative amount remains after reducing all allowable cost reimbursement to zero, the negative amount must be applied against any amounts otherwise due in determining the final year-end settlement. Finally, if after absorbing all cost reimbursement due the provider and all unpaid prospective payments due the provider, an un-recovered balance remains, that balance is declared an overpayment and is treated in accordance with the provisions of §2409ff. This subsection sets forth the ordering of adjustments for gains and losses realized from the disposition or involuntary conversion of assets and recovery of accelerated depreciation and is not intended to change the manner in which these adjustments are reported in the provider's cost report.

EXAMPLE 1: Provider A incurs the following capital-related costs during the fiscal year ended September 30, 1984: Depreciation - $600,000, Interest Expense - $470,000, Insurance Expense - $40,000, Return on Equity Capital - $10,000 (Medicare's portion) and Property Tax Expense - $1,250. During the fiscal year, the provider sold assets and the sales resulted in a net gain of $370,000 (Medicare's share as calculated in accordance with §132.4). Assuming 50% Medicare utilization, Provider A's capital-related costs would be calculated as follows:

Depreciation	$300,000
Interest expense	235,000
Insurance expense	20,000
Return on equity capital	10,000
Property tax expense	625
Total capital-related costs	$565,625
Less gain on sale	-370,000
Net capital-related costs	$195,625

EXAMPLE 2: Assume the same facts as in example 1 except that the provider terminated from the Medicare program effective September 30, 1984, and, as a result of the sale, experienced a gain of $730,000 (Medicare's share as calculated in accordance with §132.4). Provider A's capital-related costs would be calculated as follows:

Depreciation	$300,000
Interest expense	235,000
Insurance expense	20,000
Return on equity capital	10,000
Property tax expense	625
Total capital-related costs	$565,625
Less recovery of gain	730,000
Net capital-related costs	($164,375)

The amount of $164,375 is considered an overpayment subject to recovery by the program in accordance with §2409ff.

B. Taxes on land or depreciable assets used for patient care are includable in capital-related costs.

C. Lease and rental payments, including license and royalty fees, for the use of assets that would be depreciable if you owned them outright or for the use of land, are includable in capital-related costs. The distinction between an operating lease and a capital lease as those terms are defined for purposes of generally accepted accounting principles is not relevant to the inclusion of lease costs in capital-related costs. The fact that the lease or rental is for a depreciable asset is sufficient for consideration as a capital-related item. However, the lease or rental must convey to you the use, possession, and enjoyment of the asset.

A distinction must be made between the lease of equipment and the purchase of services. A lease of equipment is considered a capital-related cost while a purchase of service is considered an operating cost. Generally, for the agreement to be considered a lease or rental (and therefore a capital-related cost), the agreement must convey to the provider the possession, use, and enjoyment of the asset. There is a wide variety in such agreements and each such agreement must be examined on its own merits. Factors that would weigh in favor of treating a particular agreement as a lease of equipment include the following:

- The equipment is operated by personnel employed by the provider or an organization related to the provider under the meaning of Chapter 10;

- The physicians who perform the services with or interpret the tests from the equipment are associated with the provider;

- The agreement is memorialized in one document rather than in two or more documents (for example, one titled a "Lease Agreement" and one titled a "Service Agreement");

- The document memorializing the agreement is titled a "Lease Agreement". If one or more of the documents memorializing the agreement are titled "Service Agreements", this would indicate a purchase of services;

- The provider holds the certificate of need (CON) for the services being furnished with the equipment;

- The basis for determining the lease payment is units of time and is not volume sensitive (for example, number of scans);

- The provider attends to such matters as utilization review, quality assurance, and risk management with respect to the services involving the equipment;

- The provider schedules the patients for services involving the equipment;

- The provider furnishes any supplies required to be used with the equipment; and

- The provider's access to the equipment is not subject to interruption without notice or on very short notice.

The foregoing list represents guidelines, rather than an absolute checklist of factors evidencing a lease agreement. The fiscal intermediary may consider other factors beyond those in the list. Because no single factor is necessarily determinative of the nature of a given agreement (capital-related or operating cost), the intermediary will examine all aspects of an agreement in determining whether the arrangement constitutes a lease of equipment or a purchase of service and thus be classified as a capital-related cost or an operating cost.

1. Transactions considered sale and leaseback agreements are includable in capital-related costs. However, the amount to be included must be determined following the instructions set forth in §110A.

2. Transactions considered lease purchase agreements based on the criteria set forth in §110B are includable in capital-related costs. However, the amount to be included must be determined following the instructions in that same section.

3. Costs incurred for the repair or maintenance of equipment or facilities are specifically excluded (See 42 CFR 413.130(b)(7)) from the definition of capital-related costs. Amounts included in rentals or lease payments for repair or maintenance are therefore excluded from capital-related cost. Intermediaries must review agreements carefully to determine if such costs are included in any rental and lease agreement. If no amount is identified in the lease or rental agreement for maintenance, you are not required to carve out a portion of the lease payment to represent the maintenance portion. Where no amount is identified, the entire lease payment may be considered a capital-related cost subject to the provisions above.

D. The costs of betterments and improvements as those terms are defined in §108.2 are includable in capital-related costs. However, the amount to be included must be determined following the instructions in that same section.

E. The costs of minor equipment are includable in capital-related costs so long as the costs of the minor equipment are treated by the provider in a manner consistent with §§106(b) or (c).

F. The costs of insurance on depreciable assets used for patient care or insurance that provides for the payment of capital-related costs during business interruption are includable in capital-related costs. If an insurance policy also provides protection for other than the replacement of depreciable assets or to pay capital-related costs in the case of business interruption, only that portion of the premium(s) related to the replacement of depreciable assets or to pay capital-related costs in the case of business interruption is includable in capital-related costs.

G. Net interest expense as determined under Chapter 2 is includable in capital-related costs, if such expense is incurred in acquiring land and/or depreciable assets (either through purchase or lease) used for patient care or refinancing existing debt, if the original purpose of the refinanced debt was to acquire land and/or depreciable assets used for patient care. Since only the capital-related part of interest expense will be recognized as a capital-related cost, only a proportionate share of investment income should be offset

(if investment income offset is required under §202.2 and/or §226.4B). This proportionate share is obtained by applying a ratio of capital-related interest expense to total interest expense to the total investment income. However, investment income generated from an advance refunding, as described in §233.3D, is not subject to apportionment between capital-related interest expense and operating interest expense.

EXAMPLE 1: During the fiscal year ending September 30, 1984, Provider B incurs interest expense of $40,000 on a loan to purchase patient-care-related equipment and $10,000 on a loan to generate additional working capital. During the same fiscal year, the provider held investments purchased with income from prior operations which generated interest income of $4,500. Based on §202.2, the investment income must be used to reduce the interest expense. However, because only part of the interest expense is capital-related ($40,000), a proration must be made to ascertain that portion of the investment income to be used to reduce capital-related interest expense as follows:

$$\frac{\text{Capital-related interest expense}}{\text{Total interest expense}} = \frac{\$40{,}000}{\$50{,}000} = \frac{4}{5} \times \$4{,}500 = \$3{,}600$$

Total capital-related interest expense of $40,000 is reduced by a proportionate share of investment income of $3,600 to determine the net interest expense to be included in capital-related costs ($36,400).

EXAMPLE 2: During the fiscal year, the hospital had interest expense as follows:

Allowable capital-related interest expense	$150,000
Allowable noncapital-related interest expense	50,000
Non-allowable interest expense (related to a borrowing for non-patient care activities)	100,000
	$300,000

The hospital also had investment income as follows:

Interest income on funded depreciation account	$1,000,000
Interest income on hospital operating funds	250,000
	$1,250,000

To determine the offset:

Investment income from the funded depreciation account is not offset against interest expense (See §202.1.) The total investment income available for offset is $250,000.

The interest expense subject to offset by the investment income is $200,000 ($150,000 in allowable capital related interest and $50,000 in non-capital related interest).

The total capital-related interest expense of $150,000 is reduced by a proportionate share of the investment income determined as follows:

Capital-related interest $150,000 = 3 x $250,000 = $187,500
Total allowable interest $200,000 4

The balance of the investment income ($62,500) is offset against the non-capital interest expense of $50,000.

The investment income in excess of the interest expense ($37,500 in capital related and $12,500 in non-capital related) is not used to offset other expenses.

H. For proprietary providers, a return on equity capital as determined under Chapter 12 is includable in capital-related costs.

I. Capital-Related Costs of Related Organizations.--The capital-related costs of related organizations (as described in Chapter 10) may be included in the provider's capital-related costs. (See §1005 and §2806.3A.)

J. Debt Issuance Costs, Debt Discounts, and Debt Redemption Costs.--If the associated debt was incurred to acquire land or depreciable assets used for patient care or to refinance existing debt for which the original purpose was to acquire land or depreciable assets used for patient care, debt issuance costs, debt discounts, and debt redemption costs are includable in capital-related costs.

2806.2 Costs Excluded From Capital-Related Costs.--This section sets forth some of the costs that are excluded from capital-related costs. To the extent that these costs are allowable, they may be included in determining each provider's operating costs. Exclusions from capital-related costs include:

a. Costs incurred for the repair or maintenance of equipment or facilities;

b. Amounts included in rentals or lease payments for repair or maintenance agreements;

c. Interest expense incurred to borrow working capital (for operating expenses);

d. General liability insurance or any other form of insurance to provide protection other than for the replacement of depreciable assets or to pay capital-related costs in the case of business interruption;

e. Taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care (taxes not related to patient care, such as income taxes, are not allowable and are, therefore, not included among either capital-related or operating costs);

f. The costs of minor equipment that are charged off to expense as in §106(a);

g. Cleaning services, guard services, and utilities;

h. Abandoned planning costs. (See §2154.1.) Allowable abandoned planning costs are administrative and general costs and are included in allowable costs either in the year of abandonment or amortized over a 3-year period; and

i. Maintenance agreements. Costs incurred for maintenance and repair insurance agreements (commonly referred to as maintenance agreements) are excluded from capital-related costs even where those agreements provide for the replacement of assets in certain circumstances.

2806.3 Costs of Supplying Organizations.--

A. Supplying Organization Related to the Provider.--If the supplying organization is related to the provider within the meaning of Chapter 10, except as provided in the following paragraph, the provider's capital-related costs may include the capital-related costs of the supplier. Where organizations other than the provider are also serviced by the supplier, a reasonable allocation of the supplier's capital-related costs must be made among all organizations serviced.

EXAMPLE 1: Hospital C sends its laundry and linens out to be cleaned by a related laundry service, XYZ Laundry, Inc. The laundry service also cleans laundry for two other hospitals, a nursing home and three motels. Assume that the cost of the laundry service is less than the open market price and the exception in §1010 does not apply. The laundry and linens are processed in an identical fashion for all customers of XYZ Laundry, Inc. Hospital C may include in its capital-related costs an appropriate share of the capital-related costs of XYZ Laundry, Inc. Included in the laundry service's capital-related costs would be only costs that would be capital-related costs if Hospital C incurred the costs directly. Excluded from Hospital C's capital-related costs would be that portion of the laundry service's capital-related costs attributable to the other six customers (e.g., such apportionment could be made on the basis of relative pounds of laundry processed).

If the costs of the services, facilities or supplies being furnished exceed the open market price, or if the exception in §1010 applies, the costs will be treated as provided in subsection B. The exception in §1010 is not an option. If all the criteria in §1010 are met, the exception must be applied.

EXAMPLE 2: Assume the same facts as in the example in the preceding paragraph, except that the exception in §1010 applies to the transactions between Hospital C and XYZ Laundry, Inc. (or, alternatively, the costs of providing the laundry services exceed the open market price for such services). In that case, no part of XYZ Laundry's capital-related costs would be included in Hospital C's capital-related costs.

B. Supplying Organization Not Related to the Provider.--If the supplying organization is not related to the provider within the meaning of Chapter 10, no part of the charge to the provider may be considered a capital-related cost, unless the services, facilities or supplies are capital-related in nature (e.g., a provider purchases depreciable equipment from an unrelated supplier). However, where a provider leases or rents facilities or equipment that would be depreciable if the provider owned them outright, in conjunction with obtaining a service (see Example 1 below) from an unrelated supplier, the capital-related portion of the supplier's charge may be included in the provider's capital-related costs only if (1) the capital-related facilities or equipment are leased or rented by the provider (that is, the provider has the possession, use and enjoyment of the facilities or equipment), (2) the capital-related equipment is located on the provider's premises, and (3) the capital-related portion of the charge is separately specified in the charge to the provider. All three of the foregoing criteria must be met for a provider to include the capital-related portion of the supplier's charge in the provider's capital-related costs.

EXAMPLE 1: In conjunction with furnishing telephone service to Hospital D, MNO Bell leases the telephones and switchboard equipment to the hospital. The telephones and switchboard equipment are all located on the hospital's premises. The monthly bill that MNO Bell sends to the hospital includes two line items, one line specifying an amount for telephone service and the other line specifying a reasonable amount for rental of the equipment. Because all three criteria above are met, Hospital D may include in its capital-related costs the amount specified for rental of the telephone equipment, even though Hospital D and MNO Bell are unrelated organizations.

EXAMPLE 2: Acme Cleaning Company, an unrelated supplier, provides housekeeping services for Hospital E. In conjunction with the provision of these services, Acme keeps certain depreciable equipment (vacuum cleaners, electric buffers, etc.) permanently located on the hospital's premises for the use of the contract housekeeping staff. The bill sent by Acme Cleaning specifies two reasonable amounts to be paid by the hospital, one for housekeeping services and the other for equipment rental. Hospital E may not include in its capital-related costs the billing amount designated as equipment rental because the first criterion above is not met. This situation does not describe a true lease or rental because the hospital does not have the possession, use and enjoyment of the assets. The equipment is placed on the hospital's premises for the use of the contract housekeeping staff in fulfilling its responsibilities under the contract.

2806.4 Costs of Certain Provider-Based Physicians.--If the provider has a relationship with a physician or other entity (e.g., professional corporation, partnership) and the relationship exists as contemplated by 42 CFR 405.550(e), the capital-related portion of the costs reimbursable to the provider on a reasonable cost basis as described in 42 CFR 405.550(e)(2), which includes the costs assumed by the physician or other entity, may be included in the provider's capital-related costs. This provision applies only in situations

where the physician or other entity enters into an agreement (such as a lease or concession) with a provider, under which the physician (or entity) assumes some or all of the operating costs of the provider department in which the physician furnishes physician services in the provider. (See §2182.4D.)

2806.5 Jointly Owned Equipment.--If the equipment is jointly owned, all of the provider-owners that use the equipment may share in the capital-related costs associated with that equipment. The apportionment of the capital-related costs of jointly owned assets among the owners must be on a basis that reflects the relative use by each owner, rather than the ownership share or the amount of time the asset is located at each owner's site.

2807. PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL CAPITAL-RELATED COSTS

Effective with hospital cost reporting periods beginning on or after October 1, 1991, payment for hospital inpatient capital-related costs is made under a prospective payment system for all hospitals paid under the prospective payment system for operating costs. The final rule establishing the capital prospective payment system (capital-PPS) was published in the Federal Register on August 30, 1991 (see 56 FR 43358-43524). The rule provides for a 10-year transition from reasonable cost based reimbursement to payment based solely on a Federal rate.

This section describes the Federal rate and capital-PPS transition policies and provides further clarification of the applicable rules contained in 42 CFR 412.300ff. Changes to the capital-PPS Federal rate and other payment factors will be published annually in the Federal Register around September 1.

Hospitals and hospital units that are excluded from the prospective payment system and rural primary care hospitals (see §1820(i)(2) of the Act) continue to be paid on a reasonable cost basis for capital-related inpatient costs.

2807.1 Capital Prospective Payment System Transition Period.--The capital-PPS transition period starts with a hospital's cost reporting period beginning in Federal fiscal year (FY) 1992 (October 1, 1991, through September 30, 1992). The transition extends for a 10-year period ending with a hospital's last cost reporting period beginning before October 1, 2001, except for new hospitals that enter the program after the transition starts. (See §2807.7.)

If a hospital has a cost reporting period ending after September 30, 1991, capital-related costs for the period from October 1, 1991, to the beginning of its FY 1992 cost reporting period are paid for on a reasonable cost basis as described in §2806, subject to a 10 percent reduction for the period from October 1, 1991, to the beginning of its FY 1992 cost reporting period.

To provide an orderly 10-year transition, a hospital with a 52-53 week cost reporting period is deemed to have the same cost reporting period beginning date for capital-PPS purposes throughout the transition period. Thus, if a hospital's FY 1992 cost reporting period begins September 28, 1992, the hospital is deemed to have a September 28 cost reporting period beginning date throughout the 10-year transition. This policy applies only for purposes of the capital-PPS transition. For all other purposes, the hospital's actual fiscal year is used.

During the capital-PPS transition period, a hospital is paid for the capital-related costs of inpatient hospital services based on an increasing proportion of the capital-PPS Federal rate and a decreasing proportion of its historical costs for capital-related items and services. Payment is made under one of two alternative methods:

- The fully prospective methodology (see §2807.5A), or
- The hold harmless methodology. (See §2807.5B.)

When a hospital comes under the capital-PPS, the payment methodology applicable to the particular hospital is determined by comparing its hospital-specific rate, which is derived from the hospital's inpatient capital-related costs per discharge in a specified base year, to the applicable Federal rate (after adjustment for appropriate payment variables). If the hospital-specific rate is above the adjusted Federal rate, as described in §2807.4D, the hospital is paid under the hold harmless methodology. If the hospital-specific rate is below the adjusted Federal rate, as described in §2807.4D, the hospital is paid under the fully prospective methodology. Except in limited situations involving hospitals paid under the fully prospective payment methodology, the same payment methodology is applicable throughout the transition. (See §2807.4E.)

In addition to the basic payments a hospital receives under the hold harmless or fully prospective payment methodology, additional payments may be made for outlier cases that are extraordinarily costly or involve an atypically long stay. (See §2807.2C.) Also, a hospital may qualify for an exceptions payment if its total capital-PPS payments are below a specified level of the total Medicare inpatient capital-related costs, or if unexpected extraordinary circumstances occur. (See §2807.5C.)

2807.2 Federal Rate.--

A. Standard Federal Rate.--The Federal rate is payable on a per discharge basis. During the transition period, the percentage of the Federal rate that is payable for a discharge is dependent on the hospital's payment methodology. Effective with the hospital's cost reporting period beginning in FY 2002, payment is based on 100 percent of the Federal rate.

A single national standard Federal rate is applicable to hospitals located in the 50 States and the District of Columbia. Hospitals located in Puerto Rico are paid a blended rate based on 25 percent of the national Federal rate and 75 percent of a Puerto Rico Federal rate. For discharges occurring in FY 1992, the national standard Federal rate is $415.59, and the Puerto Rico standard Federal rate (before blending) is $319.68.

For discharges occurring in FY 1993, the national standard Federal rate is $417.29, and the Puerto Rico standard Federal rate (before blending) is $320.99.

Updated Federal rates are effective each October 1 and are published in the Federal Register as part of the final rule implementing PPS payment rates and policies that is published around September 1 of each year.

B. Payment Adjustments.--The standard Federal rate is adjusted for the diagnosis-related group (DRG) to which the discharge is assigned and the hospital's geographic location. For qualifying hospitals, additional adjustments are made for indirect teaching costs and for serving a low income patient population. The result is termed the adjusted Federal rate.

1. DRG Weight.--The standard Federal rate is multiplied by the relative weight applicable to the DRG to which the discharge is assigned. The same DRG classification system and relative weights are used under the PPS for operating costs and the capital-PPS. (See §2405.) Classification changes and revised relative weights are published in the Federal Register around September 1 of each year.

2. Geographic Adjustment Factor.--The standard Federal rate is multiplied by a geographic adjustment factor that is based on the wage index applicable to the hospital under the PPS for operating costs. If a hospital has been reclassified by the Medicare Geographic Classification Review Board for hospital wage index purposes, the geographic adjustment factor is based on the wage index that is applicable to the hospital after reclassification. If a multi-campus hospital has campuses in two wage areas, the hospital wage index that is applicable to each campus determines the geographic adjustment factor that is applicable to Federal rate payments to that campus. However, the geographic adjustment factor is applied separately by the fiscal intermediary in such cases rather than automatically through the PRICER program.

The geographic adjustment factor increases the hospital's payments based on the Federal rate by approximately 6.8 percent for every 10 percent increase in the hospital's wage index. The geographic adjustment factor is calculated by raising the hospital's wage index to the .6848 power and changes each time the hospital's wage index changes. Annual revisions in the geographic adjustment factors are published in the Federal Register around September 1 of each year.

3. Large Urban Add-on.--If a hospital is located in a large urban area, the standard Federal rate is increased by three percent; i.e., the standard Federal rate is multiplied by 1.03. Consistent with the PPS for operating costs, a large urban area is defined as a metropolitan statistical area (MSA) with a population of more than one million (or New England County metropolitan area (NECMA) with a population of more than 970,000). If a hospital is classified as a large urban hospital for purposes of the standardized amount under the PPS for operating costs, the hospital is eligible for the large urban add-on. This includes a hospital that is reclassified to a large urban area for purposes of the standardized amount by the Medicare Geographic Classification Review Board. It does not include a hospital that is reclassified to a large urban area for wage index purposes only.

4. Cost of Living Adjustment (COLA) for Hospitals Located in Alaska and Hawaii.--For a hospital located in Alaska or Hawaii, the standard Federal rate is increased by a COLA factor derived from the COLA adjustment applicable to the hospital under the PPS for operating costs. The COLA adjustment under the capital-PPS is calculated as (.3152 x (1- the applicable operating COLA) + 1) and is applied to the standard Federal rate. The effect is to increase approximately 31.5 percent of the Federal rate by the COLA applicable under the PPS for operating costs.

The COLA factor under the capital-PPS changes each time the COLA under the PPS for operating costs changes. Changes in the COLA under PPS for operating costs are published in the Federal Register around September 1 of each year.

5. Disproportionate Share of Low Income Patients.--An urban hospital with at least 100 beds that serves low income patients, as determined under 42 CFR 412.106(b), or demonstrates that 30 percent or more of its inpatient care revenues are derived from State and local government payments for indigent patient care, under 42 CFR 412.106(c)(2), receives an adjustment in its Federal rate payments. The adjustment increases its Federal rate payments by approximately 2.025 percentage points for each 10 percent increase in the hospital's disproportionate share patient ratio.

Rural hospitals and urban hospitals with fewer than 100 beds do not qualify for the disproportionate share adjustment under capital-PPS.

For purposes of this provision, a hospital is considered an urban hospital if it is classified as an urban hospital under the PPS for operating costs for purposes of the standardized amount regardless of its classification for wage index purposes. This includes a rural hospital that is reclassified to a large or other urban area for purposes of the standardized amount by the Medicare Geographic Classification Review Board. It does not include a hospital that is reclassified to an urban area for wage index purposes only.

Bed size is based on the number of bed days in the portion of the hospital covered by the prospective payment system that are available during the cost reporting period (not including beds assigned to newborns, custodial care and excluded distinct part units), divided by the number of hospital days in the cost reporting period. This determination is consistent with the bed size determination for the disproportionate share adjustment under the PPS for operating costs.

The disproportionate share patient percentage is the same as the disproportionate share patient percentage under the PPS for operating costs. It is based on the percentage of the hospital's total inpatient days that are attributable to Medicare patients receiving Supplemental Security Income (SSI) and to covered Medicaid days.

There is no minimum disproportionate share patient percentage that must be met before an urban hospital with at least 100 beds qualifies for a disproportionate share adjustment. The formula for calculating the adjustment is:

$$(e^{(.2025 \times DSH\%)}) - 1$$

where e equals the natural antilog of 1, or 2.7183, and DSH% equals the hospital's disproportionate share patient percentage.

An urban hospital with at least 100 beds that derives at least 30 percent of its total inpatient revenues from State or local government sources for the care of indigent patients who are not covered by Medicare or Medicaid receives a disproportionate share adjustment under capital-PPS equal to 14.16 percent.

The disproportionate share adjustment increases the hospital's DRG payments based on the Federal rate (basic and outlier payments but not payments for indirect medical education). The intermediary makes an interim adjustment on a per discharge basis based on its best estimate of the hospital's bed size and disproportionate share patient percentage for the cost reporting period. At final settlement of the cost report, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period.

6. Indirect Medical Education Adjustment.--A teaching hospital receives an adjustment in its Federal rate payments based on the ratio of its average number of residents to its average daily census (resident-to-day ratio). (The resident-to-day ratio is applicable to capital PPS but not to operating PPS indirect medical education adjustments.) The adjustment increases the hospital's payments based on the Federal rate by 2.822 percentage points for each 10 percent increase in the hospital's resident-to-day ratio.

In determining the hospital's resident-to-day ratio, the number of residents is determined consistent with the PPS for operating costs based on the average number of full time equivalent residents working in the portion of the hospital subject to the prospective payment system during the cost reporting period. Average daily census equals total acute inpatient days divided by the number of days in the cost reporting period.

The formula for calculating the indirect teaching adjustment is:

$$(e^{(.2822 \times \text{resident-to-day ratio})})-1$$

where e equals the natural antilog of 1, or 2.7183.

The indirect teaching adjustment increases the hospital's DRG payments based on the Federal rate (basic and outlier payments but not disproportionate share payments). The intermediary makes an interim adjustment on a per discharge basis based on its best estimate of the hospital's resident-to-day ratio. At final settlement of the cost report, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period.

C. Outlier Payments.--If a discharge is extraordinarily costly (a cost outlier) or has an atypically long stay (a day outlier), the hospital receives an additional payment for the discharge. During the transition period, the additional payment is calculated as if the hospital were receiving payment based on 100 percent of the adjusted Federal rate, and is then multiplied by the actual percentage of the adjusted Federal rate received by the hospital during the cost reporting period based on its transition payment methodology.

A single set of thresholds is used to identify outlier cases under both the operating and capital prospective payment systems. An outlier payment is made for a cost outlier only if the hospital's combined capital-related and operating costs for the discharge exceed the cost outlier threshold. The marginal cost factors used to determine the outlier payment are the same as those used in the PPS for operating costs. (See §2405.5.)

The outlier thresholds are updated effective each October 1 and are published in the Federal Register as part of the annual final rule implementing PPS payment rates and policies that is published around September 1 of each year.

2807.3 Distinguishing Between Old And New Capital Costs During Transition Period.--Under the capital-PPS, assets that were put in use to provide patient care on or before December 31, 1990, are defined as old capital and the capital-related costs associated with these assets are generally treated separately from the capital-related costs associated with assets put in use for patient care after December 31, 1990 (i.e., new capital costs). Certain capital-related costs that were obligated as of December 31, 1990, for assets that are put in use for patient care after December 31, 1990, may be recognized as old capital costs. It is necessary to distinguish between old and new capital in order to determine the applicable payment methodology (see §2807.4) and the hold harmless payment (see §2807.5B) and to redetermine the hospital-specific rate. (See §2807.4E.)

A. New Capital Costs.--New capital costs are:

- Allowable capital-related costs associated with assets first put in use for patient care after December 31, 1990, unless the costs were obligated as of December 31, 1990, and meet the conditions for recognition as old capital costs as described in subsection C;

- Allowable capital-related costs associated with assets in use for patient care as of December 31, 1990, that exceed the limitations for recognition as old capital costs described in subsection B; and

- Allowable capital-related costs obligated after December 31, 1990, for the betterment or improvement of an existing asset regardless of when the asset was initially put in use for patient care.

EXAMPLE: In FY 1994, Hospital A replaces the roof on its 20-year old building. The allowable costs for replacing the roof are recognized as new capital costs even though the building was in use as of December 31, 1990.

B. Old Capital Costs.--Old capital costs are allowable capital-related costs for land and depreciable assets put in use for patient care on or before December 31, 1990. Old capital costs are subject to the limitations described below.

1. Depreciation.--Allowable depreciation costs incurred during the cost reporting period for old capital assets, based on the applicable useful life guidelines, are recognized as old capital costs.

a. Asset Disposal.--A gain or loss to correct depreciation expense claimed upon disposal of an old capital asset (including an asset recognized as an old capital asset under the provisions in subsection C for obligated capital) qualifies as old capital costs. As described in §2807.8, the portion of the gain or loss that may be recognized as old capital costs in the year of disposal is based on the portion of the gain or loss that applies to that cost reporting period. If the allowable net loss (See §132) on an old capital asset is amortized over future cost reporting periods, the amortized costs are recognized as old capital costs in the cost reporting periods in which they are an allowable cost. (See §2807.8B).

b. Change of Ownership, Merger, Consolidation or Lease of Hospital.--If there is a change of ownership, allowable capital-related costs incurred by the new owner that would have been recognized as old capital costs in the absence of a change of ownership continue to be recognized as old capital costs under the new ownership. (See §§2807.8C and 2807.9.) In cases of merger, consolidation or leasing of the entire hospital operation, old capital retains its status within certain limits established by the original determination of old capital in the base period. (See §2807.9.)

2. Interest Costs.--The allowable capital-related interest expense the hospital was legally obligated to pay as of December 31, 1990, is recognized as old capital costs, subject to the provisions described below.

a. Variable Rate Debt.--Increased interest expense is recognized as old capital cost if the increase is due to fluctuating interest rates under a variable interest rate loan.

b. Loan Conversion.--Increased interest expense is recognized as old capital cost if the increase occurs at the time of conversion from a variable to a fixed rate loan, provided no other loan terms are changed. If there are changes in the loan terms, the interest expense that is recognized each year as old capital may not exceed the interest expense that may be recognized under the guidelines for other types of refinancing as provided in subsections 2c, 2d and 2e.

EXAMPLE: Hospital B converts from a variable rate loan to an 8 percent fixed rate loan and, at the same time, extends the remaining repayment period from 11 years to 25 years. The amount of allowable annual interest expense that is recognized as old capital cannot exceed the amount that would be recognized by applying the rules in subsection 2d.

c. Rolled-Over Debt.--A portion of allowable interest on a short term debt instrument that is used to finance assets of longer depreciable life and is rolled over may be recognized as old capital cost provided the asset remains in use. For this purpose, a loan qualifies as a short term debt instrument if the loan repayment schedule is for no more than 5 years or half the remaining useful life of the assets at the time of the financing, whichever is less. The portion of allowable interest expense that is recognized as old capital is equal to the ratio of the net book value at the beginning of the applicable cost reporting period for depreciable assets that were in patient care use in the base year, to the net book value as of the beginning of base year for those assets. In determining the ratio, the net book value equals the historical cost of the depreciable assets that were financed with the short term debt instrument less accumulated depreciation as determined for Medicare purposes. If the specific assets that were financed with the rolled-over debt cannot be identified, all depreciable assets, exclusive of those that were financed by other identifiable debt instruments, are included in the ratio. The base year net book value remains constant throughout the transition and is not adjusted for assets that have been fully depreciated, retired or otherwise disposed of subsequent to the base year. In contrast, the current year net book value reflects the net book value of only those assets which remain in use as of the beginning of the applicable cost reporting period.

To determine whether the financing qualifies as short term debt when more than one asset is involved, the average useful life of the assets financed by the debt is computed by weighting the useful life of each asset by its net book value at the time of financing. If the debt obligated as of December 31, 1990 (before roll-over) cannot be associated with specific assets, the average useful life is computed as of the base year by weighting the remaining useful life of each asset by its net book value. The remaining useful life is recomputed each time the debt is rolled over.

EXAMPLE: Hospital Q, a new hospital in 1970, financed its original buildings and equipment with a $50 million mortgage but subsequently financed asset acquisitions amounting to $20 million through short term financing that has been rolled over several times so that, except for the original mortgage, specific debt cannot be associated with specific assets. The net book value of the subsequent acquisitions at the beginning of the hospital's base year is $15 million with an average useful life of 12 years. In 1994, the hospital rolls over a 5-year note that had been issued in 1989. The actual interest expense on the 1989 note is recognized as old capital cost since the interest payments were obligated as of December 31, 1990. Since the payment term for the 1989 note is for less than half the average useful life of the subsequent acquisitions as of the base period, a portion of the interest expense on the rolled-over debt issued in 1994 is recognized as old capital cost. The value of the assets financed by the original mortgage is not included in determining the proportion of interest expense on the 1994 debt that is old capital costs. To determine the portion that is recognized as old capital cost in FY 1994, the ratio of the net asset value of the subsequent acquisitions (that were in use during the base year) at the beginning of the hospital's FY 1994 cost reporting period to $15 million is applied to Hospital Q's FY 1994 interest expense on the 1994 note. In FY 1995, the ratio of the net asset value of the subsequent acquisitions at the beginning of the hospital's FY 1995 cost reporting period to $15 million is applied to Hospital Q's FY 1995 interest on the 1994 note.

d. Refinancing Debt.--If old capital indebtedness is refinanced or the terms of the debt instrument are otherwise revised (except as provided in subsections 2b, 2c, or 2e), the annual interest expense on the refinanced debt that is recognized as old capital cost cannot exceed the amount of interest expense for which the hospital was obligated to pay each year as of December 31, 1990. If the refinancing results in a lower annual interest payment but a longer repayment term, the limitation is applied on an aggregate basis based on the amount that would have been incurred during the transition.

If old capital and new capital indebtedness is commingled, the ratio of the amount of the loan principal related to old capital debt to the total loan principal amount is applied to the allowable interest expense to determine the portion that is recognized as old capital cost, subject to the general limitation on the amount recognized as old capital cost.

EXAMPLE: In FY 1993, Hospital X refinances old capital moveable equipment to remove restrictive covenants at the same time it finances a purchase of new operating room equipment. The breakdown of loan principal for each category is:

Old capital outstanding loan principal	$240,000
New capital loan principal	$ 60,000
Total loan principal	$ 300,000

The annual interest on the loan is at 10 percent with a resulting annual cost of $30,000.

Thus, the interest expense recognized as old capital cost is:

$\frac{\$240,000}{\$300,000} \times \$30,000 = \$24,000$

However, the terms of the old loan on the old capital stipulated a 9 percent interest rate over a 10-year period, for which 5 years have elapsed, with repayment of the loan principal at the end of the 10-year term. Under those terms for the old capital debt, only $21,600 ($240,000 x .09) in interest expense in each of the remaining 5 years would have been recognized under the terms of the old loan. Therefore, only that amount can be recognized over the term of the new loan as old capital cost, and the remainder is recognized as new capital cost.

e. Advance Refunding.--Medicare recognizes all reasonable costs associated with an advance refunding under cost reimbursement rules, including debt cancellation costs on the refunded debt and the debt issuance costs on the related debt issuance, if the refunding is found to be necessary, proper and prudent. (See §233ff.) If such an advance refunding is executed for capital-related debt that was in effect or obligated on or before December 31, 1990, the allowable costs associated with the advance refunding are recognized as old capital costs.

During the capital-PPS transition period, hospitals may use advance refunding to refinance old capital assets either separately or in combination with new capital assets. If the interest expense on the refunded debt is solely old capital cost, the reasonable costs associated with the advance refunding, as defined in §233.4, are considered old capital costs subject to the limitation that the old capital costs cannot exceed the costs that would have been recognized during the transition period if the refunding had not occurred. Thus, the total advance refunding costs to be amortized during the remaining transition years must be compared with the total costs of the original financing over that same period to determine the old capital cost. Any reasonable capital-related costs (e.g., not unnecessary borrowing or excess working capital) for the advance refunding that are in excess of this limitation can be recognized only as new capital costs. If the advance refunding involves only new capital costs, all reasonable capital-related costs are recognized as new capital ascribable to the applicable periods. If the advance refunding is attributable to both old capital and new capital, the reasonable costs are allocated between old and new capital costs according to the outstanding principal that is associated with each category.

EXAMPLE: Hospital X decides to call in a 1986 construction bond issuance using a new issuance in 1992 to take advantage of lower interest rates through advance refunding. No new acquisitions are being financed through this action. Due to the life of the advance refunding, which exceeds the capital transition period by several years, the costs for the debt refunding exceed that for the refunded debt by $90,000 over the transition period. The excess is amortized over the remaining 9 year transition period at $10,000 per year and is treated as new capital.

EXAMPLE: Use the same information for Hospital X as in the above example except that in addition to the 1986 $2 million loan, the refunding of debt includes a $200,000 loan for equipment added in 1991. Prior to the adjustment to limit recognition of old capital for the $90,000 excess interest expense determined above, the allowable and reasonable costs of the advance refunding are divided between old capital and new capital in accordance with subsection 2d on a ratio of 91 percent old capital to 9 percent new capital (i.e., $2,000,000/$2,200,000 and $200,000/$2,200,000, respectively.)

f. Investment Income Offset.--Old capital interest expense is reduced by investment income (excluding investment income earned from sources listed in §202.2, such as funded depreciation accounts) based on the ratio of total old capital interest expense to total allowable interest expense in each cost reporting period.

g. Curing of Unnecessary Borrowing.--If available funded depreciation was not used at the time borrowing occurred, the interest expense may be unallowable. If the unnecessary borrowing occurred on or before December 31, 1990, and is cured through spend-down of funded depreciation accounts as provided in 42 CFR 413.134(e)(3)(i)(C), the interest expense is an allowable capital-related cost and is considered an old capital cost effective with the cost reporting period during which the curing occurs.

3. Lease and Rental Costs.--Allowable lease and rental costs for land and depreciable assets that were in patient care use or obligated as of December 31, 1990, are recognized as old capital costs. Under certain conditions, costs may be recognized as old capital costs even if the lease in effect as of December 31, 1990, expires or there are other changes in the arrangements.

a. Renewals.--If an asset has been continuously leased on and after December 31, 1990, and the lease is renewed when it expires, the lease payments under the renewal are recognized as old capital costs up to the amount of annual lease payment obligated as of December 31, 1990, provided the following conditions are met:

- The identical asset remains in use;
- The asset has a useful life of three or more years; and
- Before renewal, the annual lease payment for the asset is at least $1000.

The annual lease payment must be determined for each asset. If assets of different value are covered by the same lease agreement and the agreement does not specify the payments attributable to each asset, the lease payment is apportioned among the assets based on an estimate of what the lease payment would be if each asset were leased separately. If more than one asset is covered by the lease agreement, only that portion of the lease payment attributable to assets that meet the specified conditions is recognized as old capital cost.

EXAMPLE: Hospital X leases space for its accounting and billing departments. The lease agreement covers 1989-1993 and provides for automatic annual renewal thereafter unless either party takes appropriate action to terminate the lease. When the lease was entered into in 1989, the agreement specified that the lease payment for 1989 is $20,000 and that it increases by $1,000 annually. Thus, the hospital was obligated as of December 31, 1990, for a $24,000 lease payment in 1993. In 1994 when the lease is automatically renewed, $23,000 of the lease payment is recognized as old capital cost and the remaining $1,000 of the lease payment is recognized as new capital cost. As long as the hospital continues to lease the space, up to $24,000 in annual lease payments is recognized as old capital.

EXAMPLE: Hospital Y has an agreement with a medical equipment supplier to rent bedside monitoring devices on an as needed basis. The agreement is that the supplier furnishes the equipment as required on four hour notice at a daily charge of $250. A separate rental agreement is executed each time the equipment is delivered. Only the rental payments for monitoring devices that have been continually leased since December 31, 1990, are recognized as old capital costs. The rental payments for any monitoring devices that are rented after December 31, 1990, are recognized as new capital costs on several grounds. The rental agreement is not a renewal of a rental agreement that was in effect as of December 31, 1990, the hospital was not obligated to rent the equipment as of December 31, 1990, and the same asset has not remained in use.

EXAMPLE: In 1990, Hospital Z enters into an agreement to lease 10 bedside monitoring devices for 4 years at an annual payment of $20,000. The useful life of the devices is 10 years. When the lease expires in 1994, Hospital Z renews the lease for 2 additional years. The payments under the lease renewal are recognized as old capital costs because the annual lease payment attributable to each device is $2000 and the useful life for each asset is more than 3 years.

EXAMPLE: In 1990, Hospital Z enters into an agreement to lease a photocopy machine for 5 years. The machine breaks down in 1993, and the supplier replaces it free of charge. The lease payments through the initial lease period are recognized as old capital costs because the hospital was obligated to pay these amounts as of December 31, 1990. When the lease is renewed in 1995, the payments under the lease renewal are recognized as new capital costs because the same asset has not remained in use.

b. Lease Back Arrangements.--If an old capital asset owned by a hospital is sold or transferred to another party after December 31, 1990, and is then immediately leased back by the hospital, the asset continues to qualify as old capital. The amount that is recognized as old capital cost is limited to the amount allowed for that asset in the last cost reporting period during which the asset was owned by the hospital.

c. Lease Purchase of Assets.--A leased asset that qualifies as old capital and has been in continuous use for patient care on and after December 31, 1990, may be purchased by the hospital during or at the end of the lease/rental agreement. The allowable costs for the asset are recognized as old capital provided the identical asset remains in use and has a useful life of at least 3 years, and the annual lease payment for the asset was at least $1,000 per year. The amount that is recognized as old capital cost after the purchase is the actual allowable capital-related costs of acquisition.

d. Treatment of Old Capital for Hospitals Leased After December 31, 1990.--Hospitals may be leased and operated in their entirety after December 31, 1990, resulting in situations in which the hospital is leased without assumption of its asset costs. In such cases, the amount of allowable capital-related costs that could be recognized as old capital cost is limited to the amount that could be recognized for the same assets in the last cost reporting period before the current lease became effective. Any leased cost above that amount is treated as a new capital cost.

4. Other Capital-Related Costs.--A portion of the hospital's allowable costs for other capital-related expenses (e.g., taxes, insurance and royalty fees) is recognized as old capital cost. The amount that is recognized as old capital cost is based on the ratio of the hospital's gross old asset value to gross total asset value in each cost reporting period. For this purpose, gross asset value is the historical cost of the hospital's land and depreciable assets that are used in patient care activities.

5. Related Organization Costs.--Old capital costs include the allowable capital-related costs of related organizations, as described in Chapter 10, and §2150ff. and referenced instructions, that would be recognized as old capital costs if those costs had been directly incurred by the hospital.

EXAMPLE: Hospital W's home office reports segregate the capital-related costs attributable to assets owned as of December 31, 1990, and those acquired afterward and by type of capital-related cost (e.g., depreciation, interest, lease). The intermediary servicing the home office audits the home office cost statement and assures the limitations on old capital costs are applied properly and old, new and other capital costs incurred by the home office are appropriately allocated to Hospital W. Those costs are then included in Hospital W's capital-related costs. A portion of the hospital's total other capital costs (including other capital-related costs directly assumed by the home office) is allocated to old capital costs based on Hospital W's total old capital costs to total capital-related costs.

6. Assets Returned to Patient Care Use.--A hospital may have a nonreimbursable cost center or otherwise incur nonallowable hospital costs for a depreciable asset as of December 31, 1990. Examples of these nonallowable

costs include costs attributable to idle space or equipment, or space that is leased to another party or used to provide nonhospital services in part of a building that is also used to provide hospital services. To the extent the costs of such space or equipment becomes an allowable hospital cost after December 31, 1990, the allowable costs for the asset that are attributable to inpatient hospital services are recognized as old capital costs as long as a portion of the asset was in use for hospital patient care on December 31, 1990, and it meets all other requirements for recognition as old capital costs cited in this section. (See §2807.3B.) The allowable costs that are recognized as old capital costs are subject to the limitations in subsection B on old capital costs. If no portion of the asset was used to provide hospital patient care services prior to December 31, 1990, the allowable costs are recognized as new capital costs when the asset is put in use for hospital patient care.

EXAMPLE: Hospital A has operated an excluded rehabilitation unit in a wing of its building since 1985. Effective with its cost reporting period beginning in FY 1994, the hospital closes the unit and converts the beds to acute inpatient hospital beds. The increased capital-related costs attributable to the inpatient hospital services provided in the wing are recognized as old capital costs effective with the FY 1994 cost reporting period.

EXAMPLE: Hospital B leases its radiology department, including radiology equipment, to an outside contractor. Effective with its cost reporting period beginning in FY 1994, the hospital does not renew the contract and assumes the operations of the department. All assets within the radiology department have historical costs that date back before December 31, 1990. The increased capital costs attributable to the space are recognized as old capital costs effective with the FY 1994 cost reporting period since a portion of the asset (building) was used to provide hospital patient care service prior to December 31, 1990. The equipment costs are considered new capital because the assets were not used to provide hospital patient care services by the hospital prior to December 31, 1990.

EXAMPLE: Hospital C had gutted two floors of its building in 1989 after a physician group vacated its lease of the space as a separate clinic. In l992, the hospital reconstructs the "shelled-in space" and institutes inpatient routine acute care services in the renovated area. The costs for the existing "shelled in space" as of December 31, 1990, that otherwise meet the criteria for recognition of old capital qualify as old capital costs when it is put into patient care use. However, the additional renovation costs that were incurred after December 31, 1990, to bring the asset into patient care use are classified as new capital because the hospital was not obligated to incur those costs as of December 31, 1990. If the "shelled-in space" had not been part of an asset that was in hospital inpatient acute care use as of December 31, 1990 (e.g., in another building housing a PPS-excluded rehabilitation facility), its capital-related costs do not qualify as old capital costs, but only as new capital costs.

7. Obligated Capital Costs.--Obligated capital costs meeting the requirements for such commitments provided in subsection C qualify as old capital costs.

C. Obligated Capital Costs.--If the conditions in subparagraphs 1, 2, or 3 are met, certain capital-related costs for assets that are put into patient care use after December 31, 1990, may be recognized as old capital costs. The amount of capital-related costs associated with the asset that is recognized as old capital costs is generally limited to the lesser of the actual allowable costs of the asset when it is put in use or the estimated costs of the asset when it was obligated. The intermediary establishes the limitation on the amount of obligated capital that is recognized as old capital costs based on the best documentation available on or before December 31, 1990.

NOTE: Allowable capital-related costs for assets that do not meet these requirements are new capital costs.

If the obligated expenditures involve a multiphase capital project, the requirements of this section apply independently to each phase.

1. General Rule.--Capital-related costs that were put into patient care use after December 31, 1990, are recognized as old capital costs if the following conditions are met.

a. Binding Enforceable Agreement.--A binding enforceable agreement was entered into on or before December 31, 1990, by a hospital or related party with an outside unrelated party for the construction, reconstruction, purchase, lease, rental or financing of an asset for which allowable capital-related costs are recognized by Medicare. The agreement must be in writing and signed by authorized representatives of both parties. It must have been executed on or before December 31, 1990, and obligate the hospital on or before that date to proceed with the capital expenditure. To be considered binding, the agreement must contain specific provisions setting forth the obligations of each party and the penalties that are applicable if those obligations are not met. An agreement may be considered enforceable even if it is subject to conditions, but agreements that have conditions that are under the control of either party or a predecessor must be questioned and submitted to the CMS Regional Office for review under State contract law. Agreements that do not contain penalty or forfeiture provisions, or that limit damages to a specified amount (e.g., by use of a liquidated damages provision), also are subject to legal review. The intermediary forwards such agreements to the Regional Office servicing the State in which the hospital is located.

Only agreements that constitute a legal obligation to proceed with the actual acquisition of the asset or capital project are considered for purposes of recognizing old capital costs. Planning, design or feasibility study agreements do not constitute binding contracts for this purpose since these agreements do not commit the hospital to acquiring the asset or undertaking the project. However, the costs for such studies and plans are recognized as old capital costs for projects that do meet the conditions established for obligated capital.

b. Special Requirement for Moveable Equipment.--Moveable equipment qualifies as old capital if a binding contract for the lease or purchase of the moveable equipment was entered into on or before December 31, 1990. Otherwise, moveable equipment that is put in use after December 31, 1990, qualifies as old capital only if the following conditions are met:

(1) A binding contract for financing the acquisition was entered into on or before December 31, 1990;

(2) The equipment is an item that costs at least $100,000;

(3) The item was specifically listed in an equipment purchase plan approved by the hospital's Board of Directors on or before December 31, 1990; and

(4) If a group of assets are involved, each piece of equipment must meet the specified conditions.

EXCEPTION: In cases where the equipment at issue is a computer system, the requirement in subsection b(2) that each item's cost must be $100,000 or more is applied to the basic set of equipment needed for computer functioning; i.e., the central processing unit, one monitor and one terminal. If that configuration costs at least $100,000, the criterion in subsection b(2) is met and all additional equipment included in the total system approved under the requirement in subsection b(3) is considered part of the item involved in the determination.

EXAMPLE: A hospital entered into a binding contract for financing the acquisition of a computer system and received specific approval from the Board of Directors prior to December 31, 1990. The system was purchased in April 1991. The cost of the computer system in the aggregate was more than $100,000. However, the cost of each component of the system was less than $100,000, even after consideration of the basic configuration necessary to functioning of a computer system (i.e., the central processing unit, a monitor and a terminal together do not meet the $100,000 threshold). Therefore, the acquisition cannot meet the obligated capital criteria because no item meets the individual item cost requirement. If the basic computer configuration had met the cost criteria, the system description approved by the Board of Directors is considered old capital costs.

EXAMPLE: A hospital purchases 100 hospital beds in 1991 after securing financing and Board approval in November l990. Each bed costs $2,000. The criteria for recognition of these costs as obligated capital costs are not met since each item does not meet the threshold.

NOTE: A purchase order executed by a hospital for equipment acquisitions does not, by itself, necessarily constitute a contract binding on both parties. Most States have adopted the Uniform Commercial Code with little or no change. The code provides that an order may represent an invitation to contract for goods and is not an absolute obligation to perform on the parties involved. If the supplier of goods or services does demonstrate acceptance of the offer by December 31, 1990 (e.g., by delivery of order, return invoice or acceptance of a down payment by the deadline) or is required to perform by the deadline under State law even in the absence of such evidence of acceptance, the requirements for the existence of a binding contract may be met. When there is a question of acceptance or required performance under State law without other evidence of acceptance of the order, send the document to the Regional Office servicing the provider's State for resolution of the issue. In any other instance, the requirements of subsections b(1)-(3) must be met in such instances for equipment to be considered old capital.

c. Deadline for Notifying Intermediary.--The hospital must notify the intermediary of any obligated capital, including full documentation of contracts, agreements, approvals and expenditures by the later of October 1, 1992, or 90 calendar days after the hospital becomes subject to the capital prospective payment system. The documentation must include a project description (including details of any phased construction or financing) and an estimate of costs that was made no later than December 31, 1990.

d. In Use by September 30, 1994.--The asset is put in use for patient care on or before September 30, 1994. In the case of extraordinary circumstances that are beyond the hospital's control, CMS may extend the deadline to a later date not to exceed September 30, 1996. (See subsection C4.)

e. Limitation on Amount of Obligated Capital Recognized as Old Capital Costs.--When an asset that is put in use for patient care after December 31, 1990, qualifies as old capital, the actual reasonable costs for the asset that are recognized as old capital are generally limited to the lesser of the actual allowable costs when the asset is put in use or the estimated costs of the asset when the binding agreement was entered into. Except in the limited situations described in subparagraph (2), any allowable costs in excess of the estimated costs of the asset are recognized as new capital costs. Any increased costs arising from changes in the nature of the binding contract which occur after December 31, 1990, but which relate back to the initial date of the agreement, are recognized as new capital costs.

(1) Assets Acquired by Lease or Purchase.--Generally, the old capital cost limitation for an asset acquired by lease or purchase equals the cost specified in the lease or purchase agreement. If the asset is an item of moveable equipment for which only a financing agreement had been entered into by December 31, 1990 (and the item qualifies under subsections 1b, 1c and 1d as old capital), the amount that can be recognized as old capital costs is limited to the lower of the actual cost or the estimated costs approved by the hospital's Board of Directors on or before December 31, 1990.

(2) Construction Contracts--The amount of the limitation on obligated capital costs for a construction project applies only to the amount of the project's construction costs. Moveable equipment that is acquired as part of a construction project is included in the limitation and recognized as old capital costs only if the conditions in subsections 1b, 1c and 1d are met. Otherwise, the allowable costs for moveable equipment acquired as part of a construction project are recognized as new capital costs. The limitation on obligated capital costs does not apply to other costs that are related to the project and are capitalized as part of the asset's historical costs, such as legal and architect fees and planning costs. These costs qualify as old capital when the project is completed and the asset is put in use for patient care.

The amount of obligated capital costs recognized as old capital cannot exceed the estimated construction costs for the project established as of December 31, 1990. Primary sources for the estimated cost of the project are the project description and the estimated cost identified in contractual documents related to the financing and construction of the project. Additional costs that are documented as a revised estimate of the project costs are recognized only if that estimate was prepared on or before December 31, 1990. In addition, increases that are documented as being directly attributable to changes in life safety codes or other building requirements established by government ordinance

that occurred after the project was obligated are recognized as old capital costs. Other increases in allowable project costs, such as those resulting from changes in project specifications or from construction delays, are not recognized as old capital but are allowable as new capital costs.

(3) Financing Costs.--The limitation on financing costs is based on the interest expense for which the hospital was legally obligated as of December 31, 1990. Interest expense not legally obligated as of that date is treated as old capital only to the extent the expenses are specified in a detailed financing plan approved by the hospital's Board of Directors on or before December 31, 1990, for a capital acquisition or project that was legally obligated on or before that date. Increases in interest expense are recognized only on variable rate debt instruments.

2. Special Provision for Significant Delay in Certificate of Need (CON) Approval.--If a hospital is subject to a lengthy certificate of need approval process, a capital expenditure that does not meet the criteria under the general rule for recognizing obligated capital may nevertheless qualify for recognition as old capital costs if the following criteria are met.

a. General Criteria.--A capital expenditure must meet the following criteria to be recognized as old capital under this special provision.

(1) CON Approval Required.--The hospital is required under State law to obtain approval of the capital project or acquisition by a designated State or local planning agency in its State. If CON approval is not required for the asset (e.g., the cost of the item of equipment is less than the dollar threshold requiring pre-approval), the capital-related costs associated with the asset cannot qualify for recognition as old capital under this special provision. In such cases, the costs associated with a project or acquisition can only be recognized as old capital if it meets the general criteria in subsections 1a-1e.

(2) Application Filed by December 31, 1989.--The hospital filed an initial application for approval of the capital project or acquisition on or before December 31, 1989. At a minimum, the application must have included a detailed description of the capital expenditure project and its estimated costs. Although modifications in the scope of the project may be made between the initial application and the final project as part of the approval process, the project must be an identifiable component of the initial application.

(3) Approval Received After September 30, 1990.--The hospital had not received approval for the capital project or acquisition on or before September 30, 1990.

(a) Conditional Approval.--If the hospital received conditional approval for the project, the intermediary assesses the nature of the conditions to determine whether the hospital received sufficient approval for the scope of the project to enter into a binding contract. For example, if a hospital received approval before September 30, 1990, for a construction project that was contingent on the hospital securing adequate financing or making minor design modifications, the hospital may be considered to have received approval before September 30, 1990, since the scope of the project has

been approved. On the other hand, if the hospital received approval before September 30, 1990, that was contingent on a reduction in the size of an addition from 50 beds to 20 beds, the hospital is not considered to have received approval by September 30, 1990, because the approval was conditional on a substantial change in the scope of the project that requires additional planning before the hospital could enter into a contract for the actual construction project.

A hospital is considered to have received approval for the project as of September 30, 1990, if the intermediary determines that the hospital received sufficient approval for the project to proceed without significant delay.

(b) Partial Approval.--A hospital's application for CON approval may have covered several projects that could be undertaken independently or in separate phases. If the hospital received approval on or before September 30, 1990, for a phase or segment of the project that could be undertaken independently of the rest of the project, the costs of those phases or segments of a project that received CON approval prior to September 30, 1990, may be recognized as old capital only if they were legally obligated by December 31, 1990, and meet all the other criteria for recognition of obligated capital under the general rule in subsection C1. Those phases or segments that did not receive approval on or before September 30, 1990, can be recognized as old capital only if they meet all the criteria of the special provision for significant delay in CON approval in this subsection.

EXAMPLE: A hospital's CON application included proposals to expand its inpatient acute care capacity and to renovate its radiology department in conjunction with the addition of MRI equipment. The hospital received partial approval for the inpatient expansion as of September 30, 1990, but had not yet received approval for the MRI project. Unless the hospital had entered into a binding contract for the inpatient expansion project on or before December 31, 1990, the costs for the inpatient expansion are not recognized as old capital. The MRI project can be recognized as old capital only if it meets the significant cost requirement and the deadline for putting assets in use.

(4) Significant Cost Incurred By December 31, 1990.--The hospital incurred the lesser of $750,000 or 10 percent of the project's estimated cost on or before December 31, 1990. To determine whether the cost threshold has been met, the reasonable costs incurred by the hospital that are directly related to the planned capital expenditure and are capitalized as part of the depreciable asset's historical costs are considered. This includes legal, architect and accounting fees, and costs incurred by the hospital for studies, surveys, designs, plans, working drawings, specifications and other activities related to the capital expenditure. It does not include marketing or general feasibility studies that relate to overall institutional strategic planning activities. Further, it does not include nondepreciable costs of land but does include depreciable land improvements.

(5) Put in Use Within 4 Years or By September 30, 1996.--The asset is put in use for patient care services on or before the earlier of September 30, 1996, or 4 years from the date the certificate of need is approved. In the case of extraordinary circumstances that are beyond the hospitals control, CMS may extend the deadline to no later than September 30, 1996. (See subsection C4.)

b. Additional Requirement for Moveable Equipment.--The costs of moveable equipment may qualify as old capital under the special rule for delays in the CON approval process, but only if the State or local authority requires separate CON approval for the equipment. The initial application for approval must have been filed on or before December 31, 1989, and the equipment must cost at least $100,000 for each item. If these requirements are not met, the equipment is considered new capital when it is put in use for patient care.

c. Limitation on Amount of Cost Recognized as Old Capital Costs.--Only those portions of a project that require CON approval are recognized as old capital under this paragraph. In most cases, this includes fixed capital projects and major moveable equipment that cost a specified dollar threshold. Any other portions of the project (e.g. equipment that costs less than the specified threshold for CON approval) is subject to the provisions in subsection C1. The amount of capital-related costs that is recognized as old capital costs under this paragraph is based on the most recent estimate of the costs for the old capital portion that was documented on or before December 31, 1990.

Generally, the intermediary relies on the most recent cost estimate that was developed on or before December 31, 1990, as part of the CON approval process to establish the limitation on the amount of costs that is recognized as old capital costs. An expansion in the scope of the project or a change in its nature is not recognized unless specifically required by the planning agency as a condition of approval. If the approval involves a reduction in the scope of the project, the estimated costs of the project that are recognized as old capital are reduced accordingly.

(1) Assets Acquired by Purchase or Lease.--The capital-related costs that are recognized as old capital cost for assets that are purchased or leased is based on the purchase price or annual leasing costs that were estimated on or before December 31, 1990. If the estimate covers only the first few years of a lease arrangement, the estimated annual payment for the last year included in the estimate serves as the limitation on the amount that is recognized as old capital costs in succeeding years.

(2) Construction Project.--The limitation on the amount of capital-related costs for a construction project that is recognized as old capital costs applies only to the construction costs. Planning, legal and architectural costs that are part of the project are not subject to the limitation but are capitalized with the construction costs as old capital at the time the asset is put into patient care use. Separate limitations apply to moveable equipment and financing costs that are part of the construction project.

(3) Financing Costs.--Financing costs are recognized as old capital only to the extent such expenses are specified in a detailed financing plan for the project that provides a description of and identifies the cost estimates for each project, phase, or component of construction or renovation and that was formally approved by the hospital's Board of Directors on or before December 31, 1990.

3. Special Criteria for Construction in Progress.--Construction in progress as of March 31, 1991 that does not meet the criteria in subsection C1 or C2 may nevertheless qualify for recognition as old capital costs if all of the following criteria are met:

a. CON Approval Received by December 31, 1990.--The hospital received any necessary certificate of need approval on or before December 31, 1990.

b. Board of Directors Approval by December 31, 1990.--The hospital's Board of Directors formally authorized the capital project with a detailed description of its scope and costs on or before December 31, 1990.

c. Major Project.--The estimated cost of the project exceeds 5 percent of the hospital's total patient revenues during its base year. To determine whether this requirement is met, the estimated amount for the project that was approved by the hospital's Board of Directors on or before December 31, 1990, is divided by the hospital's total inpatient and outpatient revenues in its 12-month or longer cost reporting period ending on or before December 31, 1990. Thus, for purposes of this calculation the base year consists of at least a 12-month period. Hospitals that must use more than 12 months, use the average monthly revenues (inpatient plus outpatient) for the period to develop a 12-month total of patient revenues. Determine whether the 5 percent minimum level is met by dividing the estimated amount of the project that was approved by the Board of Directors on or before December 31, 1990, by total patient revenues for 12 months.

d. Significant Cost Incurred by December 31, 1990.--The capitalized cost that had been incurred for the project as of December 31, 1990, exceeded the lesser of $750,000 or 10 percent of the estimated project cost. For purposes of determining whether the cost threshold has been met, include the reasonable costs incurred by the hospital that are directly related to the planned capital expenditure and that would be capitalized as part of the depreciable asset's historical costs once the asset was put into use for patient care. This includes legal, architect and accounting fees and costs incurred by the hospital for studies, surveys, designs, plans, working drawings, specifications and other activities related to the capital expenditure. It does not include marketing or general feasibility studies that relate to overall institutional strategic planning activities. Further, it does not include nondepreciable costs of land but does include depreciable land improvements.

e. Construction in Progress by March 31, 1991.--The hospital began actual construction or renovation (groundbreaking) on or before March 31, 1991.

f. Put In Use By September 30, 1994.--The project is completed and the asset is put in use on or before September 30, 1994. If there are extraordinary circumstances beyond the hospital's control, CMS may extend the deadline to no later than September 30, 1996. (See subsection C4.)

g. Limitation on Amount of Costs Recognized as Old Capital Costs.--Only buildings and other fixed assets are recognized as old capital under this provision. Any moveable equipment associated with the construction in progress is considered new capital unless it meets the general requirements for recognition as obligated capital under subsection C1. The amount of construction costs that are recognized as old capital is limited to the estimated construction costs approved by the hospital's Board of Directors on or before December 31, 1990. Financing costs associated with the construction costs are recognized as old capital only if the financing was described in a detailed financing plan adopted by the Board of Directors on or before December 31, 1990. Allowable planning, legal and architectural costs associated with the construction project are not subject to the limitation but are capitalized with the construction costs as old capital at the time the asset is put into patient care use.

4. Extension of Deadline for Putting Asset in Use.--CMS may extend the applicable deadline for putting an asset in use for patient care to no later than September 30, 1996, for extraordinary circumstances beyond the control of the hospital. Extraordinary circumstances may include a construction strike or atypically severe weather conditions that significantly delay construction. Normal construction delays do not constitute extraordinary circumstances.

a. Developing Extension Requests.--A hospital must submit its request for an extension to its fiscal intermediary by the later of January 1, 1993, or within 180 days after the occurrence that the hospital believes is extraordinary and beyond its control and is expected to delay placing the asset in patient care use by the deadline. The request must be in writing, and, at a minimum, contain a description of the circumstances, an explanation of why it is extraordinary and beyond the hospital's control, why the delay attributable to the circumstances cannot be overcome, and a new estimated completion date established by the contractor, supplier or other servicing party. The request must be accompanied by documentation of the circumstances (e.g., media releases, insurance or underwriter documents, public agency reports).

b. Processing Extension Requests.--The intermediary reviews and verifies the documentation submitted by the hospital and forwards the request along with its recommendation and the results of its review to CMS within 60 days of receipt for a determination. The extension request is sent to:

Health Care Financing Administration
Office of Payment Policy, BPD
Room 181, East High Rise
6325 Security Boulevard
Baltimore, MD 21207

CMS makes a determination within 90 days of receipt of the request and appropriate documentation.

5. Determination Process for Obligated Capital.--Any hospital that expects to put assets into patient care use after December 31, 1990, that would qualify as old capital must submit documentary evidence of binding agreements, contracts, cost estimates, estimated completion dates, Board of Director minutes, certificate of need documents, groundbreaking evidence and other documentation needed to verify and determine a hospital's obligated capital costs during the transition period. The hospital must submit its documentation to its intermediary by the later of October 1, 1992, or 90 days after the start of its first cost reporting period that begins on or after October 1, 1991. If the hospital cannot document the project description and the estimated cost for the project as of December 31, 1990, the expenditure does not qualify as old capital.

The intermediary determines if the capital cost qualifies as obligated old capital cost and the applicable limitation on the amount of obligated capital costs that are recognized as old capital costs. If necessary, the intermediary consults with the CMS Regional Office in making its determination. The intermediary notifies the hospital in writing of its determination by the later of the close of the hospital's first cost reporting period under the capital-PPS, or 9 months from the date the hospital submits its completed documentation. The intermediary's determination is contingent upon the asset being put into patient care use by the applicable deadline.

The intermediary's determination is subject to appeal during the hospital's first cost reporting period in which the intermediary's obligated capital determination affects the amount of payment under capital-PPS. Appeals are processed under the provisions of 42 CFR Part 405, Subpart R, with respect to recognition of the capital-related cost as obligated capital or the amount so recognized, or both.

D. Consistent Cost Finding During Transition Period.--During the transition period, a hospital must follow consistent cost finding methods for classifying and allocating capital-related costs for all cost reporting actions involving step down or direct assignment of capital-related costs.

1. Old Capital.--Except as indicated below, the hospital must continue the same cost finding methods for old capital costs, including its practices for the direct assignment of capital-related costs and its cost allocation bases, that were in effect in the hospital's last cost reporting period ending on or before October 1, 1991.

a. If the intermediary approved on or before August 30, 1991, a hospital's request to change one or more of its cost finding practices for capital-related costs effective for a cost reporting period beginning before October 1, 1991, the cost finding methods in effect for that cost reporting period must be used for old capital during the transition.

b. If there is a change of ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices. The request for a change and the intermediary's approval is subject to the provisions in §§2300ff.

2. New Capital.--A hospital may change its capitalization policy or cost finding methods for new capital only if the intermediary determines that there is reasonable justification for the change. Any request for change must be made in writing to the intermediary prior to the beginning of the cost reporting period for which the change is to apply. The request must justify why the change will result in more appropriate and accurate cost finding. The request must also show that the change will meet the applicable provisions in §§2300ff.

2807.4 Capital-PPS Transition Payment Methodologies.--The payment methodology applicable to a particular hospital during the capital-PPS transition period is determined by comparing the hospital's hospital-specific rate, which is derived from the hospital's inpatient capital-related costs in a specified base year, to the applicable Federal rate. (See §2807.4D.) If the hospital-specific rate is above the Federal rate, the hospital is paid under the hold harmless methodology. A hospital with a hospital-specific rate below the Federal rate is paid under the fully prospective methodology. Except as provided in §2807.4E, the same payment methodology is applicable throughout the transition period.

A. Capital-PPS Base Year.--The initial base year used to determine the hospital-specific rate for all hospitals, other than new hospitals, is the latest 12 month or longer cost reporting period (or combination of periods totaling at least 12 months in the case of short cost reporting periods) ending on or before December 31, 1990. In the case of a new hospital (see §2807.7), the initial base period is the 12 month or longer (or combination of periods totaling at least 12 months) cost reporting period that begins at least one year after the hospital accepts its first patient. (See §2807.7 for further discussion of treatment of new hospital base year and old capital costs.)

If a hospital, other than a new hospital as defined in §2807.7, does not have a 12-month or longer cost reporting period or does not have adequate Medicare utilization to file a cost report in a period ending on or before December 31, 1990, the hospital's old capital costs per discharge as described in subsection B for its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) ending after December 31, 1990, is used to establish the hospital-specific rate. However, the criteria for determining old and new capital costs remain the same as for all other hospitals subject to capital-PPS.

As discussed in §2807.4E, a hospital paid under the fully prospective payment methodology may request that its hospital-specific rate be redetermined through the later of its cost reporting period beginning in FY 1994 or after obligated capital that qualifies as old capital has been put in use based on its old capital costs in the later cost reporting period. The redetermination year serves as the new base year.

B. Capital-PPS Hospital-Specific Rate.--The intermediary determines the hospital-specific rate according to the following steps:

Step 1.--To establish an initial hospital-specific rate, determine the total allowable Medicare inpatient capital-related cost for the hospital in the capital-PPS base year. Include only the capital-related costs attributable to inpatient hospital stays covered under the prospective payment system.

To redetermine a hospital-specific rate using a later base period in accordance with §2807.4E, determine the total allowable Medicare inpatient old capital costs in the new base year.

Exclude the costs attributable to skilled nursing facility level days in swing bed hospitals and to inpatient stays in units that are excluded from the prospective payment system.

If a depreciable asset is disposed of in the base year, include only that portion of the gain or loss that is allocated to the base year cost reporting period. Any gain or loss on assets owned in the base year and subsequently disposed of is not reflected in the hospital-specific rate.

Step 2.--Determine the transfer case adjusted discharge count for the base year.

a. CMS determines a transfer adjustment factor for each hospital using the base year MEDPAR data on file as of June 30, 1991, for hospitals subject to the capital-PPS in FY 1992. For later base years beginning before FY 1992 (involving a new hospital or a redetermination of the hospital-specific rate), CMS determines a transfer adjustment factor for the hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least six months after the close of the base period. CMS calculates a transfer adjusted discharge value for each transfer case by dividing the length-of-stay for the case by the geometric mean length of stay for DRG to which the case is classified and assigning the result, not to exceed 1.0, to the transfer case. CMS assigns each nontransfer case a value of 1.0. To determine the transfer adjustment factor, CMS adds together the transfer adjusted discharge values and divides the result by total discharges, including transfer cases.

b. The intermediary determines the transfer adjustment factor for a base year beginning in FY 1992 or later based on the most recent billing data available from the Provider Statistical and Reimbursement System as of the date of the final determination of the hospital-specific rate.

c. The intermediary determines the transfer adjusted discharge count by multiplying the Medicare discharges, determined by the intermediary for the applicable cost report, by the transfer adjustment factor.

Step 3.--Determine the transfer adjusted case mix index for the base year.

a. CMS determines a transfer-adjusted case mix index for each hospital using the base year MEDPAR data on file as of June 30, 1991, for hospitals subject to capital-PPS in FY 1992. For later base years beginning before FY 1992, CMS determines a transfer-adjusted case mix index for the hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least six months after the close of the base period. CMS calculates a transfer-adjusted DRG weight for each transfer case by multiplying the transfer-adjusted discharge value for the case determined in step 2 by the relative weight assigned to the DRG to which the case is classified. CMS assigns to each nontransfer case the relative weight for the DRG to which the case is classified. To determine the transfer-adjusted case mix index, CMS adds together the transfer adjusted DRG weights and divides by the transfer-adjusted discharge count.

b. The intermediary determines the transfer adjusted case mix index for a base year beginning in FY 1992 or later based on the most recent billing data available as of the date of the final determination of the hospital-specific rate.

Step 4.--Calculate the base year average cost per discharge by dividing the total allowable Medicare inpatient capital-related costs (or the total allowable Medicare inpatient old capital costs in the case of a redetermination) (see step 1) by the transfer-adjusted discharge count (see step 2c).

Step 5.--Calculate the case mix adjusted base year average cost per discharge by dividing the base year average cost per discharge (see step 4) by the transfer-adjusted case mix index. (See step 3.)

Step 6.--Update the case mix adjusted base year average cost per discharge (see step 5) to Federal fiscal year 1992 based on the national average increase in Medicare inpatient capital cost per discharge (adjusted for changes in case mix) published by CMS, as follows:

12-Month Cost Reporting Period Ending	Update Factor
Jan. 31, 1990	1.22185
Feb. 28, 1990	1.21453
Mar. 31, 1990	1.20725
Apr. 30, 1990	1.20002
May 31, 1990	1.19283
June 30, 1990	1.18568
July 31, 1990	1.17858

Aug. 31, 1990	1.17151
Sept. 30, 1990	1.16449
Oct. 31, 1990	1.15719
Nov. 30, 1990	1.14993
Dec. 31, 1990	1.14272
Jan. 31, 1991	1.13555
Feb. 28, 1991	1.12843
Mar. 31, 1991	1.12135
Apr. 30, 1991	1.11432
May 31, 1991	1.10733
June 30, 1991	1.10038
July 31, 1991	1.09348
Aug. 31, 1991	1.08662
Sept. 30, 1991	1.07980

NOTE: If the base period covers more than 12 months, the intermediary must request the appropriate update factor from CMS, Bureau of Policy Development, Office of Payment Policy, Division of Hospital Payment Policy.

Step 7.--Multiply the updated amount calculated in step 6 by the applicable budget neutrality adjustment factor and exceptions adjustment factor for estimated capital-PPS exceptions payments for the fiscal year. The FY 1992 adjustment factors are as follows:

Exceptions Adjustment Factor: .9813
Budget Neutrality Adjustment Factor: .9602

The resulting amount is the hospital's hospital-specific rate. The hospital-specific rate is updated annually at the beginning of each Federal fiscal year. Future update factors, exceptions adjustment factors, and budget neutrality adjustment factors for the hospital-specific rate will be published annually in the Federal Register.

EXAMPLE: Hospital A has a base year ending September 30, 1990. The hospital's FY 1992 hospital-specific rate is calculated as follows:

Base year total allowable Medicare inpatient capital-related costs	$2,457,024
Total Medicare discharges for FY 1990	1,563
Transfer-adjusted discharges (1563 base year discharges x .9921 transfer adjustment)	1550.7
Transfer-adjusted case mix index (see 56 FR 43465.)	1.4331
Base year cost per discharge ($2,457,024/1,550.7)	$1,584.46
Case mix index adjustment ($1,584.46/1.4331)	$1,105.62
Update to FY 1992 ($1,105.62 x 1.16449)	$1,287.48
Exceptions payments adjustments ($1,287.48 x .9813)	$1,263.41
Budget neutrality adjustment ($1,263.41 x .9602)	$1,213.12
Hospital A's FY 1992 hospital-specific rate	$1,213.12

NOTE: The budget neutrality and exceptions reductions factors are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the hospital-specific rate. Therefore, when updating the hospital specific rate for FY 1993 and beyond, the exceptions reduction and budget neutrality factors for the preceding year are first removed before the factors for the current year are applied. For example, to determine Hospital A's hospital specific rate for FY 1993, the following recalculation is necessary.

Budget neutrality adjustment for FY 1993	.9162
Exceptions reduction adjustment for FY 1993	.9756
Net budget neutrality adjustment for FY 1993 (.9162/.9602)	.9542
Net exceptions reduction adjustment for FY 1993 (.9756/.9813)	.9942
FY 1993 update factor (See 57 FR 39837)	1.0607
Cumulative FY 1993 adjustment (.9542 x .9942 x 1.0607)	1.0062
FY 1993 hospital-specific rate (1.0062 x $1,213.12)	$1,220.64

C. Limitations on Changes to the Hospital-Specific Rate.--The intermediary updates the hospital-specific rate each Federal fiscal year for inflation and changes in the exceptions payment adjustment factor and the budget neutrality adjustment factor. Otherwise, the hospital-specific rate cannot be changed throughout the transition period except in the following situations.

- The initial base year hospital-specific rate determination may be revised as a result of a reopening of the base year cost report that affects the determination of base year costs per discharge. (See §2807.6A.)

- The hospital requests a redetermination of its hospital-specific rate based on its old capital costs in a subsequent base period in accordance with §2807.4E.

- The hospital merges with another hospital, or different campuses of a multi-campus hospital become separate providers (see §2807.9).

D. Payment Methodology Determination.--The intermediary compares the hospital's hospital-specific rate to its Federal rate (after taking into account the effect of estimated outlier payments and the payment adjustments other than case mix) to determine if the hospital is paid during the transition period under the hold harmless methodology or the fully prospective methodology.

The initial payment methodology determination is based on the hospital-specific rate and Federal rate applicable to the hospital's first cost reporting period under the prospective payment system. For cost reporting period beginning dates other than October 1, an average hospital-specific rate and Federal rate for the cost reporting period is determined based on the number of months of each Federal fiscal year in the cost reporting period.

If the hospital-specific rate is redetermined in accordance with §2807.4E using a base year beginning on or after October 1, 1992, the payment methodology is also redetermined by comparing the hospital-specific rate and Federal rate applicable to the redetermination base year.

In making the comparison, the Federal rate for the cost reporting period is determined by adjusting:

- For outliers by dividing the standard Federal rate by the outlier reduction factor applied to the rate for that fiscal year; and

- For the payment adjustment factors (other than case mix) applicable to the hospital (i.e., adjustments for geographic location, disproportionate share of low income patients and indirect teaching costs). The result is referred to as the adjusted Federal rate for a hospital.

EXAMPLE: Hospital A is located in San Jose, California, a large urban area, and has a disproportionate patient percentage of 25 percent and a resident-to-day ratio of 0.1456 in FY 1992. Its hospital-specific rate is $1,205.52. The hospital's cost reporting period begins October 1.

The adjusted Federal rate for Hospital A is:

$415.59 (FY 1992 standard Federal rate) divided by .9497 (FY 1992 outlier reduction) equals $437.60 multiplied by 1.2995 (geographic adjustment) multiplied by 1.03 (large urban adjustment) multiplied by (1+.0519+.0419) (disproportionate share and indirect medical education adjustments) equals $640.66.

Since Hospital A's hospital-specific rate is higher than its adjusted Federal rate, Hospital A is paid under the hold harmless methodology throughout the transition period. If the hospital-specific rate was equal to or lower than the adjusted Federal rate, the hospital would have been paid under the fully prospective methodology throughout the capital-PPS transition period unless a hospital-specific rate redetermination results in a subsequent change to the hold harmless methodology.

E. Redetermination of Hospital-Specific Rate.--If requested by the hospital, the intermediary redetermines the hospital-specific rate for a hospital paid under the fully prospective methodology using the process described below.

1. A hospital may request redetermination of its hospital-specific rate for any 12-month or longer cost reporting period or combination of cost reporting periods beginning subsequent to its original base year but no later than its cost reporting period beginning in FY 1994 or its first cost reporting period beginning after obligated capital that is recognized as old capital is put in use in accordance with §2807.3C. The hospital may request that its hospital-specific rate be redetermined more than once.

2. A hospital may request a redetermination only when there is an increase in the hospital's total old capital costs from its base period. Requests for redetermination cannot be recognized for any other conditions that could affect the hospital-specific rate, such as a decline in utilization that produced an increase in a hospital's old capital cost per case. However, if a hospital's total old capital costs increase over the base period determination and, in addition, the hospital experienced a decline in discharges in the same cost reporting period, the hospital's request for redetermination is appropriate.

3. The hospital's request for redetermination must be made in writing no later than the date the cost report must be filed with the hospital's intermediary for the cost reporting period that will serve as the new base year or its first cost reporting period beginning on or after October 1990, whichever is later. If the hospital receives an extension in filing its cost report for the new base year from the intermediary, the deadline for requesting the determination is automatically extended.

4. The hospital's request for redetermination must be accompanied by the hospital's cost report for the new base period, an estimate of its old capital costs for the new base year and its calculation of the redetermined hospital-specific rate. The estimate must demonstrate that the redetermined hospital-specific rate is higher than the hospital's current hospital-specific rate. If the intermediary determines, after audit of the final cost report data, that the redetermined hospital-specific rate is lower than the hospital's current hospital-specific rate, it advises the hospital that its request is denied and provides the hospital with an explanation of the intermediary's decision.

5. The intermediary redetermines the hospital-specific rate based on the hospital's actual old capital costs in the new base period following the steps in §2807.4B. The intermediary accounts for the changes in allowable old capital costs that have occurred subsequent to the base year. The intermediary includes in old capital costs the capital-related costs for obligated capital that is recognized as old capital under §2807.3C and for assets acquired before January 1, 1991, that were not fully represented in the base year capital-related cost determination. The intermediary excludes from the hospital-specific rate determination all new capital costs and the costs of old capital assets that were retired or disposed of subsequent to the original base year.

6. The intermediary compares the redetermined hospital-specific rate to the Federal rate applicable to the new base year (after taking into account the estimated effect of the payment adjustments and outlier payments pursuant to §2807.4D). Based on the results of that comparison, the intermediary determines whether the hospital is paid under the fully prospective or hold harmless methodology. The revised hospital-specific rate and payment methodology determination are effective retroactively to the beginning of the new base year (or the hospital's first cost reporting period under the capital-PPS if later). If the hospital's redetermined hospital-specific rate is higher than its previously established hospital specific rate, but is still lower than the adjusted Federal rate, the hospital continues to be paid under the fully prospective payment methodology. However, the new (increased) hospital-specific rate is used in determining payments effective with the start of the cost reporting period used as the new base period and onward.

EXAMPLE: Hospital E, whose cost reporting period begins January 1, is paid under the fully prospective payment methodology. The hospital opens a new inpatient wing on June 1, 1992, that the intermediary determined qualifies as old capital costs pursuant to §2807.3C. In January 1993, the hospital requests a redetermination of its hospital-specific rate due to the substantial obligated capital costs incurred during the 6 months the new wing has been in use for patient care ($1,000,000) and provides an estimate showing the redetermined hospital-specific rate is higher than the current hospital-specific rate for its FY 1992 cost reporting period. The

hospital revises its old capital costs to reflect actual FY 1992 old capital costs. Changes since the original base year include the 6 months capital-related costs for the new wing, the elimination of capital-related costs for retired equipment and expired leases, and lower interest payments on the hospital's original mortgage. In addition, the insurance costs apportioned to old capital costs are affected by a revised ratio of old capital asset value to total asset value. The intermediary makes final settlement on the FY 1992 cost report and redetermines the hospital-specific rate using the revised old capital costs and the new base year's transfer adjusted discharges and case mix index and the exceptions payment and budget neutrality adjustment factors provided by CMS.

The intermediary determines that the redetermined hospital-specific rate is higher than the hospital's new base year Federal rate. As a result, the hospital is paid under the hold harmless methodology effective January l, 1992, and the FY 1992 cost report is revised on that basis. Since the hospital is now paid under the hold harmless methodology, the annual capital-related costs for the new wing are automatically recognized as old capital in subsequent transition years. If the hospital remained on the fully prospective methodology (i.e., its redetermined hospital-specific rate was lower than its new base year Federal rate), it could request another redetermination in FY 1993 so that the annual costs of the new wing are reflected in its hospital-specific rate.

2807.5 Transition Payments.--Based on the capital-PPS transition payment methodology applicable to a hospital, the intermediary makes an interim payment for each discharge during a cost reporting period pursuant to procedures in §§2406ff. The final payment determination is made during final settlement of the cost report. Any adjustments based on the actual payment parameters or capital-related costs for the cost reporting period are effective retroactively to the beginning of the cost reporting period.

NOTE: The Federal rate used in the following calculations is the payment rate specific to each hospital after adjustment for its case mix, geographic location, and, as applicable, the disproportionate share and indirect teaching factors and any outlier amounts payable for the discharge. The rate is referred to as the adjusted Federal rate.

A. Fully Prospective Payment Methodology.--The payment for each inpatient discharge is determined by multiplying the hospital's hospital-specific rate by the DRG relative weight assigned to the discharge and multiplying that product by the applicable hospital-specific rate blend percentage for the cost reporting period. The applicable percentage of the adjusted Federal rate for the period is added to the hospital-specific amount. The blend percentages are as follows:

Cost Reporting Period Beginning On or After	Federal Rate Percentage	Hospital-Specific Rate Percentage
10/1/91	10	90
10/1/92	20	80
10/1/93	30	70
10/1/94	40	60
10/1/95	50	50
10/1/96	60	40
10/1/97	70	30
10/1/98	80	20
10/1/99	90	10
10/1/2000	100	0

B. Hold Harmless Payment Methodology.--The payment amount for each inpatient discharge is the higher of:

- An old capital payment equal to 85 percent of the hospital's allowable Medicare inpatient old capital costs per discharge for the cost reporting period, plus a new capital payment based on a percentage of the adjusted Federal rate. The percentage of the adjusted Federal rate equals the ratio of the hospital's allowable Medicare inpatient new capital costs to its total Medicare inpatient capital costs in the cost reporting period. For sole community hospitals, the old capital payment equals 100 percent of the hospital's allowable Medicare inpatient old capital costs per discharge; or

- 100 percent of the adjusted Federal rate.

Once a hospital receives payment based on 100 percent of the adjusted Federal rate in a cost reporting period beginning on or after October 1, 1993 (or the first cost reporting period after obligated capital that qualifies as old capital is put in use for patient care, if later), the hospital continues to receive capital-PPS payments on that basis throughout the remainder of the transition. The hospital may not switch to a payment based on its old and new capital costs in a subsequent cost reporting period.

If the status of a sole community hospital changes during the cost reporting period, an average percentage payment for old capital is determined based on the number of days the cost reporting period during which the hospital was classified as a sole community hospital. For example, if the hospital was classified as a sole community hospital for three months of the cost reporting period, the hospital receives 88.75 percent [(85 x .75) + (100 x .25)] of its allowable old capital costs for the cost reporting period.

Any hospital that is eligible to receive capital-PPS payments under the hold harmless methodology may elect to receive 100 percent of the adjusted Federal rate even if the separate old and new capital payments are higher. A hospital that does not maintain records adequate to identify its old capital costs is deemed to have selected payment based on 100 percent of the adjusted Federal rate.

C. Exceptions Payments.--During the capital-PPS transition period, a hospital may receive additional payments under an exceptions process when its capital-PPS payments are less than its Medicare allowable inpatient capital-related costs.

1. Minimum Payment Level by Class of Hospital.--The amount of the exceptions payment is determined as the difference between a percentage, or minimum payment level, of the hospital's reasonable inpatient capital-related costs and the payments that the hospital would receive under the capital-PPS in the absence of an exceptions payment. The comparison is made on a cumulative basis for all cost reporting periods during which the hospital is subject to the capital-PPS transition payment method. The minimum payment levels are determined by class of hospital and are subject to revision, if necessary, to keep total payments under the exceptions process at no more than 10 percent of capital prospective payments. The minimum payment levels for portions of cost reporting periods occurring during FY 1992 are:

- For sole community hospitals, 90 percent;

- For urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or that received more than 30 percent of net revenues from State or local funds for indigent care, 80 percent; and

- For all other hospitals, 70 percent of the hospital's reasonable inpatient capital-related costs.

Any revisions in the minimum payment levels are published in the Federal Register as part of the annual final rule implementing of PPS rates and policies.

For purposes of determining the hospital's minimum payment level for a given cost reporting period, a hospital's eligibility to receive the 80 percent minimum payment level as a disproportionate share hospital is determined consistent with §2807.2B5. An urban hospital with at least 100 beds that derives at least 30 percent of its inpatient revenues from State or local government sources for the care of indigent patients who are not covered by Medicare or Medicaid qualifies for the 80 percent payment threshold. If a hospital's status as a sole community hospital changes during a cost reporting period, the minimum payment level is determined based on the number of days in the cost reporting period during which the hospital was classified as a sole community hospital.

The exceptions payment is made during the cost report settlement process based on the hospital's class and minimum payment level for that cost reporting period. If the hospital's payments under the capital-PPS are less than its minimum payment level for the cost reporting period, a cumulative comparison is made between the hospital's capital-PPS payments in each cost reporting period and the minimum payment level applicable to the respective cost reporting periods. Any amounts by which, on a cumulative basis, the hospital's capital-PPS payments exceeded its minimum payment levels for those cost reporting periods are subtracted from the difference between the hospital's costs and minimum payment level in the current cost reporting period. If the result is positive, the hospital's exceptions payment equals this amount. If the result is negative, no exceptions payment is payable for the cost reporting period. Any additional payments made under this provision are further reduced by any payments received pursuant to the extraordinary circumstance exceptions provision. (See subsection C2.)

NOTE: CMS does not recover prior exceptions payments if a hospital receives payments in excess of the minimum payment level in any year subsequent to a year in which exceptions payments were made. However, any prior exceptions payments are included in the cumulative cost comparison to determine eligibility for an exceptions payment in a subsequent year.

EXAMPLE: Hospital Z is an urban hospital with more than 100 beds and a disproportionate share patient percentage of 16 percent. It has not received any exceptions payments for extraordinary circumstances. During its cost reporting period beginning in FY 1992, it has allowable capital-related inpatient costs amounting to $1 million and receives capital-PPS payments totaling $710,000 for that period. Hospital Z does not qualify for an exceptions payment because its capital-PPS payments exceed 70 percent of its allowable inpatient capital-related costs by $10,000.

For FY 1993, CMS announces continuance of the prior year minimum payment levels. Hospital Z again has $1 million in inpatient capital-related costs but receives only $670,000 in total capital-PPS payments, or $30,000 less than its minimum payment level. To determine its exceptions payment, the $10,000 excess over the FY 1992 minimum payment level is subtracted from the $30,000 shortfall in FY 1993. The exceptions payment is made for $20,000 and, consistent with the minimum payment levels, the hospital receives payment equal to 70 percent of its allowable inpatient capital-related costs on a cumulative basis.

EXAMPLE: Same as above except that in FY 1993, Hospital Z's disproportionate share patient percentage increases to 23 percent and the hospital qualifies for an 80 percent minimum payment level. Thus, Hospital Z receives $130,000 less than its minimum payment level in the absence of the exceptions process. To determine its FY 1993 exceptions payment, the $10,000 excess over the FY 1992 minimum payment level is subtracted from the $130,000, resulting in a $120,000 exceptions payment.

2. Exceptions Payments for Extraordinary Circumstances.--If a hospital experiences extraordinary circumstances beyond its control such as flood, fire or earthquake damage which result in unanticipated capital expenditures in excess of $5 million (after applying insurance proceeds), it may request and be eligible for an additional payment for such costs during the capital-PPS transition period. The minimum payment level applicable under this exceptions provision is:

- For sole community hospitals, 100 percent of Medicare's share of the allowable inpatient capital-related costs attributable to the extraordinary circumstances. (If a hospital loses its SCH status during a cost reporting period, to apportion its payments properly multiply the 100 percent by the ratio of patient days it did qualify for exceptions payments to the total of patient days in the cost reporting period.); or

- For all other hospitals, 85 percent of such costs.

A hospital must apply to its CMS Regional Office by the later of October 1, 1992, or within 180 days after the extraordinary circumstances causing the unanticipated expenditures for a determination by the CMS Administrator of whether the hospital is eligible for an additional payment based on the nature of the circumstances, any recovery proceeds from other parties and the amount of financial loss documented by the hospital. The request must be made in writing and provide an explanation with supporting documentation of the circumstances that led to the unanticipated capital expenditure and the estimated amount of the expenditure, along with the sources and amounts of any

anticipated reimbursement from insurance and other sources directly related to the capital expenditure. The Regional Office evaluates the request and forward its recommendation to the Administrator for a decision.

EXAMPLE: Hospital X, a 75-bed rural hospital, receives capital prospective payments effective with its cost reporting period beginning January 1, 1992. On July 3, it sustains severe structural damage to an inpatient wing as a result of a tornado. Prior to January 3, 1993, the hospital files a request with the servicing CMS Regional Office for an additional payment under the extraordinary circumstances provision along with the following supporting documentation:

- Evidence of the extraordinary circumstance from public media releases, insurance company and public agency damage reports;
- Independent capital replacement and repair cost estimates from architects and construction firms, and current equivalent equipment replacement cost statements from manufacturers and suppliers; and
- An explanation with appropriate documentation of the extent to which the loss will be covered by insurance proceeds and other sources such as government relief funds.

Upon completion of the CMS review process, CMS grants conditional approval for the exception request pending reopening of the wing and verification, by the intermediary, of the net cost to the hospital.

During Hospital X's 1996 fiscal year, the rebuilt wing is reopened. The hospital submits documentation with its cost report that the increase in the hospital's cost base for depreciable assets that is attributable to the hospital's allowable loss on the damaged wing as calculated in accordance with Medicare reasonable cost principles (see §133) and the building repairs equal $6 million. The Regional Office notifies the intermediary and the hospital of final approval of the extraordinary circumstances exception request. Since the increased cost basis is amortized over the remaining life of the wing, Medicare's share of the increased costs is determined in each remaining transition year based on the depreciation and interest expenses in that year attributable to the building damage repairs.

In its cost reporting period beginning January 1, 1998, the hospital reports $400,000 in depreciation and interest expenses attributable to the extraordinary circumstances and $1.2 million in other inpatient capital-related costs. Assuming the hospital is subject to the 70 percent minimum payment level, the minimum payment level for the cost reporting period is $1,180,000 ($400,000 x .85 plus $1,200,000 x .70). If the hospital's capital prospective payments for the cost reporting period are less than this amount, the hospital receives an additional payment equal to the difference between the payments and the adjusted minimum floor, less any cumulative excess payments over the minimum payment levels in prior cost reporting periods.

2807.6 Determination Process.--During the capital-PPS transition period, the intermediary makes interim determinations of the hospital's hospital-specific rate, its old, new and obligated capital costs, the appropriate payment methodology, and the payment amounts for the cost reporting period. Final determinations are not made until after the close of the applicable cost reporting period when final data for that period is available.

Interim determinations are not subject to administrative or judicial review. All final determinations are subject to administrative and judicial review as provided in 42 CFR Part 405, Subpart R.

A. Hospital-Specific Rate Determinations.--If the initial base year cost report has not been settled, the intermediary makes an interim determination of the hospital-specific rate based on the hospital's submitted cost report and notifies the hospital of its determination at least 30 days before the start of the hospital's first cost reporting period beginning on or after October 1, 1991. The final determination of the hospital specific rate normally is made when the base year cost report is settled. The final determination is effective retroactively to the beginning of the hospital's first cost reporting period under the capital-PPS. In cases where the base period cost report remains open only for reasons unrelated to the determination of the hospital-specific rate (when the remaining issues do not affect hospital specific rate calculation), the intermediary issues a final determination as soon as possible instead of delaying until final settlement. Appeal of the final hospital specific rate determination is subject to the rules in 42 CFR Part 405, Subpart R, and therefore, coincides with the settlement of the first capital-PPS cost report the hospital files.

If the hospital requests a redetermination of its hospital-specific rate in accordance with §2807.4E, the intermediary makes an interim determination based on the submitted cost report and notifies the hospital within 90 days of receipt of the hospital's fully documented request. The final determination of the redetermined hospital-specific rate is normally made when the new base year cost report is settled. The final determination of the redetermined hospital-specific rate is effective retroactively to the beginning of the later of the hospital's first cost reporting period under the capital-PPS or the new base year.

The intermediary adjusts the hospital-specific rate to reflect any changes in base year capital-related costs per discharge that result from administrative or judicial review of the initial determination. The adjustments are effective retroactively to the date of the intermediary's initial determination.

B. Payment Methodology Determination.--Any time the intermediary makes a hospital-specific rate determination, the intermediary also determines which payment methodology is applicable based on a comparison of the hospital-specific rate and the Federal rate for the cost reporting period and notifies the hospital of its determination. The intermediary makes an interim payment methodology determination until it makes a final determination of the hospital-specific rate. If the hospital is receiving Federal rate payment adjustments for indirect teaching costs or for serving low income patients, the intermediary continues to make an interim determination until the cost report for the applicable cost reporting period under the capital-PPS is settled. Until the cost report is settled, the intermediary makes the comparison using the best available estimate of the payment adjustments for indirect teaching costs and disproportionate share applicable during the cost reporting period.

The intermediary makes a final payment methodology determination when a final determination of the hospital-specific rate has been made and the cost report under the capital-PPS (the first year or a redetermination base year, as applicable) has been settled. The final determination is effective retroactively to the beginning of the later of the hospital's first cost reporting period under the capital-PPS or the new base year. If the hospital-specific rate is adjusted as a result of administrative or judicial review, the intermediary makes a new payment methodology determination on the basis of the new hospital-specific rate. The new determination is effective with the beginning of the cost reporting period in which the new hospital-specific rate is applicable.

C. Determination of Payment Amounts.--The payment rates under the capital-PPS are determined prospectively; however, since the amount of payment during the transition may depend in part on adjustments made to rates and costs, adjustments to the actual payment amounts may be made when the cost report is settled.

1. Fully Prospective Payment Methodology.-- If a hospital is paid under the fully prospective payment methodology, the intermediary makes a final determination of any Federal rate payment adjustments for indirect teaching costs and for serving low income patients based on the final cost report data. In addition, the intermediary makes a determination of any additional amounts payable under the exceptions process.

2. Hold Harmless Payment Methodology.--If a hospital is paid under the hold harmless payment methodology, the intermediary makes interim payments based on the best available data concerning the hospital's old and new capital costs for the cost reporting period. For the hospital's first cost reporting period under the capital-PPS, this data usually includes supplemental information submitted by the hospital estimating its discharges and old capital-related costs for the first period that the hospital is subject to the capital-PPS. The supplemental information must be submitted by the hospital in sufficient time for the intermediary to take it into account in its interim determination. If the necessary data and cost report(s) are not available to the intermediary, the intermediary bases its determination on the available information.

The intermediary makes the final determination of the hospital's payments under the hold harmless payment methodology, including any additional amounts payable under the exceptions process, when the cost report is settled based on the hospital's actual old and new capital costs and Federal rate payments for the cost reporting period.

In addition to the intermediary's final determination of the hold harmless payment amounts for the cost reporting period, the intermediary's final determination of assets that qualify for recognition as old capital and any limitation on the amount of capital-related costs that are recognized as old capital costs is subject to administrative and judicial review for the first cost reporting period for which the determination affects the amount of program reimbursement. If administrative or judicial review results in an adjustment to old capital costs, the adjustment is effective with the intermediary's initial determination.

2807.7 Payments to New Hospitals.--A new hospital is a hospital that has operated (under current or previous ownership) for less than two years and does not have a 12-month cost reporting period (or a combination of cost reporting periods covering at least 12 months) ending on or before December 31, 1990. A new hospital is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost reporting period ending at least two years after the hospital accepts its first patient. The new hospital exemption is only available to those hospitals that have not received reasonable cost payments in the past and need special protection during their initial period of operation. The exemption does not apply to a facility that opens as an acute care hospital if that hospital operated in the past, under current or previous ownership, and has an historic asset base. Also, a hospital that replaces its entire facility (regardless of change of ownership) does not qualify for a new hospital exemption even if it experiences a significant change in its asset base. Thus, the new hospital exemption does not apply in the following situations:

- A hospital that changes status from an excluded hospital paid under §1886(b) of the Act (i.e., TEFRA limitation on reasonable cost reimbursement) to an acute care hospital subject to PPS;

- A hospital that has been in operation for more than 2 years but has been participating in the Medicare program for less than 2 year;

- A hospital that closes and then reopens under the same or different ownership; or

- A hospital that builds a new or replacement facility at the same or a new location, even if a change in ownership or new leasing arrangements are involved.

For its first cost reporting period beginning at least 2 years after a new hospital accepts its first patient, the hospital is paid under the applicable capital-PPS payment methodology based on a comparison of its hospital-specific rate and its adjusted Federal rate in accordance with §2807.4D. The base year used to establish the hospital-specific rate is the new hospital's 12-month or longer cost reporting period (or combination of periods totaling at least 12 months) that begins at least one year after the hospital accepts its first patient. The hospital's allowable capital-related costs for land and depreciable assets that were put in use on or before the last day of its base year cost reporting period qualify as old capital costs. The limitations in §2807.3B on the amount of capital-related costs that are recognized as old capital costs apply except that the limitations are based on the amount that the hospital is obligated to pay as of the last day of its base year cost reporting period instead of December 31, 1990.

If the new hospital is paid under the fully prospective payment methodology, the hospital is paid based on the appropriate Federal/hospital-specific blend. If the hospital is paid based on the hold harmless payment methodology, it is eligible to receive a hold harmless payment for up to 8 years, beginning with the cost reporting period that it first begins to receive prospective payments. The hold harmless payment may continue beyond the FY 2001 cut-off for hold harmless payments to other hospitals. However, eligibility to receive an exceptions payment ceases with the hospital's cost reporting period beginning in FY 2001.

The rules for obligated capital are applicable to new hospitals without modification. (See §2807.3C.) As is the case with other hospitals, a new hospital may request that its hospital-specific rate be redetermined through the later of its cost reporting period beginning in FY 1994 or the cost reporting period beginning after obligated capital that is recognized as old capital is put in use. (See §2807.4E.)

If a hospital has been in operation for more than two years as of December 31, 1990, but does not have a 12-month cost reporting period ending before December 31, 1990, because it is newly participating in the Medicare program, the hospital does not qualify as a new hospital. The hospital's base year is its first 12-month cost reporting period (or combination of cost reporting periods totaling 12 months) under the Medicare program. However, the hospital's old capital costs are based on its capital-related costs attributable to assets that were put in use for patient care as of December 31, 1990, and the hospital is subject to all other capital-PPS transition payment rules. (See §2807.4A for implementing capital-PPS transition rules in such cases.)

2807.8 Gain or Loss on Disposal of Old Capital.--Under Medicare's reasonable cost principles (see §§132 ff.), a gain or loss to correct depreciation expense claimed upon disposal of an asset is recognized in the year that the asset disposal takes place, even though some portion of the gain or loss applies to the years prior to the asset disposal. However, in determining Medicare's share of the gain or loss, the gain or loss is spread over the cost reporting periods for which Medicare shared in the cost of the asset. Medicare's share of the gain or loss applicable to prior cost reporting periods is determined based on Medicare utilization in each of the prior cost reporting periods and is recognized as a prior period adjustment on the settlement worksheet (Worksheet E) of the Medicare cost report (Form CMS-2552). The portion of the gain or loss applicable to the cost reporting period during which the disposal occurs is reflected in that period's costs.

A. Disposal Occurring in the Base Year.--If there is a gain or loss in the capital-PPS base year, only that portion of the gain or loss applicable to the base year is reflected in the hospital-specific rate. The remaining gain and loss amounts are ascribed to prior years on the Worksheet E.

B. Disposal Occurring After the Base Year.--After a hospital becomes subject to the capital-PPS, the treatment of the gain or loss adjustments for current and prior cost reporting periods is dependent upon the capital-PPS payment methodology applicable to the hospital. In all cases, any adjustment to prior periods reflects the appropriate capital discount applicable to that period. In the few cases where gains or losses on disposals are carried forward to future periods, any adjustment depends on the capital-PPS methodology under which the hospital is paid in each cost reporting period for old capital costs and, as appropriate, the provisions of 42 CFR 413.134(f).

1. Fully Prospective Payment Methodology.--For hospitals paid under the fully prospective methodology, prior period adjustments in these cases are made as Medicare Part A settlement adjustments only for those years prior to the capital-PPS since reasonable cost reimbursement was only applicable in those periods. This does not affect the hospital-specific rate determination if the base year is a prior adjustment period. (See §2807.4B.) Medicare Part B adjustments are made for all cost reporting periods. For new assets purchased and disposed of after the hospital's capital-PPS effective date, only the gain or loss applicable to Medicare Part B payments may be reflected as a cost reporting adjustment.

2. Hold Harmless Payment Methodology.--Under the hold harmless methodology, gains or losses on disposals after the effective date of the capital-PPS for hospitals paid based on 100 percent of the Federal rate are handled in the same fashion as fully prospective methodology hospitals. For hospitals receiving a hold harmless payment for old capital, the gain or loss on old capital assets is handled through the cost report for appropriate period adjustments, pursuant to the appropriate capitalization policies in 42 CFR 413.134(f), for both Medicare Part A and Part B, and for both the pertinent capital-PPS and prior periods. In the case of disposal of new capital assets by a hospital paid under the hold harmless method, only gains or losses on disposal of such assets that are applicable to Medicare Part B payments are adjusted on Worksheet E of the cost report.

C. Change of Ownership.--Gains or losses associated with a change of ownership situation must be treated in accordance with special rules due to the provisions of §1861(v)(1)(o) of the Act. If the sale price of the asset is greater than or less than the net book value of the asset and cost reimbursement rules are applicable to Medicare capital payments in the prior period, Medicare adjusts for the resultant gain or loss, respectively. This adjustment, which represents a correction of Medicare's share of the depreciation recognized during the years that the asset was in use, is made to the seller's share of Medicare payments in the year that the asset is sold. For treatment of the purchaser's costs and any effect on the hospital's capital-PPS payment methodology or amount, see §2807.9 regarding change of ownership situations.

2807.9 Change Of Ownership.--

A. Single Hospital Involved.--If there is a change of ownership involving a single hospital during its base period under the capital-PPS, the base period capital-related costs used to determine the hospital-specific rate include any portion of the old owner's gain or loss that is attributable to the base year only. The base year capital-related costs do not include any prior period adjustments for the gain or loss. The base period capital-related costs are used to determine the new owner's hospital-specific rate and to identify its old capital costs that qualify for any hold harmless payment.

If there is a change of ownership subsequent to the base period, the new owner receives capital-PPS payments under the same payment methodology and rates as the previous owner if the change of ownership results in a single surviving hospital. If the hospital is paid under the fully prospective methodology, the new owner may request that its hospital-specific rate be recalculated based on its old capital costs in a cost reporting period beginning subsequent to the initial base year, if appropriate under §2807.4E. If the hospital is paid under the hold harmless methodology, the depreciation costs associated with the old capital assets in patient care use as of December 31, 1990, may decline if the purchase price of the new owner affects the valuation under the original depreciation schedule used to establish the old capital costs for those assets. However, the depreciation costs cannot increase since the same depreciation guidelines used in the hospital's base period must be maintained in determining any change in the old capital asset valuation in accordance with 42 CFR 412.302(b)(1).

B. Formation of Separate Hospitals.--If a change of ownership, or other action, involving a multi-campus hospital results in the formation of two separate PPS hospitals from facilities that are subject to capital-PPS payments, the intermediary determines a new hospital specific rate for each separate hospital effective with the date of dissolution. The intermediary determines if the base year capital-related costs for each hospital can be reconstructed. If the base year capital-related costs can be reconstructed, the hospital-specific rate for each hospital is recomputed based on the original base period costs. If the base year capital-related costs for each hospital cannot be reconstructed based on the original base year records, each hospital's hospital-specific rate is recalculated, pursuant to the guidelines in §2807.4, by establishing the respective hospital's base year as its first 12-month or longer cost reporting period (or combination of cost reporting periods covering at least 12 months) subsequent to the dissolution. In determining each hospital's old capital-related costs, the amount that is recognized as old capital is limited to the capital-related costs attributable to assets in patient care use as of December 31, 1990. The hospitals also are subject to all other transition period rules. Payments are made subject to the requirements in §2807.5. However, during the period before the hospital specific rate is recalculated for each hospital, interim payments for such hospitals are determined by the intermediary on the basis of the best data available prior to receipt of the new base period cost reports. The final hospital-specific rates are applied retroactively to the later of the hospitals' first cost reporting period under capital-PPS or the effective date of the dissolution that required the recalculation.

C. Hospital Merger or Consolidation.--If two or more hospitals merge or consolidate into one hospital during the base period, the hospitals' latest cost reporting period(s) of at least 12 months duration ending on or before December 31, 1990, is the base period, and an average discharge-weighted, hospital-specific rate is calculated.

NOTE: This provision for recalculation of the hospital-specific rate, and any applicable effect on the capital-PPS payments due the resulting hospital, is applicable only to those cases that meet the previously existing capital-related reasonable cost rules regarding the criteria for recognizing a merger or consolidation in 42 CFR 413.134(k). In cases in which the merger or consolidation rules are not met, the transaction is treated simply as a normal asset acquisition for Medicare program purposes. Thus, even if a hospital purchases the entire stock of assets of another hospital without meeting the merger or consolidation criteria (e.g., when a hospital has filed for bankruptcy and all the assets are purchased by another hospital at auction or through the court), those assets of the acquired hospital are considered new capital for the purchasing hospital.

EXAMPLE: Hospital A merged with Hospital B (pursuant to 42 CFR 413.134(k)(2)(ii)) on September 1, 1990, and Hospital B is the surviving hospital. Hospital A had a fiscal year ending June 30, 1990, and Hospital B had a fiscal year ending December 31, 1990, which it retains after the merger. The following data is obtained for each hospital:

	Medicare Discharges	Medicare Inpatient Capital Cost	Case Mix Index	Case Mix Adjusted Cost Per Case
Hospital A:				
FY End 6/30/90	1,200	$1,200,000	1.12	$892.86
Short Period 7/01/90 - 8/31/90	410	400,000	1.14	$855.80
Hospital B:				
Short Period 1/01/90 - 8/31/90	1,100	2,400,000	1.18	$1,849.00
Short Period 9/01/90 - 12/31/90	700	980,000	1.15	$1,217.39

Hospital A's combined adjusted base year cost is determined as:

$$\frac{(\$892.86 \times 1200) + (\$855.80 \times 410)}{1200 + 410} = \$883.42$$

Hospital B's combined adjusted base year cost is determined as:

$$\frac{(\$1849.00 \times 1100) + (\$1217.39 \times 700)}{1100 + 700} = \$1,603.37$$

The combined adjusted base year cost per case for each hospital is multiplied by the applicable update factor:

Hospital A: $883.27 x 1.17858 = $1,041.00
Hospital B: $1,603.37 x 1.14272 = $1,832.20

The combined average cost per case is then determined by weighting for the applicable number of discharges.

$$\frac{(\$1,041.00 \times 1610) + (\$1,832.20 \times 1800)}{1610 + 1800} = \$1,458.64$$

The combined cost per case is then multiplied by the FY 1992 exceptions reduction factor and the budget neutrality adjustment factor to yield the hospital-specific rate:

.9813 x $1,458.64 = $1,431.37
.9602 x $1,431.37 = $1,374.40

The hospital-specific rate of $1,374.40 is then used to determine the payment methodology that is applicable during the transition period. The assets and other capital-related costs on the books of the merged facilities as of December 31, 1990, are recognized as old capital for hold harmless determination purposes as well as any obligated costs of either hospital that meet the requirements in §2807.3C.

If the merger or consolidation occurs after the base period, an average hospital-specific rate, weighted as in the above example by the number of base year discharges, is determined based on each hospital's base year data and compared to the Federal rate applicable to the resulting hospital to determine which payment methodology the hospital is paid during the remainder of the transition period. If the weighted hospital-specific rate is below the Federal rate, the hospital is paid under the fully prospective methodology during the remainder of the transition even if one of the hospitals had been paid under the hold harmless methodology prior to the merger. The weighted hospital- specific rate is applied effective with the date of the merger. The capital-related costs related to the assets of each merged or consolidated hospital as of December 31, 1990, are recognized as old capital costs during the remaining transition period. If the hospital is paid under the hold harmless methodology after the merger, only the capital-related costs for the remaining old capital are eligible for hold harmless payments.

2810 SPECIAL TREATMENT OF SOLE COMMUNITY HOSPITALS UNDER *THE INPATIENT* PROSPECTIVE PAYMENT SYSTEM

Effective with cost reporting periods beginning on or after October 1, 1983, Medicare pays most hospitals for inpatient operating costs on the basis of prospectively determined rates per discharge, as described in §2801. (See §2803 for excluded hospitals.) However, the law requires special payment provisions for sole community hospitals (SCHs) that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, are the sole source of inpatient hospital services reasonably available in a geographic area to individuals who are entitled to Part A benefits under the program. *For guidance on the special treatment of SCHs for cost reporting periods beginning prior to January 1, 2009, see 42 CFR 412.92(d). For cost reporting periods beginning on or after January 1, 2009, a*pproved SCHs are paid *based upon whichever of the following yields the greatest aggregate payment for the cost-reporting period:*

- *The IPPS Federal rate;*
- *The greatest of the updated hospital-specific rate based on fiscal years (FY) costs per discharge for FY 1982, FY 1987, FY 1996, or FY 2006.*

A. Criteria for SCH Classification.--

1. Automatic Classification.--A hospital that has been granted an exemption from the hospital cost limits as an SCH before October 1, 1983, or whose request for the exemption was received by the appropriate *Medicare Administrative Contractor (contractor)* before October 1, 1983, and was subsequently approved, is classified as an SCH under the *inpatient prospective payment system (I*PPS*)* unless there is a change in the circumstances under which the classification was approved. An example of a situation in which an existing SCH's continued classification is questioned is the opening of another hospital in the area. In evaluating whether SCH classification continues, *CMS* considers whether the hospital meets the criteria with respect to isolation and serving as the sole source of care reasonably available to Medicare beneficiaries.

2. All Other Hospitals.--A hospital that requested SCH designation on or after October 1, 1983, may be classified as a SCH and receive payment adjustments under the *I*PPS if it is located in a rural area and meets the criteria in *(*a*)*, *(*b*)*, *(*c*), or (d)* below. *A hospital that requested SCH designation on or after June 4, 1991, may be classified as a SCH and receive payment adjustments under the IPPS if it meets (a) below, or is located in a rural area and meets (b), (c), or (d) below.*

a. The hospital is located more than 35 miles from other like hospitals.

b. The hospital is located between 25 and 35 miles from other like hospitals and *meets one of the following criteria*:

(1) No more that 25 percent of the residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted for care to other like hospitals within a 35 mile radius of the hospital or, if larger, within its service area; or

(2) The hospital has fewer than 50 beds and the *contractor* certifies that the hospital would have met the criteria in item (1) were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital.

(3) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each year for 2 out of 3 years.

c. The hospital is located between 15 and *25* miles from other like hospitals, *but* because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years.

d. Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

In evaluating the distance between hospitals, *CMS* measures the most direct (i.e., shortest) route between the facilities using improved road miles. An improved road is a road that is maintained for regular use by a governmental entity (i.e., local, State, or Federal) and that is available for use by the general public.

The term "like hospitals," for purposes of making a determination on SCH designations, applies to those hospitals furnishing short-term acute care services. *For cost reporting periods beginning on or after October 1, 2002, a hospital is defined as a "like hospital" if the total inpatient days attributable to units of the hospital that provides a level of care characteristic of the level of care payable under the acute care hospital IPPS are greater than 8 percent of the similarly calculated total inpatient days of the hospital seeking SCH classification. For example, a hospital that has an intensive care unit would not be classified as an SCH on the basis that another neighboring acute care hospital does not furnish this specialty service. The neighboring acute care hospital can be considered a like hospital even if it does not furnish a particular specialty service.*

A hospital's service area is the area from which the hospital draws at least 75 percent of its inpatients during the most recently completed cost reporting period ending before it files for SCH status. A hospital may define its service area as the lowest number of *ZIP* codes from which the hospital draws at least 75 percent of its inpatients, or it may use boundaries established by the statewide health planning agency. Additionally, documented data from any independent source that can be used to identify the hospital's service area, such as a State hospital association, will be considered and reviewed, provided that *CMS* is able to verify that a hospital drew at least 75 percent of its inpatients from the defined service area.

B. Requesting SCH Classification.--A hospital that believes it qualifies as a SCH under the criteria listed above may submit a written request to be designated as an SCH to its *contractor* at any time during its cost reporting period. The hospital's request must include the following documentation to substantiate its request:

1. Information on Requesting Hospital.--A hospital's request must show the requesting hospital's name, address, county, urban/rural classification, type, bed size, and provider number.

2. Location of Neighboring Hospitals.--The hospital must submit the name and address of all hospitals within a 35-mile radius of the requesting hospital. In addition, the requesting hospital must submit a detailed road map showing the most direct route to each neighboring hospital using "improved roads" as defined above and actual road mileage to each hospital.

3. Utilization Data.--If a hospital is requesting SCH classification on the basis that it is located between 25 and 35 miles of another hospital and no more than 25 percent of the service area residents utilize services at another hospital (see subsection A.2.b.), the requesting hospital must submit the following information on utilization and service areas.

a. A map depicting the hospital's service area and a description of how the service area was determined must be submitted.

b. If a statewide planning agency has not established the boundaries of the hospital's service area, admissions data showing the address of every patient admitted during the most recently completed cost reporting period must be submitted. Admissions data must be displayed so that the reviewer may easily verify the construction of the service area from this documentation. For example, if the service area was established by using postal *ZIP* codes, the admissions data must be grouped by area *ZIP* codes.

c. In order to document that no more than 25 percent of the residents or, if applicable, Medicare beneficiaries from the hospital's service area were admitted to other like hospitals for care, admissions data from all hospitals located within 35 miles of the requesting hospital or, if larger, the requesting hospital's service area, must be analyzed. In many areas, the State hospital association periodically analyzes hospital market areas and can produce the utilization data necessary for making this determination.

In the event that existing data are not available on utilization, the requesting hospital gathers the information necessary to permit an evaluation of utilization of other like hospitals. These utilization data are gathered on general resident usage or Medicare beneficiary utilization. Such data gathering may involve the cooperation of the neighboring hospitals in order to assure that information is valid and reliable.

If a hospital is unable to collect the data necessary to document the percentage of patients it admits, it may request *CMS* assistance. Using central office records, *CMS* can furnish data on Medicare admissions to identified hospitals for specific periods of time. The hospital's request is submitted through its *contractor* and must include its full name, provider number, and a statement that it is requesting admissions information for SCH qualification. The hospital's request must furnish a listing of *ZIP* codes within the hospital's service area and it must provide the full name and address and, if available, the Medicare provider number of every other hospital located within the larger of the hospital's service area or a 35-mile radius. The request must also include the beginning and ending dates of the hospital's most recently completed cost reporting period.

If a hospital fails to achieve SCH status based on *CMS*-generated data, it may not substitute other patient-origin data for the same time period. That is, once a hospital elects to have *CMS* furnish the patient origin data, only *CMS* data are considered in the determination.

If general resident utilization is used, the documentation may be gathered from a sample period. However, the sample period must be of sufficient duration to produce reliable results. A minimum of 6 months *of* admission data, or such other sample as the *CMS* Regional Office finds acceptable, is essential for this evaluation.

Since the universe of Medicare beneficiary utilization is significantly smaller than general resident usage, a sample period is not appropriate for documenting utilization of other like hospitals for only the Medicare beneficiary population. Therefore, in requesting SCH status under this criterion, a hospital must provide utilization data for 12 months using its most recently completed cost reporting period.

Regardless of the population used to document patient origin utilization, the data must be displayed by the requesting hospital so that reviewers may easily verify those patients that reside in the requesting hospital's service area.

EXAMPLE: Hospital A (the requesting hospital) is located 27 miles from Hospital B and 30 miles from Hospital C. Hospital A defines its service area as postal *ZIP* codes 21345, 21347, and 21350. The following is a summary of the admissions data submitted.

Area	Number of Admissions			Total Admissions
	Hospital A	Hospital B	Hospital C	
21345	300	50	25	375
21347	250	25	50	325
21350	500	50	50	600
Total	1,050	125	125	1,300
Other Areas	275	1,000	525	1,800
Grand Total	1,325	1,125	650	3,100

Thus, of the 1,300 patients in Hospital A's service area who have been hospitalized during the year, only 19 percent (250) received services from other hospitals.

d. The criterion in A.2.b.(2) provides that hospitals with fewer than 50 beds that do not meet the criterion in *B.3.*c. may provide additional data to justify the reasons residents or beneficiaries sought care outside the service area. This alternative is available only to these small rural hospitals that are located between 25 and 35 miles of other like hospitals. Qualifying hospitals requesting SCH status under this provision gather the necessary data using the patient origin data obtained under B.3.c. The hospital obtains information as to the diagnoses and services necessary for those residents or Medicare beneficiaries who obtained care outside the requesting hospital's service area during the survey period. If the hospital is unable to obtain the data from any other source, the *contractor* provides assistance by making available Medicare discharge data by patient origin for neighboring hospitals.

The hospital must group the cases by type of service to simplify and expedite the *contractor's* certification process. For example, assume the utilization data showed that, of the 1,300 patients in Hospital A's service area who were hospitalized during the survey period, 500 patients (38.5 percent) were admitted to alternative hospitals. However, Hospital A obtained certifications

that 200 patients required intensive care unit services and 50 were obstetrical patients. Hospital A does not provide either of these services. Therefore, these cases are removed from both the out-of-area services and the total services, leaving utilization data for Hospital A's service area of 800 of 1,050 total cases (76.2 percent) treated at Hospital A. Consequently, the hospital meets the criteria for SCH designation.

4. Accessibility Data.--If a hospital is requesting SCH classification on the basis that it is at least 15 miles from another hospital but, because of local topography or severe weather conditions, the other hospital is inaccessible for more than 30 days in each *year for* 2 out of 3 years, the requesting hospital must submit data to document a history of such inaccessibility. The fact that alternative hospital services were not available for a total of 30 days in a single 12-month period is not sufficient evidence to substantiate the prolonged and predictable inaccessibility intended in this criterion. Thus, we are requiring official documentation demonstrating inaccessibility for 30 days in each *year for* 2 out of 3 years. Documentation, such as reports of a State highway department or local public safety officials, must specify the location of the road closure and the periods of time the road was inaccessible. In addition, the requesting hospital must detail the alternate route to the neighboring hospital and the mileage using the alternate route.

C. Approval of SCH Classification.--The *contractor* reviews the documentation submitted by the requesting hospital. If the request is incomplete, the *contractor* contacts the hospital to obtain additional information. Once all the necessary data have been obtained, the *contractor* forwards the completed package to the appropriate *CMS* Regional Office with its recommendation for further action.

The *CMS* Regional Office makes the final determination on the hospital's request and responds in writing to the *contractor*. The hospital receives notification of the decision from its *contractor*. *For applications received on or before September 30, 2018, SCH status becomes effective for discharges occurring 30 days after the date of CMS approval except as provided in 42 CFR 412.92(b)(2)(v). For applications received on or after October 1, 2018, SCH status is effective as of the date the MAC receives the complete application, except as provided in 42 CFR 412.92(b)(2)(v).* There are no retroactive effective dates on SCH designations other than requests granted by a court order or PRRB decision.

Once a hospital has been designated as an SCH, it retains that classification indefinitely unless there is a change in the circumstances under which the classification was approved suggesting a need for reevaluation or the hospital requests its SCH classification be cancelled.

D. Cancellation of SCH Classification.--It might be to a hospital's advantage in certain instances to give up its SCH classification and elect to be paid as other hospitals in the region. Therefore, a hospital may voluntarily cancel its SCH classification at any time by notifying the Regional Office in writing of its request. The Regional Office notifies the *contractor* of the decision.

Hospitals are expected to notify the Regional Office in advance of their decision to give up their SCH designations. No SCH cancellations are made effective retroactively. The change to fully national rates becomes effective no later than 30 days after the hospital submits its request. The "no later than 30-day" time frame allows the hospital, the Regional Office, and the *contractor* to select a mutually agreeable date, e.g., at the end of a month.

Once a hospital gives up its SCH designation, it may reapply for SCH status only after one full year has passed since the cancellation was effective. SCH status is granted to the hospital only if it meets the qualifying criteria in effect at the time it reapplies.

2810.1 Additional Payments to SCHs that Experience a Decrease in Discharges.--If, due to circumstances beyond its control, a hospital that is classified as a SCH experiences a decrease of more than five percent in its total number of discharges compared to the immediately preceding cost reporting period, the hospital may receive a payment adjustment. This additional payment provision applies to cost reporting periods beginning on or after *October 1, 1983. For additional payments to a Medicare dependent hospital (MDH) that experiences a decrease in discharges, see 2810.1.H.*

A. Criteria for Determining Eligibility for Additional Payments.--*A provider that qualifies* as a SCH, for at least a part of the cost reporting period, *may qualify for a volume decrease adjustment (VDA) payment when the hospital meets the following criteria:*

1. Circumstances Beyond the Hospital's Control.--*The* decrease in *discharges* must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control. These situations may include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious and prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects. *CMS will take into consideration how frequently a SCH requests this adjustment and/or uses a particular set of circumstances to request this adjustment, and whether or not the SCH took reasonable steps to mitigate the cause of the decrease in discharges (for example, recruiting efforts to replace a physician, efforts to cut costs where possible etc.).*

2. Decrease in Discharges.--*A* SCH must experience a *more than five percent* decrease in *its total* discharges of *inpatients as* is compared to *its* immediately preceding cost reporting period. *If* a hospital experiences an occurrence toward the end of a cost reporting period that does not result in *more than* a five percent decrease in *total* discharges *for* the cost reporting period, additional payments are not made to the hospital *(see Example A)*. Similarly, if a hospital experiences an occurrence that results in a sustained decrease in *total discharges*, *each cost reporting period must be compared to each immediately preceding cost reporting period, and* an adjustment is made only for *a cost reporting period* where the change resulted in a decrease *more than* five percent of the *total* discharges *(see Example B)*.

EXAMPLE A: The nursing staff of Hospital X, a SCH, went on strike 6 weeks before the end of the cost reporting period ending December 31, *2004*, resulting in a sharp decrease in discharges during the end of that period and the beginning of the next period.

- Discharges for the cost reporting period ending December 31, *2003*, equal 2,500.
- Discharges for the period January 1, *2004*, through November 15, *2004*, equal 2,400.
- Discharges for the period November *16, 2004*, through December 31, *2004*, equal 10.
- Discharges for the period ending December 31, *2005*, equal 2,410.

In this case, Hospital X is not eligible for additional payment because there was not a *more than* five percent decrease in total discharges from the previous cost reporting period (2,500 vs. 2,410 = 3.6 percent decrease).

EXAMPLE B: Hospital Y's community physician retires in January of its cost reporting period ending September 30, *2004*. This results in a sustained lower case load until June *2005*, when the physician is replaced.

- Discharges for cost reporting period ended September 30, *2003*, equal 5,000.
- Discharges for cost reporting period ended September 30, *2004*, equal 3,000.
- Discharges for cost reporting period ended September 30, *2005*, equal 3,500.

Additional payment is available only for the cost reporting period ending September 30, *2004*. Even though discharges for the period ending September 30, *2005*, were more than five percent less than the cost reporting period ending September 30, *2003*, an adjustment for this period is not available because the comparison must be made to the immediately preceding cost reporting period.

B. Amount of Payment Adjustment.--Additional payment is made to an eligible SCH for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's *total payment for inpatient operating costs*.

Fixed costs are operating costs that remain constant and do not vary with short-term changes in hospital operations and business practices. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food, laundry costs, *billable medical supplies, and billable drug costs*.

In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semi-fixed. Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with *utilization*. For purposes of this adjustment, many semi-fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.

In evaluating semi-fixed costs, the *contractor* considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semi-fixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses *to align them with revised expectations for volume projections*. Therefore, if a hospital did not take such action, some of the semi-fixed costs may not be included in determining the amount of the payment adjustment.

The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The *contractor* reviews the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

C. Requesting Additional Payments.--*A SCH must submit a VDA request, by mail or electronically, to its contractor. The SCH may submit the VDA request by mail or electronically with its submission of the cost report for the period for which the VDA payment is requested, or any time following the submission, but no later than 180 days after the date of the Notice of Program Reimbursement for that cost report.* The request must include the following documentation *or the information must be readily available to the contractor*.

1. General Information.--The *VDA* request must *be signed by an official of the hospital and* include the requesting hospital's name, address, provider *CCN*, and date of classification as a SCH.

2. Discharge Data.--The SCH must submit data on the number of discharges in the cost reporting period for which the payment adjustment is being requested and the number of discharges in the cost reporting period immediately preceding the period in question. If either the preceding cost reporting period or the period in which the *decrease* occurred is not 12 months in duration, the hospital must annualize discharges in the short cost reporting period.

EXAMPLE: A hospital requests a VDA payment for a less-than-12-month cost reporting period and a 12-month cost reporting period. For the less-than-12-month cost reporting period, the total discharges must be annualized.

Cost Reporting Period	*Discharges*
January 1, 2004 through December 31, 2004	*1,500*
January 1, 2005 through May 31, 2005	*600*
June 1, 2005 through May 31, 2006	*1,225*

Discharges for cost reporting period ending May 31, 2005, are annualized to 1,440 discharges (600 ÷ 5 = 120 x 12 = 1,440).

The provider is not eligible for an adjustment for cost reporting period ending May 31, 2005, as discharges only decreased 4 percent (1500 - 1440 = 60 ÷ 1500 = 4 percent).

The provider is eligible for an adjustment for cost reporting period ending May 31, 2006, as discharges decreased 14.9 percent (1440 - 1225 = 215 ÷ 1440 = 14.9 percent).

3. Circumstances.--The hospital's request must include documentation outlining the circumstances that resulted in the decrease in discharges. This must include a narrative description of the occurrence, date of its onset, *date of its conclusion as applicable,* and how it affected the number of discharges.

4. Cost Data.--The hospital's request must *identify* the cost reporting period *for which the VDA is requested* and the immediately preceding *cost reporting* period. The *hospital* must demonstrate that the total Program inpatient operating cost, excluding pass-through costs, exceeds *total payment for inpatient operating costs (the higher of the federal payment amount or the hospital-specific payment amount) plus the operating portion of a provider's low volume hospital payment adjustment (42 CFR 412.101). For example, total Program inpatient operating cost excluding pass-through costs, reported on Form CMS-2552-10, Worksheet D-1, Part II, line 53, must exceed the total payment for inpatient operating costs reported Form CMS-2552-10, Worksheet E, Part A, line 49, plus the operating portion of a provider's low volume hospital payment adjustment.*

5. Costs.--The request must include a narrative description of those actions taken by the hospital to reduce costs *and/or align them with revised volume expectations*.

6. Core Staff and Services.--

a. For cost reporting periods beginning on or after October 1, 2007, and prior to October 1, 2017, a comparison, by cost center, of full-time equivalent *(FTE)* employees and salaries in both cost reporting periods must be submitted. The requesting hospital must identify core staff and services in each center and the cost of these staff and services. The request must

include justification of the selection of core staff and services including minimum staffing requirements imposed by an external source. The *contractor's* analysis of core staff is limited to those cost centers (general service, inpatient, ancillary, etc.) *where* costs are components of Medicare inpatient operating cost.

Core nursing staff is determined by comparing FTE staffing in the Adults and Pediatrics and Intensive Care Unit cost centers to FTE staffing in the prior year and FTE staffing in peer hospitals. Peer hospital information is obtained from data on nursing hours per patient day *using the results of the occupational mix survey or the AHA Annual Survey* for hospitals of the same size, geographic area (Census Division), and period of time. Acceptable core nursing staff for a year in which a hospital had a volume decline is the lesser of actual staffing in the prior fiscal year or core staff for the prior fiscal year as determined from *the occupational mix survey or the AHA Annual Survey* data from peer hospitals. *When determining core staff hours for other than a full year, the standard hours worked must be multiplied by the actual number of weeks in the cost reporting period. For example, a hospital with a standard work week of 37.5 hours requesting a VDA for a a cost reporting period of January 1, 2008, through June 30, 2008, has a paid hours per year of 975 (26 weeks x 37.5 hours per week).*

EXAMPLE A: Hospital A is a 100-bed SCH located in Nebraska (Census Division 6). Its discharges for its cost reporting period ending June 30, 2008, were 1,160; its discharges for cost reporting period ending June 30, 2007, were 1,450. The hospital is eligible for a payment adjustment on the basis of a 20 percent volume decrease (1,450 – 1,160 = 290 ÷ 1,450 = 20 percent). For cost reporting period ending June 30, 2007, Hospital A had 115.50 routine service (Adults and Pediatrics) nursing FTEs and 21,783 routine inpatient days. Hospital A had 12 intensive care unit (ICU) FTEs and 767 ICU inpatient days. For cost reporting period ending June 30, 2008, Hospital A had 82.14 total nursing FTEs (routine and ICU). Compute the patient care core staff determination for Hospital A as follows:

Hospital A Core Staff Determination Cost Reporting Period Ending June 30, 2008	
Paid average nursing hours per patient day (from FY 2006 Occupational Mix Survey)	*19.77*
Hospital A total routine days and ICU days (21,783 + 767)	*22,550*
Core staff hours (19.77 x 22,550)	*445,813.50*
Paid hours per year (based on standard 40-hour work week)	*2,080*
Core staff FTEs (445,813.50 ÷ 2,080)	*214.33*
Hospital A cost reporting period ending June 30, 2007, actual routine service and ICU FTEs (115.50 + 12)	*127.50*
Hospital A cost reporting period ending June 30, 2008, total actual nursing FTEs	*82.14*

Hospital A's actual nursing FTEs of 82.14 for cost reporting period ending June 30, 2008, are less than the lower of the actual nursing FTEs of 127.50 from the prior year, or the core staff FTEs of 214.33 calculated from the FY 2006 Occupational Mix Survey data. Hospital A is eligible for a payment adjustment for cost reporting period ending June 30, 2008, up to the difference between its Program inpatient operating cost (excluding cost of excess staffing) and its total payment for inpatient operating costs (including the operating portion of the LVA payment amount) for the fiscal year.

EXAMPLE B: Hospital B is a 75-bed SCH located in Colorado (Census Division 8). Its discharges for its cost reporting period ending September 30, 2012, were 946; its discharges for cost reporting period ending September 30, 2011, were 1,075. The hospital is eligible for a payment adjustment on the basis of a 12 percent volume decrease (1,075 – 946 = 129 ÷ 1,075 = 12 percent). For cost reporting period ending September 30, 2011, Hospital B had 72.35 routine service (Adults and Pediatrics) nursing FTEs and 5,215 routine inpatient days. For cost reporting period ending September 30, 2012, Hospital B had 70.54 nursing FTEs. Compute the patient care core staff determination for Hospital B as follows:

Hospital B Core Staff Determination Cost Reporting Period Ending September 30, 2012	
Paid average nursing hours per patient day (from FY 2009 AHA annual survey)	*25.14*
Hospital B total routine days	*5,215*
Core staff hours (25.14 x 5,215)	*131,105.10*
Paid hours per year (based on standard 40-hour work week)	*2,080*
Core staff FTEs (131,105.10 ÷ 2,080)	*63.03*
Hospital B cost reporting period ending September 30, 2011, actual nursing FTEs	*72.35*
Hospital B cost reporting period ending September 30, 2012, actual nursing FTEs	*70.54*

Hospital B's actual nursing FTEs of 70.54 for cost reporting period ending September 30, 2012, exceeds the core staff FTEs by 7.51. Hospital B is eligible for a payment adjustment, but its cost in the Adults and Pediatrics cost center must be reduced by the salary costs of the 7.51 FTEs in excess of core staff and the revised the Program inpatient operating cost must be used for the basis of the payment adjustment.

b. For cost reporting periods beginning on or after October 1, 2017, hospitals are no longer required to demonstrate that they adjusted the number of staff in hospital inpatient areas based on the decrease in the number of inpatient days. Contractors are no longer required to adjust the VDA payment amount for excess staffing, and the VDA payment is not subject to the payment ceiling (or cap), which is the lesser of the prior year inpatient operating costs updated to current year dollars or the current year Program inpatient operating costs.

D. Determination on Requests.--The *contractor* reviews a hospital's request for additional payment for completeness and accuracy*; requests* missing, incomplete, or inaccurate, *documentation; and,* makes a determination on the request and notifies the hospital of the decision within 180 days of the date the *contractor* receives all required information.

1. Types of Determinations.--The contractor may make an interim VDA determination and/or a final VDA determination.

a. Interim VDA Determinations.--The regulations do not preclude a hospital from submitting a request for a VDA prior to issuance of the NPR. The contractor may issue an interim VDA determination prior to issuing the NPR. The interim VDA determination is not appealable and must be followed by a final VDA determination once the contractor issues the NPR. For an interim VDA determination, the contractor:

- *notifies the provider of the interim VDA determination;*
- *specifies on the notification that the decision is an interim VDA determination and not appealable; and,*
- *includes in the notification that information regarding appeal rights will be included with the final VDA determination.*

b. Final VDA Determination.--The contractor issues a final VDA determination either with the NPR or after the NPR has been issued. Only the final VDA determination is appealable. For a final VDA determination, the contractor:

- *notifies the provider of the final VDA determination;*
- *specifies on the notification that the decision is a final VDA determination and informs the provider of their appeal rights;*
- *issues a Notice of Reopening, if the final VDA determination is not included in the NPR, follows the normal reopening process, and issues a revised NPR; and,*
- *includes the amount of the interim VDA determination, if applicable, as a tentative payment on Form CMS-2552, Worksheet E-1.*
- *includes the amount of the final VDA determination on Worksheet E, Part A (line 24, or subscript thereof, on Form CMS-2552-96; or line 70.88 on Form CMS-2552-10).*

2. Calculating the VDA Payment Amount.--

If *a contractor* determines that the procedures in this section, when applied to a specific adjustment request, generate an anomalous result, the *contractor* may request a review by *CMS*. This may occur, for example, when the decrease in Medicare discharges is significantly less than the decrease in total discharges.

a. Cost Reporting Periods Beginning Prior to October 1, 2017.--The *VDA* payment *amount* is calculated under the same assumption used to evaluate core staff, i.e., the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost. Therefore, the adjustment allows an increase in cost up to the prior year's total Program inpatient operating cost (excluding pass-through costs), increased by the *I*PPS update factor. *The contractor determines a provider's VDA payment amount as the lesser of the pre-ceiling VDA payment or the payment ceiling. The contractor calculates the VDA payment amount as follows:*

Step 1--Determine the maximum allowable cost as the lesser of the prior cost reporting period Program inpatient operating cost updated by the IPPS update factor for the cost reporting period for which the provider requests the VDA compared to the actual Program inpatient operating cost of the cost reporting period for which the provider requests the VDA.

Step 2--Determine the payment ceiling as the maximum allowable cost from Step 1 minus the total payment for inpatient operating costs (including the operating portion of the LVA payment amount) for the cost reporting period for which the provider requests the VDA.

Step 3--Determine the pre-ceiling VDA payment as the Program inpatient fixed costs (as identified by the provider and verified by the contractor) for the cost reporting period for which the provider requests the VDA (excluding the cost of excess staffing), minus the total payment for inpatient operating costs (including the operating portion of the LVA payment amount) for the cost reporting period for which the provider requests the VDA.

Step 4--Determine the VDA payment amount as the lesser of the payment ceiling determined in Step 2 or the pre-ceiling VDA payment determined in Step 3.

EXAMPLE A: Hospital C is eligible for a VDA for cost reporting period ending September 30, 2005. Hospital C's Program inpatient operating costs for cost reporting period ending September 30, 2004, were $2,900,000 (Worksheet D-1, Part II, line 53). For cost reporting period ending September 30, 2005, the Program inpatient operating costs were $2,800,000. Hospital C received a LVA payment amount of $200,000 ($180,500 operating and $19,500 capital). The total payment for inpatient operating costs (Form CMS-2552-96, Worksheet E, Part A, line 8) was $2,319,500. The VDA payment amount is calculated as follows:

Step 1: Determine maximum allowable cost.	
Cost reporting period ending September 30, 2004, Program inpatient operating costs	*$2,900,000*
FFY 2005 IPPS update factor	*1.033*
Cost reporting period ending September 30, 2004, updated Program inpatient operating costs ($2,900,000 x 1.0330)	*$2,995,700*
Cost reporting period ending September 30, 2005, Program inpatient operating costs	*$2,800,000*
Maximum allowable cost (lesser of $2,995,700 or $2,800,000)	*$2,800,000*
Step 2: Determine the payment ceiling.	
Cost reporting period ending September 30, 2005, total payment for inpatient operating costs (Form CMS-2552-96, Worksheet E, Part A, line 8) plus the operating portion of the LVA payment amount ($2,319,500 + $180,500)	*$2,500,000*
Payment ceiling ($2,800,000 - $2,500,000)	*$ 300,000*
Step 3: Determine the pre-ceiling VDA payment.	
Hospital C cost reporting period ending September 30, 2005, Program inpatient operating fixed costs (as identified by provider and verified by contractor)	*$2,683,000*
Cost of excess staffing	*$ 70,000*
Cost reporting period ending September 30, 2005, Program inpatient operating fixed costs excluding the cost of excess staffing ($2,683,000 - $70,000)	*$2,613,000*
Cost reporting period ending September 30, 2005, pre-ceiling volume decrease adjustment payment ($2,613,000 - $2,500,000)	*$ 113,000*
Step 4: Determine the VDA payment amount.	
VDA payment amount (lesser of $300,000 or $113,000)	*$ 113,000*

Application of the Payment Ceiling to VDA:

Hospital C's cost reporting period ending September 30, 2005, Program inpatient operating cost was less than that of cost reporting period ending September 30, 2004, increased by the IPPS update factor. Therefore, the payment ceiling is the difference between the cost reporting period ending September 30, 2005, Program inpatient operating costs minus the total payment for inpatient operating costs (including the operating portion of the LVA payment amount).

Hospital C's cost reporting period ending September 30, 2005, pre-ceiling VDA payment is less than the payment ceiling. Therefore, its VDA payment amount is equal to the entire difference between the cost reporting period ending September 30, 2005, Program inpatient operating fixed costs (excluding the cost of excess staffing), and the total payment for inpatient operating costs (including the operating portion of the LVA payment amount), or $113,000.

EXAMPLE B: Hospital D is eligible for a VDA for cost reporting period ending September 30, 2010. Hospital D's Program inpatient operating costs for cost reporting period ending September 30, 2009, were $1,400,000 (Worksheet D-1, Part II, line 53). For cost reporting period ending September 30, 2010, the Program inpatient operating costs were $1,800,000. Hospital D did not receive a LVA payment amount. The total payment for inpatient operating costs (Form CMS-2552-96, Worksheet E, Part A, line 8) was $1,020,000. The VDA payment amount is calculated as follows:

Step 1: Determine maximum allowable cost.	
Cost reporting period ending September 30, 2009, Program inpatient operating costs (Worksheet D-1, Part II, line 53)	*$1,400,000*
FY 2010 IPPS update factor	*1.021*
Cost reporting period ending September 30, 2009, Program inpatient operating costs (updated)	*$1,429,400*
Hospital D cost reporting period ending September 30, 2010, Program inpatient operating costs (Worksheet D-1, Part II, line 53)	*$1,800,000*
Maximum allowable cost (lesser of $1,429,400 or $1,800,000)	*$1,429,400*
Step 2: Determine the payment ceiling.	
Cost reporting period ending September 30, 2010, total payment for inpatient operating costs (Form CMS-2552-96, Worksheet E, Part A, line 8)	*$1,020,000*
Payment ceiling ($1,429,400 - $1,020,000)	*$ 409,400*
Step 3: Determine the pre-ceiling VDA payment.	
Hospital D cost reporting period ending September 30, 2010, Program inpatient operating fixed costs (as identified by provider and verified by contractor)	*$1,544,000*
Cost of excess staffing	*$ 15,000*
Cost reporting period ending September 30, 2010, Program inpatient operating fixed costs excluding the cost of excess staffing ($1,544,000 - $15,000)	*$1,529,000*
Cost reporting period ending September 30, 2010, pre-ceiling VDA payment ($1,529,000 - $1,020,000)	*$ 509,000*
Step 4: Determine the VDA payment amount.	
VDA payment amount (lesser of $409,400 or $509,000)	*$ 409,400*

** From Form CMS-2552-96, Worksheet E, Part A, line 8; or Form CMS-2552-10, Worksheet E, Part A, line 49 (as applicable)*

Application of the Payment Ceiling to VDA

Hospital D's cost reporting period ending September 30, 2010, Program inpatient operating costs exceeded that of cost reporting period ending September 30, 2009, increased by the IPPS update factor. Therefore, the payment ceiling is the difference between the cost reporting period ending September 30, 2009, Program inpatient operating costs adjusted by the IPPS update factor minus the cost period ending September 30, 2010, total payment for inpatient operating costs.

Hospital D's cost reporting period ending September 30, 2010, pre-ceiling VDA payment is greater than the payment ceiling. The VDA payment amount cannot exceed the payment ceiling; therefore, Hospital D's final VDA payment amount is equal to the payment ceiling of $409,400.

b. Cost Reporting Periods Beginning on or after October 1, 2017.--The contractor determines a provider's VDA payment amount as the difference between the Program inpatient operating fixed costs and the fixed cost portion of the total payment for inpatient operating costs (including the fixed cost portion of the operating portion of the LVA payment amount). The contractor calculates the VDA payment amount as follows:

Step 1--Determine the fixed cost ratio for the cost reporting period for which the provider requests the VDA by dividing the inpatient fixed and semi-fixed costs (as identified by the provider and verified by the contractor) for the period by the total inpatient operating costs for the period.

Step 2--Determine the fixed cost portion of the Program inpatient operating costs by applying the fixed cost ratio from Step 1 to the Program inpatient operating costs of the cost reporting period for which the provider requests the VDA.

Step 3--Determine the fixed cost portion of the Program payment for inpatient operating costs by applying the fixed cost ratio from Step 1 to the total payment for inpatient operating costs (including the operating portion of the LVA payment amount) of the cost reporting period for which the provider requests the VDA.

Step 4--Determine the VDA payment amount as the fixed portion of the Program inpatient operating costs from Step 2 minus the fixed portion of the Program payment for inpatient operating costs from Step 3.

EXAMPLE C: Hospital E is eligible for a VDA for cost reporting period ending September 30, 2018. Hospital E's total inpatient operating costs were $3,200,000 (inpatient operating fixed and semi-fixed costs, as identified by provider and verified by contractor, were $2,720,000; and variable costs were $480,000). The Program inpatient operating costs were $1,600,000, and the total payment for inpatient operating costs was $1,200,000. Hospital E received a LVA payment amount of $250,000 ($200,000 operating and $50,000 capital). The VDA payment amount is calculated as follows:

Step 1: Determine the fixed cost ratio.	
Cost reporting period ending September 30, 2018, total inpatient operating costs	*$3,200,000*
Cost reporting period ending September 30, 2018, inpatient operating fixed and semi-fixed costs (as identified by provider and verified by contractor)	*$2,720,000*
Fixed cost ratio ($2,720,000 ÷ $3,200,000)	*.85*
Step 2: Determine the fixed cost portion of the Program inpatient operating costs.	
Cost reporting period ending September 30, 2018, Program inpatient operating costs (Worksheet D-1, Part II, line 53)	*$1,600,000*
Cost reporting period ending September 30, 2018, fixed cost portion of the Program inpatient operating costs ($1,600,000 x .85)	*$1,360,000*
Step 3: Determine the fixed cost portion of the Program payment for inpatient operating costs.	
Cost reporting period ending September 30, 2018, total payment for inpatient operating costs (Worksheet E, Part A, line 49) plus the operating portion of the LVA payment amount ($1,200,000 + $200,000)	*$1,400,000*
Cost reporting period ending September 30, 2018, fixed portion of the Program payment for inpatient operating costs ($1,400,000 x .85)	*$1,190,000*
Step 4: Determine the VDA payment amount.	
VDA payment amount ($1,360,000 - $1,190,000)	*$ 170,000*

Application of the Fixed Cost Ratio:

Hospital E's cost reporting period ending September 30, 2018, fixed cost portion of the Program inpatient operating costs exceeded the fixed cost portion of the Program payment for for inpatient operating costs. Therefore, the VDA payment amount as determined using the fixed cost ratio is $170,000.

E. Reporting Final Determinations.--*Within 5 working days of each VDA final determination, the contractor must complete and email a Volume Decrease Adjustment Report to CMS Central Office (VDADetermination@cms.hhs.gov) with a copy to the appropriate regional office.*

When completing the report, the contractor must enter their name; the date of the hospital's VDA request; the hospital name, address, CCN, status (circle the applicable choice); the cost reporting period for which the VDA was requested; and the date of the VDA final determination. If the

contractor denies the VDA request, enter an explanation for the denial. If the contractor grants the VDA request, enter the data elements as applicable, and the provider's explanation for the volume decrease.

Sole Community Hospital / Medicare Dependent Hospital
Volume Decrease Adjustment Report
42 CFR 412.92 and 412.108

Medicare Contractor		
Date of Request		
Provider Name		
Address (City, State, ZIP code)		
CCN		
Status	*SCH*	*MDH*
Cost Reporting Period	*From:*	*To:*
Date of Final Determination		
Explanation for Denial:		
Granted (enter data elements)		
Total Inpatient Operating Costs		*$*
Fixed Inpatient Operating Costs		*$*
Fixed Cost Percentage		*%*
Program Inpatient Operating Costs		*$*
Program Inpatient Operating Costs - Fixed portion		*$*
Total Payment for Inpatient Operating Costs		*$*
Total Payment for Inpatient Operating Costs - Fixed portion		*$*
Amount of Adjustment		*$*
Explanation for Volume Decrease:		

Send to VDADetermination@cms.hhs.gov with a copy to the appropriate Regional Office.

F. Reconsideration.--A hospital that is dissatisfied with the determination on its request for additional payment may request a reconsideration by the *contractor*. A request for a reconsideration may be based on an alternative interpretation of previously submitted information, on new or additional information, or both. A request for a reconsideration of *a contractor's* determination must be made within 60 days of the date of the *contractor's* letter to the hospital notifying it of the determination. *A contractor* entertains only one request for reconsideration of its determination on each request for a payment adjustment.

G. Appeals.--A hospital that is dissatisfied with the determination on its adjustment request may appeal the determination in accordance with the procedures in *42 CFR 405 Subpart R*.

H. A MDH, as defined under 42 CFR 412.108, may also qualify for a VDA in accordance with 42 CFR 412.108(d). The VDA payment amount is determined in accordance with the methodology set forth in 42 CFR 412.92(e)(3), and as described in preceding sections A through G.

2810.2 *Reserved for future use.*

2810.3 *Reserved for future use.*