Medicare

Department of Health and Human Services (DHHS)

Provider Reimbursement Manual

Centers for Medicare and Medicaid Services (CMS)

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

Transmittal 7 **Date: March 2015**

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NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Ending on or After October 1, 2014.

Pub. 15-2-40

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

Revisions include:

- Worksheet S-2, Part I:
  - Added questions 22.02 and 22.03 to identify newly merged hospitals and hospitals that undergo an involuntary reclassification from urban to rural in accordance with the 2015 Inpatient Prospective Payment Systems (IPPS) Final Rule.
  - Added questions 40, 81, 110 and 171 to identify hospitals that are subject to the hospital acquired condition (HAC) reduction adjustment, long term care hospitals that are co-located in another hospital, hospitals that participate in the 410A Demo and hospitals claiming Medicare days for individuals enrolled in 1876 Medicare cost plans.

- Worksheet E, Part A:
  - Modified lines 1.02 and 1.03 and added line 1.04 for cost reporting periods that overlap or begin on or after October 1, 2013**.**
  - Clarified instructions for lines 6, 10, 16 and 20 for Indirect Medical Education (IME) FTEs**.**
  - Added lines 22.01, 28.01 and 29.01, to compute the IME adjustment for managed care patients in a teaching hospital and revised line 49 to add in the IME adjustment amount for managed care patients effective for cost reporting periods beginning on or after October 1, 2014 in accordance with the 2015 IPPS Final Rule.
  - Added instructions for lines 35, 35.01 and 35.02 to calculate uncompensated care for newly merged hospitals in accordance with the 2015 IPPS Final Rule and Sole Community Hospitals that do not have a hospital uncompensated care payment amount determined by CMS.
  - Added lines 70.90, 70.91, and 100 through 104, effective for discharges occurring on or after October 1, 2013, to compute the value based purchasing adjustment amount and the hospital readmissions reduction adjustment amount for Medicare Dependent Hospitals that receive a hospital specific bonus payment amount.
  - Modified instructions for line 34 for hospitals that undergo an involuntary reclassification from urban to rural as a result of CMS' adoption of new standards for delineating new statistical areas in accordance with 2015 IPPS Final Rule.
  - Added line 70.99 and Exhibit 5 to reconcile the HAC reduction adjustment amount in accordance with the §3008 of the Patient Protection Affordable Care Act (ACA) of 2010, effective for discharges occurring on or after October 1, 2014.

- Worksheet E-4:
  - Clarified instructions for lines 2, 8 and 15 for Direct Graduate Medical Education (GME) FTEs**.**

- Worksheets E, Part A; E, Part B; E-2; E-3, Parts I through VI; H-4; J-3; and M-3:
  - Added lines for the Pioneer Accountable Care Organization demonstration payment adjustment in accordance with section 3022 of the ACA, effective for discharges occurring on or after April 1, 2014.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for Cost Reporting Periods Ending on or After October 1, 2014.

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

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2552-10	E-2		XVIII	Swing Bed SNF
2552-10	E-2		XIX	Swing Bed SNF
2552-10	E-2		XIX	Swing Bed NF
2552-10	E-3	I - V	XVIII	Hospital
2552-10	E-3	I - III or V	XVIII	Subprovider
2552-10	E-3	IV	XVIII	LTCH
2552-10	E-3	VI	XVIII	SNF
2552-10	E-3	VII	V & XIX	Hospital
2552-10	E-3	VII	V & XIX	NF, ICF/MR
2552-10	E-3	VII	V & XIX	SNF
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2552-10	G-1			
2552-10	G-2			
2552-10	G-3			
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2552-10	H-2	I & II		Hospital-based HHA
2552-10	H-3	I & II	V, XVIII, & XIX	Hospital-based HHA
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4003. WORKSHEET S - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

4003.1 Part I - Cost Report Status.--This section is to be completed by the provider and fiscal intermediary (FI)/Medicare administrative contractor (MAC) (hereafter referred to as contractor) as indicated on the worksheet.

Lines 1 *through* 3, column 1--The provider must check the appropriate box to indicate on line 1 or 2, whether this cost report is being filed electronically or manually, *respectively.* For electronic filing, indicate on the appropriate line the date and time corresponding to the creation of the electronic file. This date and time remains as an identifier for the file by the contractor and is archived accordingly. This file is your original submission and is not to be modified. If this is an amended cost report, enter on line 3 the number of times the cost report has been amended.

Line 4, column 1--The provider must enter an "F" if this is full cost report or an "L" for low Medicare utilization (requires prior contractor approval, see Pub. 15-2, chapter 1, section 110).

Line 5, column 1--Enter the Healthcare Cost Report Information System (HCRIS) cost report status code on line 5, column 1 of Worksheet S that corresponds to the filing status of the cost report: 1=As submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 6, column 2--Enter the date (mm/dd/yyyy) an accepted cost report was received from the provider.

Line 7, column 2--Enter the 5 position contractor number.

Lines 8 and 9, column 2--If this is an initial cost report, enter "Y" for yes in the box on line 8. If this is a final cost report, enter "Y" for yes in the box on line 9. If neither, enter "N".

An initial report is the very first cost report for a particular provider CCN. A final cost report is a terminating cost report for a particular provider CCN.

If the cost report is both initial and terminating in the same year, for example, the provider started Medicare and decided to leave the program in the same year, and if the cost report is a full Medicare utilization report, please submit to HCRIS an as submitted and a final settled report. The as submitted extract should be the initial report, and the final settled should be the final report.

If the cost report is both initial and terminating in the same year, and if the cost report is No or Low Medicare utilization, please only submit to HCRIS a final settled with or without audit report. This would be the only situation in which a HCRIS extract would be both initial and final.

Line 10, column 3--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2 or 3.

Line 11, column 3--Enter software vendor code of the cost report software used by the contractor to process this HCRIS cost report file. Use "4" for HFS or "3" for KPMG.

Line 12, column 3--If this is a reopened cost report (response to line 5, column 1 is "4"), enter the number of times the cost report has been reopened. This field is only *to* be completed if the cost report status code in line 5, column 1 is 4.

4003.2 Part II - Certification.--This certification is read, prepared, and signed by an officer or administrator of the provider after the cost report has been completed in its entirety.

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

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

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

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

Line 19--For any component type not identified on lines 3 through 18, enter the required information in the appropriate column.

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

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

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

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

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

Line 22.02--Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on and after October 1. For a newly merged hospital as defined in the IPPS FY 2015 final rule, 79 FR 50022 (August 22, 2014), the final Factor 3 would be recalculated based on the Medicaid days and SSI days reported on the cost report used for the applicable fiscal year since the Factor 3 that was published in the final rule did not reflect the merger. For example, for a newly merged hospital that merged in FY 2015, the numerator of its Factor 3 would be recalculated based on the FY 2015 SSI days and the Medicaid days reported on its 2015 cost report. See 79 FR 50021 (August 22, 2014).

For the purpose of this question, a merger is defined as an acquisition where the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving provider. We would not consider a merger to be an acquisition where a new owner voluntarily terminates the provider agreement of the hospital it purchased by rejecting assignment of the previous owner's provider agreement.

Line 22.03--For cost reporting periods ending on or after October 1, 2014 and before October 1, 2016, 42 CFR 412.102 provides for a two year transition to a rural DSH payment amount from an urban DSH payment amount, for hospitals that received a geographic reclassification from urban to rural under the OMB standards for delineating statistical areas adopted by CMS in FY2015. Impacted hospitals whose DSH payment adjustment exceeds 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2015 and 1/3 of the difference between the urban and rural operating DSH for FY 2016. Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. Does this hospital contain 100 or fewer beds in accordance with 42 CFR 412.105? Enter in column 3, "Y" for yes or "N" for no.

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

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

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

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

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

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

Lines 28 through 34--Reserved for future use.

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

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

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

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

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

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

NOTE: 42 CFR 412.101(c)(2) provides for a temporary change in the low-volume adjustment for qualifying hospitals for federal fiscal years (FFYs) 2011 through *2014 and the portion of FY 2015 before April 1, 2015* as follows:

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

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

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

Line 40--Section 3008 of the ACA 2010 established the Hospital Acquired Condition (HAC) Reduction Program, beginning in FFY 2015. Enter in column 1, "Y" for yes or "N" for no if your hospital is subject to the HAC reduction adjustment for discharges occurring prior to October 1. For cost reporting periods that overlap October 1, 2014, enter "N" in column 1. Enter in column 2, "Y" for yes or "N" for no if your hospital is subject to the HAC reduction adjustment for discharges occurring on or after October 1.

Lines *41* through 44--Reserved for future use.

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

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

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

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

Lines 49 through 55--Reserved for future use.

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 63--Has your facility trained residents in a nonprovider setting during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. See 75 *FR* 72139-*721*40 *(November 24, 2010)*. If column 1 is "Y" for yes, complete lines 64 through 67 and applicable subscripts. If "N" for no, but your facility trained residents in a nonprovider setting during the base year period (cost reporting period that begins on or after July 1, 2009 and before June 30, 2010), complete lines 64 and 65 and applicable subscripts effective for cost reporting periods beginning on or after July 1, 2010.

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

Line 64--If line 63 is yes or your facility trained residents in the base year period, enter in column 1, for cost reporting periods that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.

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

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

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

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

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

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

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

Lines 68 *through* 69--Reserved for future use.

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

Line 71--If this facility is an IPF or contains an IPF subprovider (response to line 70, column 1 is "Y" for yes), were residents training in this facility **in the most recent cost report filed on or before November 15, 2004?** Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in new teaching programs in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter in column 2 "Y" for yes or "N" for no. (Note: questions 1 and 2 must have opposite answers, i.e., if column 1 is "Y", then column 2 must be "N" and vice versa; columns 1 and 2 cannot be "Y" simultaneously, columns 1 and 2 can be "N" simultaneously.) If *column 2 is* yes, enter a "1", "2", or "3", respectively, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that begins during the current cost reporting period. If the current cost reporting period covers the beginning of the fourth academic year of the first new teaching program's existence, enter the number "4" in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program's existence, enter the number "5" in column 3. *For facilities that participate in training residents in a new program for the first time on or after October 1, 2012 (see 42 CFR 413.79(e)(1)), if the current cost reporting period covers the beginning of the sixth or any subsequent academic year of the first new teaching program's existence, enter the number "6" in column 3 (see 79 FR 50110 (August 22, 2014)).*

Lines 72 *through* 74--Reserved for future use.

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

Line 76--If this facility is an IRF or contains an IRF subprovider (response to line 75, column 1 is "Y" for yes), did the facility train residents in teaching programs **in the most recent cost reporting period ending on or before November 15, 2004?** Enter in column 1 "Y" for yes or "N" for no. *If* the facility *is* training residents in new teaching programs in accordance with 70 *FR* 47929 *(*August 15, 2005*), e*nter in column 2*,* "Y" for yes*; otherwise, enter* "N" for no. (Note: questions 1 and 2 must have opposite answers*;* i.e., if column 1 is "Y", then column 2 must be "N" and vice versa*. C*olumns 1 and 2 cannot be "Y" simultaneously, *and,* columns 1 and 2 can be "N" simultaneously.) If *column 2 is* yes, enter a "1", "2", or "3" in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that begins during the current cost reporting period. If the current cost reporting period covers the beginning of the fourth academic year of the first new teaching program's existence, enter the number "4" in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program's existence, enter the number "5" in column 3. *For facilities that participate in training residents in a new program for the first time on or after October 1, 2012 (see 42 CFR 413.79(e)(1)), if the current cost reporting period covers the beginning of the sixth or any subsequent academic year of the first new teaching program's existence, enter the number "6" in column 3. (See 79 FR 50110 (August 22, 2014)).*

Lines 77 *through* 79--Reserved for future use.

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

Line 81--Are you an independent or freestanding LTCH located within another hospital, subject to the special payment provisions of 42 CFR 412.534? Enter "Y" for yes or "N" for no. To be considered as independent or a freestanding facility, a LTCH located within another hospital must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22.

Lines *82 through* 84--Reserved for future use.

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

Line 86--Have you established a new "Other" subprovider (excluded unit) under 42 CFR §413.40 (f)(1)(ii)? Enter "Y" for yes or "N" for no in column 1. If there is more than one subprovider, subscript this line. Do not complete this line.

Line 87 *through* 89--Reserved for future use.

Lines 90--Do you provide title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.

Line 91--Is this hospital reimbursed for title V and/or XIX through the cost report in full or in part? Enter "Y" for yes or "N' for no in the applicable column.

Line 92--If all of the nursing facility beds are certified for title XIX, and there are also title XVIII certified beds (dual certified), are any of the title XVIII beds occupied by title XIX patients? Enter "Y" for yes or "N" for no in the applicable column. You must complete a separate Worksheet D-1 for title XIX for each level of care.

Line 93--Do you operate an ICF/MR facility for purposes of title XIX? Enter "Y" for yes or "N" for no.

Line 94--Does title V and/or XIX reduce capital costs? Enter "Y" for yes or "N" for no in the applicable column.

Line 95--If line 94 of the corresponding column is "Y" for yes, enter the percentage by which capital costs are reduced.

Line 96--Does title V and/or XIX reduce operating costs? Enter "Y" for yes or "N" for no in the applicable column.

Line 97--If line 96 of the corresponding column is "Y" for yes, enter the percentage by which operating costs are reduced.

Lines 98 *through* 104--Reserved for future use.

Line 105--If this hospital qualifies as a CAH, enter "Y" for yes in column 1. Otherwise, enter "N" for no, and skip to line 108. (See 42 CFR 485.606ff.)

Line 106--If line 105 is yes, has this CAH elected the all-inclusive method of payment for outpatient services? Enter "Y" for yes or "N" for no. If yes, an adjustment for the professional component is still required on Worksheet A-8-2.

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

Line 107--If line 105 is yes, is this CAH eligible for 101 percent reasonable cost reimbursement for I&R in approved training programs? Enter a "Y" for yes or an "N" for no in column 1. If yes, the GME elimination is **not** made on Worksheet B, Part I, column 25 and the program is cost reimbursed. If yes, complete Worksheet D-2, Part II.

Line 108--Is this a rural hospital qualifying for an exception to the certified registered nurse anesthetist (CRNA) fee schedule? (See 42 CFR 412.113(c).) Enter "Y" for yes or "N" for no, in column 1.

Line 109--If this hospital qualifies as a *CAH* (response to line 105 is yes) or is a cost reimbursed provider, are therapy services provided by outside suppliers? Enter "Y" for yes or "N" for no under the corresponding physical, occupational, speech and/or respiratory therapy services as applicable.

Line 110--Did this facility participate in the Rural Community Hospital Demonstration Project (also known as the 410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.

Lines *111 through* 114--Reserved for future use.

Line 115--Is this an all-inclusive rate provider (see instructions in CMS Pub. 15-1, chapter 22, §2208). Enter "Y" for yes or "N" for no in column 1. If yes, enter the applicable method (A, B, or E only) in column 2. If column 2 is "E", enter the inpatient Medicare calculation percentage in column 3. Enter "93" for short-term hospitals where over 50 percent of all patients admitted stay less than 30 days or "98" for long-term hospitals where over 50 percent of all patients stay 30 days or more. (See CMS Pub. 15-1, chapter 22, §2208.1.E.)

Line 116--Are you classified as a referral center? Enter "Y" for yes or "N" for no. See 42 CFR 412.96.

Line 117--Are you legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no. Malpractice insurance, sometimes referred to as professional liability insurance, is insurance purchased by physicians and hospitals to cover the cost of being sued for malpractice.

Line 118--Is the malpractice insurance a claims-made or occurrence policy? A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a "claims-made" contract. The occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. If the policy is claims-made, enter 1. If the policy is occurrence, enter 2.

Line 118.01--Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of *self-insurance* paid in column 3.

Line 118.02--Indicate if malpractice premiums and paid losses are reported in a cost center other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.

Malpractice insurance premiums are money paid by the provider to a commercial insurer to protect the provider against potential negligence claims made by their patients/clients. Malpractice paid losses is money paid by the healthcare provider to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the provider where the healthcare provider acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often providers will manage their own funds or purchase a policy referred to as captive insurance, which protects providers for excess protection that may be unavailable or cost-prohibitive at the primary level.

Line 119--This question is eliminated and this line must not be used.

Line 120--If this is an SCH (or EACH), that qualifies for the outpatient hold harmless provision in accordance with ACA section 3121, enter "Y" for yes or "N" for no in column 1. If this is a rural hospital with 100 or fewer beds, that qualifies for the outpatient hold harmless provision in accordance with ACA section 3121, enter "Y" for yes or "N" for no in column 2. *The* ACA *§*3121 was amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, *§108*; the Temporary Payroll Tax Cut Continuation Act of 2011, *§*308; and the Middle Class Tax Relief and Job Creation Act of 2012, *§*3002. Note that for SCHs and EACHs, the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012, regardless of bed size, and from March 1, 2012 through December 31, 2012, for SCHs and EACHs with 100 or fewer beds. Rural hospitals with 100 or fewer beds are also extended through December 31, 2012. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.

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

Lines 122 through 124--Reserved for future use.

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

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

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

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

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

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

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

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

Line 133--Use this line if your facility contains a Medicare certified transplant center not specifically identified on lines 126 through 132. Enter the certification date in column 1 and termination date in column 2, if applicable. Subscript this line as applicable; however, do not complete a separate Worksheet D-4 for each Medicare certified transplant center type. For organs identified on this line, enter the corresponding cost on Worksheet A, line 112 and subscripts as applicable.

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

Lines 135 through 139--Reserved for future use.

Line 140--Are there any related organization or home office costs claimed as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, complete Worksheet A-8-1. If this facility is part of a chain and you are claiming home office costs, enter in column 2 the home office chain number and complete lines 141 through 143. See CMS Pub. 15-1, chapter 21, §2150 for a definition of a chain organization.

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

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

Line 143--Enter the city, State and ZIP code of the home office.

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

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

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

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

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

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

Lines 150 through 154--Reserved for future use.

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

Lines 162 through 164--Reserved for future use.

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

Line 166--If you responded "Y" for yes to question 165, enter information for each campus (including the main campus) as follows: name in column 0, county in column 1, State in column 2, ZIP code in column 3, geographic CBSA in column 4, and the FTE count for this campus in column 5. If additional campuses exist, subscript this line as necessary. Enter the information in columns 0 through 5 for the main campus first, and then enter the information in each column for the subordinate campuses, in any order. For example, for the main campus, enter on line 166 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus. For the first subordinate campus, enter on line 166.01 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus. *Report only FTE information associated with IPPS areas and not the FTE information for excluded areas, i.e., hospital-based IPF and hospital-based IRF.*

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

Line 168--If this provider is a CAH (line 105 is "Y" for yes) and is also a meaningful EHR technology user (line 167 is "Y" for yes) enter, if applicable, the reasonable acquisition cost incurred for EHR assets either purchased or initially rented under a virtual purchase lease (see *42 CFR 413.130(b)(5) and (8), and CMS Pub. 15-1, chapter 1,* §110.B.1.b) in the current cost reporting period. If applicable, also enter the un-depreciated cost (i.e., net book value), as of the beginning of the current cost reporting period, for assets purchased or initially rented under a virtual purchase lease in prior cost reporting period(s) which were used for EHR purposes in the current cost reporting period. Do not enter on this line any cost for EHR assets which was already claimed for the same assets in previous cost reporting period(s). The reasonable acquisition cost incurred is for depreciable assets such as computers and associated hardware and software necessary to administer certified EHR technology. (See 75 *FR* 44461 *(*July 28, 2010*)* and 42 CFR 495.106(a) and (c)(2).)

Additionally, if the amount on this line is greater than zero, submit a listing of the EHR assets showing the following information for each asset: (1) nature of each asset and acquisition cost; (2) an annotation whether the asset was purchased or leased under a virtual purchase lease (42 CFR 413.130(b)(8)); (3) date of purchase or date the virtual purchase lease was initiated; (4) name(s) of original purchaser (e.g., CAH, CAH's home office, group of unrelated providers); (5) information regarding the asset's use (i.e., indication whether the asset (hardware of software) will be shared with CAH's non-EHR systems); and (6) tag number and location (department unit).

Line 169--If this is a §1886(d) provider that responded "N" for no to question 105 and "Y" for yes to question 167, enter the transition factor to be used in the calculation of your *EHR* incentive payment.

See 75 *FR* 44458-*444*60 *(*July 28, 2010*)*. The transition factor equals:

If a hospital first becomes a meaningful EHR user in fiscal year 2011, 2012 or 2013*:*

- The first year transition factor is 1.00
- The second year transition factor is 0.75
- The third year transition factor is 0.50
- The fourth year transition factor is 0.25
- Any succeeding transition year is 0

If a hospital first becomes a meaningful EHR user in fiscal year 2014*:*

- The first year transition factor is 0.75
- The second year transition factor is 0.50
- The third year transition factor is 0.25
- Any succeeding transition year is 0

If a hospital first becomes a meaningful EHR user in fiscal year 2015*:*

- The first year transition factor is 0.50
- The second year transition factor is 0.25
- Any succeeding transition year is 0

Line 170--If line 167 is "Y", enter the EHR reporting period. Enter in column 1 the reporting period beginning date and in column 2 the ending date in accordance with 42 CFR §495.4. The EHR reporting period may be a full federal fiscal year or if this is the first payment year, any continuous 90-day period within a federal fiscal year. If the EHR reporting period ending date is on or after April 1, 2013, the EHR incentive payment will be subject to the 2 percent sequestration adjustment. The response to this question impacts the sequestration calculation on Worksheet E-1, Part II, line 9.

Line 171--If this provider is a meaningful EHR technology user (line 167 is "Y"), the days associated with individuals enrolled in section 1876 Medicare cost plans must be included in the calculation of the incentive payment. Indicate if you have section 1876 days included in the days reported on Worksheet S-3, Part I, line 2, column 6, by entering "Y" for yes and "N" for no.

Line 30--Enter in column 8, the employee discount days if applicable. These days are used on Worksheet E, Part A, line 31, in the calculation of the DSH adjustment and Worksheet E-3, Part III, line 3, in the calculation of the LIP adjustment. *The days reported on this line must reflect hospital services provided in the beds reported on line 1, column 2.*

Line 31--Enter in column 8, the employee discount days, if applicable, for IRF subproviders.

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

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

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

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

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

only those distinct ancillary labor and delivery room beds which are occupied by inpatients or are unoccupied are ultimately counted as "beds."

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

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

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

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

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

Column 2

General instructions for completing column 2:

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

NOTE: Methodology for including *and accruing direct salaries, paid* vacation, *paid* holiday, *paid* sick*, and* other *PTO* in the wage index:

> *S*alary cost--The required source for costs on Worksheet A is the *g*eneral *l*edger (see §4013 and 42 CFR 413.24(e)). Worksheet S-3, Part II (wage index) data are derived from Worksheet A; therefore, the proper source for costs for the wage index is also the *g*eneral *l*edger. A hospital's current year *g*eneral *l*edger includes both costs that are paid during the current year and costs that are expensed in the current year but paid in the subsequent year (current year accruals). *Include* on Worksheet S-3, Part II, the current *year costs* incurred *from* the *g*eneral *l*edger; that is, both the current *year costs* paid and the current *year* accrual*s*. (Costs that are expensed in the prior year but paid in the current year (prior year accruals) are not included on a hospital's current year *g*eneral *l*edger and should not be included on the hospital's current year Worksheet S-3, Part II.)

*H*ours--The source for paid hours on Worksheet S-3, Part II is the *provider's p*ayroll *r*eport. Hours are included on the *p*ayroll *r*eport in the period the *associated expense* is paid. *I*nclude on Worksheet S-3, Part II*, the hours from* the current year *p*ayroll *r*eport, *including* hours associated *with costs* expensed in the prior year but paid in the current year. The *payroll report* time period must cover the weeks that best match the provider's cost reporting period. (Hours associated *with costs* expensed in the current year but not paid until the subsequent year (current *year accrual*) are not included on the current year *p*ayroll *r*eport and should not be included on the hospital's current year Worksheet S-3, Part II.) Although this methodology does not provide a perfect match between *paid costs* and *paid hours* for a given year, it approximate*s* a match between cost*s* and hours.

NOTE: *The above methodology is recommended by CMS but does not preclude using a different approach that would produce a more accurate finding for purposes of the wage index. A hospital must obtain approval from its contractor to use a different methodology. For example, when the hospital is unable to match the general ledger and payroll report direct salaries and hours within the exact dates of its cost reporting period, they may request approval to accrue salaries and hours on Worksheet S-3, Part II (up to 15 days before the cost reporting period beginning date or 15 days after the cost reporting period ending date in order to include 365 or 366 days, depending on the year). Accrued costs must have associated hours and must be excluded from the subsequent Worksheet S-3, Part II.*

Regardless of the methodology used, costs and hours reported must be consistent. That is, accrued costs must have associated hours reported in the same cost center and in the same cost reporting period. The hospital must ensure that supporting documentation for both salaries and hours are based on actual data maintained in a form that permits validation by the contractor. The use of estimates for these amounts is unacceptable for the wage index.

Line 1--Enter from Worksheet A, column 1, line 200, the direct salaries and wages, including the amounts for related paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay, paid to hospital employees. See Worksheet A instructions (§ 4013).

Lines 2 through 10--The amounts reported must be adjusted for vacation, holiday, sick, other paid time off, severance, and bonus pay if not already included. Do not include in lines 2 through 8 the salaries for employees associated with excluded areas lines 9 and 10.

Line 2--Enter the salaries for directly-employed Part A non-physician anesthetist (for rural hospitals that have been granted CRNA pass through) to the extent these salaries are included in line 1. Add to this amount the costs for CRNA Part A services furnished under contract to the extent hours can be accurately determined. Report only the personnel costs associated with these contracts. DO NOT include cost*s* for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 9 and 10. Additionally, contract CRNA cost must be included on line 11. Report in column 5 the hours that are associated with the costs in column 4 for directly employed and contract Part A CRNAs.

Line 3--Enter the non-physician anesthetist salaries included in line 1, subject to the fee schedule and paid under Part B by the contractor. Do not include salary costs for physician assistants, clinical nurse specialists, nurse practitioners, and nurse midwives.

Line 4--Enter the physician Part A administrative salaries, (excluding teaching physician salaries), which are included in line 1. Also do not include intern and resident (I & R) salary on this line. Report I & R salary on line 7. Subscript this line and report salaries for Part A teaching physicians on line 4.01.

Lines 5 and 6--Enter the total physician, physician assistant, nurse practitioner and clinical nurse specialist salaries billed under Part B that are included in line 1. Under Medicare, these services are related to patient care and billed separately under Part B. Also include physician salaries for patient care services reported for rural health clinics (RHC) and federally qualified health centers (FQHC) included on Worksheet A, column 1, lines 88 and/or 89 as applicable. Report on line 6 the non-physician salaries reported for hospital-based RHC and FQHC services included on Worksheet A, column 1, lines 88 and/or 89 as applicable. Do not include on these lines amounts that are included on lines 9 and 10 for the SNF or excluded area salaries.

Do not include physician assistants, clinical nurse specialists, nurse practitioners, and nurse midwives.

Line 7--Enter from Worksheet A the salaries reported in column 1 of line 21 for interns and residents. Subscript this line and report salaries for contracted interns and residents in an approved program on line 7.01. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 9 and 10. Additionally, contract intern and resident costs must be included on line 11. DO NOT include contract intern and residents costs on line 13. Report in column 5 the hours that are associated with the costs in column 4 for directly employed and contract interns and residents.

Line 8--If you are a member of a chain or other related organization as defined in CMS Pub. 15-1, chapter 21, §2150, enter from your records, the wages and salaries for home office related organization personnel that are included in line 1.

Lines 9 and 10--Enter on line 9 the amount reported on Worksheet A, column 1 for line 44 for the SNF. On line 10, enter from Worksheet A, column 1, the sum of lines 20, 23, 40 through 42, 45, 45.01, 46, 94, 95, 98 through 101, 105 through 112, 114, 115 through 117, and 190 through 194. DO NOT include on lines 9 and 10 any salaries for general service personnel (e.g., housekeeping) which, on Worksheet A, column 1, may have been included directly in the SNF and the other cost centers detailed in the instructions for Line 10.

General Instructions for Contract Labor:

In general, for contract labor, the minimum requirement for supporting documentation is the contract itself. If the wage costs, hours, and non-labor costs are not clearly specified in the contract, then other documentation is necessary, such as a representative sample of invoices which specify the wage costs, hours, and non-labor costs or a signed declaration from the vendor in conjunction with a sample of invoices. Hospitals must be able to provide such documentation when requested by the contractor. A hospital's failure to provide adequate supporting documentation may result in the cost being disallowed for the wage index. Report only personnel costs associated with the contract. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs).

Workers who are contracted solely for the purpose of providing services on-call can only be included on Worksheet S-3 when they actually work the on-call schedule. That is, they are actually delivering patient care at the hospital, or are at the hospital so as to be available to deliver patient care. If either of these latter two scenarios occur, then both the wages and associated hours actually worked must be included in the appropriate contract labor line on Worksheet S-3.

Line 11--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, as defined below. Do not include costs applicable to excluded areas reported on line 9 and 10. Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and 7.01, respectively). Include on this line contract pharmacy and laboratory wage costs as defined below.

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

Contract pharmacy services are furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts.

Contract laboratory services are furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts.

If you have no contracts for direct patient care as defined above, enter a zero in column 2. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 2.

Line 12--Enter the amount paid for **contracted top level management services, and other contract management and administrative services** furnished under contract, rather than by employees. Include on this line contract management and administrative services associated with cost centers other than those listed on lines 26 through 43 (and their subscripts) of this worksheet that are included in the wage index.

Contracted Top Level Management: Include the amount paid for **top level management services**, as defined below, furnished under contract rather than by employees. Contract management is limited to the personnel costs for those individuals who are working at the hospital facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract top level management services DO NOT include the following: physician Part A services, consultative services, clerical and billing services, legal and accounting services, unmet physician guarantees, physician services, planning contracts, independent financial audits, or any services other than the top level management contracts listed above. Per instructions on Worksheet S-2, Part II, for top level management contracts, submit to your Medicare contractor the aggregate wages and hours.

Other Contract Management and Administrative Services: Examples of other contract management and administrative services that would be reported on line 12 include department directors, administrators, managers, ward clerks, and medical secretaries. Report only those personnel costs associated with the contract. DO NOT include on line 12 any contract labor costs associated with lines 26 through 43 and subscripts for these lines.

Line 13--Enter from your records the amount paid under contract (in accordance with the general *instructions for* contract labor) for Part A physician services - administrative, excluding teaching physician services. DO NOT include contract I & R services (to be included on line 7). DO NOT include the costs for Part A physician services from the home office allocation and/or from related organizations (to be reported on line 15).

Line 14--Enter the salaries and wage-related costs (as defined on lines 17 and 18) paid to personnel who are affiliated with a home office and/or related organization, who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office/related organization salaries included on line 8 and the associated wage-related costs. This figure must be based on recognized methods of allocating an individual's home office/related organization salary to the hospital. If no home office/related organization exists or if you cannot accurately determine the hours associated with the home office/related organization salaries that are allocated to the hospital, then enter a zero in column 1. All costs for any related organization must be shown as the cost to the related organization.

NOTE: Do not include any costs for Part A physician services from the home office allocation and/or related organizations. These amounts are reported on line 15.

If a wage related cost associated with the home office is not “core” (as described in the Worksheet S-3, Part IV) and is not a category included in “other” wage related costs on line 18 (see Worksheet S-3, Part IV and line 18 instructions below), the cost cannot be included on line 14. For example, if a hospital’s employee parking cost does not meet the criteria for inclusion as a wage-related cost on line 18, any parking cost associated with home office staff cannot be included on line 14.

Line 15--Enter from your records the salaries and wage-related costs for Part A physician services - administrative, excluding teaching physician Part A services from the home office allocation and/or related organizations.

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

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

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

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

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

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

These lines provide for the collection of hospital wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. These lines are completed by all hospitals if the ratio of Part II, column 5, sum of lines 9 and 10 divided by the result of column 5, line 1 minus the sum of lines 2, 3, 4.01, 5, 6, 7, 7.01 and 8 equals or exceeds a threshold of 15 percent. However, all hospitals with a ratio greater than 5 percent must complete line 7 of Part III for all columns. Calculate the percent to two decimal places for purposes of rounding.

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

Lines 28, 33, and 35--Enter the amount paid for services performed **under contract** (in accordance with the general instructions *for contract labor* above), rather than by employees, for administrative and general, housekeeping, and dietary services, respectively. Continue to report on the standard lines (line 27, 32, and 34), the amounts paid for services rendered by employees not under contract.

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

Lines 32 through 35--All hospitals must incur costs for housekeeping and dietary services, either direct, under contract, or both. It is not acceptable to report zeroes for housekeeping or dietary services. Report wages and hours for housekeeping services on either line 32 (direct) or line 33 (contract), and for dietary services, on either line 34 (direct) or line 35 (contract). Hospitals are encouraged to ensure that their contracts clearly specify the salaries, wages, and hours related to all of their contract labor. If, in rare instances, hours for these services cannot be determined exactly from the contract, determine the hours based on a reasonable estimation. Examples of reasonable estimates are regional average hourly rates, including an average of the wages and hours for dietary and housekeeping services of other hospitals in the same CBSA. Hospitals also may conduct time studies to determine hours worked. If regional averages or time studies cannot be used, data from the Bureau of Labor Statistics may be used to obtain average wages and hours for housekeeping and dietary services.

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

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

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

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

NOTE: Workers who are contracted solely for the purpose of providing services on-call can only be included on Worksheet S-3 when they actually work the on-call schedule; that is, they are actually delivering patient care at the hospital, or are at the hospital so as to be available to deliver patient care. If either of these latter two scenarios occur, then both the wages and associated hours actually worked must be included in the appropriate contract labor line on Worksheet S-3.

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

4005.3 Part III - Hospital Wage Index Summary.--This worksheet provides for the calculation of a hospital's average hourly wage (without overhead allocation, occupational mix adjustment, and inflation adjustment) as well as analysis of the wage data.

Columns 1 through 6--Follow the same instructions discussed in Part II, except for column 6, line 5.

Line 1--From Part II, enter the result of line 1 minus the sum of lines 2, 3, 4.01, 5, 6, 7, 7.01, and 8. Add to this amount lines: 28, 33, and 35.

Line 2--From Part II, enter the sum of lines 9 and 10.

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

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

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

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

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

Definitions:

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

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

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

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

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

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

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

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

Enter the number of hours in your normal work week.

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

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

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

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

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

Line 20--Enter each 5-digit CBSA and/or non-CBSA (rural) code where the reported HHA visits were performed. Subscript the line to accommodate the number of CBSAs you service. Rural CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the State of Maryland the rural CBSA code is 99921.

PPS Activity Data--Applicable for Medicare Services.

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

4010. WORKSHEET S-8 - HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain *sufficient* statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to *hospital*-based rural health clinics (RHCs) and *hospital*-based federally qualified health centers (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility. RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-4, chapter 9, §30.8.

Lines 1 and 2--Enter the full address of the RHC/FQHC.

Line 3--For FQHCs only, enter your appropriate designation of "R" for rural or "U" for urban. See §505.2 of the RHC/FQHC Manual for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor. RHCs do not complete this line.

Lines 4 *through* 9--In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 10--If the facility provides other than RHC or FQHC services (e.g., laboratory or physician services), answer "Y" for yes and enter the type of operation on subscripts of line 11, otherwise enter "N" for no.

Line 11 --Enter in columns 1 through 14 the starting and ending hours in the applicable columns for the days that the facility is available to provide RHC/FQHC services. Enter the starting and ending hours in the applicable columns 1 through 14 for the days that the facility is available to provide other than RHC/FQHC services. *Enter* time as military time, e.g., 2:00 p.m. is 1400.

Line 12--Have you received an approval for an exception to the productivity standards? Enter a "Y" for yes or an "N" for no.

Line 13--Is this a consolidated cost report as defined in the Rural Health Clinic Manual? If yes, enter in column 2 the number of providers included in this report, complete line 14, and complete only one worksheet series M for the consolidated group. If no, complete a separate Worksheet S-8 for each component accompanied by a corresponding Worksheet M series.

Line 14--Identify provider's name and CCN number filing the consolidated cost report.

Line 15--Are you claiming allowable GME costs as a result of your substantial payment for interns and residents. Enter a "Y" for yes or an "N" for no in column 1. If yes, enter in the appropriate column the number of program visits (columns 2-4) and total visits (column 5) performed by interns and residents.

For cost reporting periods ending on or after October 1, 2014, do not complete this line. The regulations at 42 CFR 413.78(a) state that the GME payment to the hospital includes all residents working in the hospital complex in determining the amount due. Therefore, separate intern and resident counts are not collected for hospital-based RHCs and FQHCs for the purpose of calculating GME costs.

4011. WORKSHEET S-9 - HOSPICE IDENTIFICATION DATA

In accordance with 42 CFR 418.310 hospice providers of service participating in the Medicare program are required to submit annual information for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.24(f) requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a hospital-based hospice. Complete a separate Worksheet S-9 for each hospital-based hospice.

4011.1 Part I - Enrollment Days.--

NOTE: Columns 1 and 2 contain the days identified in column 3 and 4. Column 3 and 4 identify the SNF and NF days out of the total for title XVIII and XIX.

Lines 1 *through* 4--Enter on lines 1 through 4 the enrollment days applicable to each type of care. Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four types of care. Where a patient moves from one type of care to another, count only one day of care for that patient for the last type of care rendered. For line 4, an inpatient care day should be reported only where the hospice provides or arranges to provide the inpatient care.

Line 5--Enter the total of columns 1 through 6 for lines 1 through 4.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Continuous Home Care Day - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. **Note: Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.**

Routine Home Care Day - A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

Inpatient Respite Care Day - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

General Inpatient Care Day - A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

COLUMN DESCRIPTIONS

Column 1--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Column 2--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 5 the total unduplicated Medicaid days.

Column 3--Enter only the unduplicated days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 5 the total unduplicated days.

Column 4--Enter only the unduplicated days applicable to the four types of care for all Medicaid hospice patients residing in a nursing facility. Enter on line 5 the total unduplicated days.

4017. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organization, except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the hospital by organizations related to you or costs associated with the home office. In addition, it shows certain information concerning the related organizations with which you have transacted business as well as home office costs. (See CMS Pub. 15-1, chapter 10, and *chapter 21,* §2150, respectively.)

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

Columns 1, 2, and 3--Enter in columns 1 and 3, respectively, the worksheet A line number and specific expense category from your books and/or records associated with the acquisition of services, facilities, and/or supplies from related organizations. Column 2 is automatically completed based on the cost center in column 1.

Column 4--Enter the allowable cost from the books and/or records of the related organization which includes only the actual cost incurred by the related organization for services, facilities, and/or supplies and excludes any markup, profit or amounts that otherwise exceed the acquisition cost of such items.

Column 5--Enter the amount included on Worksheet A for services, facilities, and/or supplies acquired from related organizations.

Column 6--Enter the result of column 4 minus column 5.

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

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

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

Columns 1 and 2--Enter in column 1 the appropriate symbol which describes your relationship to the related organization. If the symbol A, D, E, F, or G is entered in column 1, enter the name of the related individual in column 2.

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

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

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

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

4018. WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

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

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

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

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

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

Where several physicians work in the same department, see CMS Pub. 15-1, §2182.6C, for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

NOTE: The adjustments generated from this worksheet for physician compensation are limited to the cost centers on Worksheet A, lines 4 *through 41, 43, 50 through 76, 90 through* 99, 10*5 through 111*, and 115, and subscripts as allowed.

Column Descriptions

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

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

Line 75--Enter in column 3 the outpatient ASC facility charges and Part B charges for the hospital *non-distinct* part ambulatory surgery center. These charges represent the ASC facility charge only (i.e., in lieu of operating or recovery room charges), and do not include charges for the ancillary services provided to the patient.

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

NOTE: For lines 88, 89 and 90, any ancillary service billed as clinic, RHC, or FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.

Line 92--Enter in column 2 the title XVIII Part B charges for observation beds. These are the charges for patients who were treated in the *non-distinct* observation beds and released. These patients were not admitted as inpatients.

Line 94--The only home program dialysis services which are cost reimbursed are those rendered to beneficiaries who have elected the option to deal directly with Medicare. Home program dialysis services reimbursed under the composite rate regulation (see 42 CFR 413.170) are not included on this line. This line includes costs applicable to equipment-related expenses only.

Line 95--Only CAHs eligible for cost reimbursement for ambulance services complete this line. Report charges for ambulance services from your records or the PS&R report type 85C in column 3. Multiply column 1 times column 3 and enter the result in column 6. All other hospital provider types are reimbursed under the ambulance fee schedule and do not complete this line.

Lines 96 and 97--For title XVIII, DME is paid on a fee schedule through the contractor and, therefore, is not paid through the cost report.

Line 200--Enter the sum of lines 50 through 98.

Line 201--Enter in columns 3 and 4 program charges for provider clinical laboratory tests where the physician bills the provider for program patients only. Obtain this amount from line 61.

Line 202--Enter in columns 3, 4, 6 and 7 and subscripts, the amount on line 200 plus or minus the amounts on line 201, if applicable.

Transfer Referencing: For title XVIII, transfer the sum of the amounts in columns 3 and 4 and applicable subscripts, line 202 to Worksheet E, Part B, line 12 (ancillary services charges). Make no transfers of swing bed charges to Worksheet E-2 since no LCC comparison is made.

For titles V and XIX (other than IPPS), transfer the sum of the amounts in columns 2, 3 and /or 4 plus subscripts as applicable, line 202 plus the amount from Worksheet D-3, column 2, line 202 to the appropriate Worksheet E-3, Part VII, line 9.

For titles V and XIX (under IPPS), transfer the amount in columns 2, 3 and /or 4 plus subscripts as applicable, line 202 to the appropriate Worksheet E-3, Part VII, line 9.

NOTE: If the amount on line 202 includes charges for professional patient care services of provider-based physicians, eliminate the amount of the professional component charges from the total charges, and transfer the net amount as indicated. Submit a schedule showing these computations with the cost report.

Transfer References

From Wkst. D, Part V	Title XVIII, Part B Swing Bed	to	Titles V or XIX or Title XVIII, Part B
Column 6, line 202 and column 7, line 73 and subscripts	N/A		Wkst. E, Part B, col. 1 (*and* subscripts), line 1
Columns 5, line 202	N/A		Wkst. E, Part B, col. 1 (*and* subscripts), line 2
Sum of columns 2, 3 and 4 as applicable (SNF only), line 202	N/A		Wkst. E, Part B, line 12, or Wkst. E-3, Part VII, col. 1, line 9 for titles V or XIX
Sum of column 6 and 7 (SNF only) line 202	Wkst E-2, col. 2, line 3		Wkst. E, Part B, line 1, or Wkst. E-3, Part VII, col. 1, line 2 for titles V or XIX

4028. WORKSHEET D-4 - COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS

Only certified transplant centers (CTCs) are reimbursed directly by the Medicare program for organ acquisition cost. This worksheet provides for the computation and accumulation of organ acquisition costs and charges for CTCs. Check the appropriate box (heart, liver, lung, pancreas, intestine, kidney, or islet) to determine which organ acquisition cost is being computed. Use a separate worksheet for each type of organ.

Hospitals that are not CTCs are not reimbursed by the Medicare program for organ acquisition costs and do not complete this worksheet. Such hospitals have to obtain revenue by the sale of any organs excised to an organ procurement organization (OPO) or CTC.

Worksheet D-4 consists of the following four parts:

- Part I - Computation of Organ Acquisition Cost (Inpatient Routine and Ancillary Services)
- Part II - Computation of Organ Acquisition Cost (Other than Inpatient Routine and Ancillary Service Costs)
- Part III - Summary of Costs and Charges
- Part IV - Statistics

4028.1 Part I - Computation of Organ Acquisition Costs (Inpatient Routine and Ancillary Services)--

Lines 1 through 7--These lines provide for the computation of inpatient routine service costs applicable to organ acquisition and for the accumulation of inpatient routine service charges for organ acquisition.

Column 1--Enter on lines 1 through 6, as appropriate, the inpatient routine charges applicable to organ acquisition. Enter on line 7 the sum of the amounts reported on lines 1 through 6.

Column 2--Enter on lines 1 through 6, as appropriate, the average per diem cost from Worksheet D-1:

Description	To Worksheet D-4, Part I, Col. 2	From Worksheet D-1, Part II
Adults & Pediatrics	line 1	col. 1, line 38
Intensive Care	line 2	col. 3, line 43
Coronary Care	line 3	col. 3, line 44
Burn Intensive Care Type Unit	line 4	col. 3, line 45
Surgical Intensive Care Type Unit	line 5	col. 3, line 46
Other Intensive Care Type Unit	line 6	col. 3, line 47

Column 3--Enter from your records on lines 1 through 6, as appropriate, total organ acquisition days (Medicare and non-Medicare). An organ acquisition day is an inpatient day of care rendered to *a potential recipient/donor (before admission for the actual transplant) solely for a medical evaluation for an anticipated organ transplant; or* an organ donor patient who is hospitalized for the surgical removal of an organ for transplant*;* or a day of care rendered to a cadaver in an inpatient routine service area for the purpose of surgical removal of its organs for transplant. Enter on line 7 the sum of the days on lines 1 through 6. *See CMS Pub. 100-02, chapter 11, §§140.4 - 140.8.*

Column 4--Enter on lines 1 through 6, as appropriate, the amount in column 2 multiplied by the amount in column 3. Enter on line 7 the sum of lines 1 through 6.

Lines 8 through 40--These lines provide for the computation of ancillary service cost applicable to organ acquisition. These lines also provide for the accumulation of inpatient and outpatient organ acquisition ancillary charges.

Column 1--Enter on lines 8 through 40, the "cost or other" cost to charges ratio from Worksheet C, column 9.

Column 2--Enter from your records inpatient and outpatient organ acquisition ancillary charges. Enter on line 41 the sum of lines 8 through 40.

Column 3--Enter on lines 8 through 40, the organ acquisition costs. Compute this amount by multiplying the ratio in column 1 by the amount in column 2 for each cost center. Enter on line 41, the sum of lines 8 through 40.

4028.2 Part II - Computation of Organ Acquisition Costs (Other Than Inpatient Routine and Ancillary Service Costs)--

Lines 42 through 47--Use these lines to apportion the cost of inpatient services attributable to organ acquisitions rendered in each of the inpatient routine areas by interns and residents not in an approved teaching program.

Column 1--Enter on the appropriate lines the average per diem cost of interns and residents not in an approved teaching program in each of the inpatient routine areas. Obtain these amounts from Worksheet D-2, Part I, column 4, lines as indicated.

Column 2--Enter the number of organ acquisition days in each of the inpatient routine areas from Part I, column 3, lines 1 through 6, as appropriate.

Column 3--Multiply the per diem amount in column 1 by the number of days in column 2 for each cost center.

Line 48--For columns 2 and 3, enter the sum of lines 42 through 47.

Lines 49 through 54--These lines provide for the computation of the cost of outpatient services attributable to organ acquisitions rendered in each of the outpatient service areas by interns and residents not in an approved teaching program.

Column 1--Enter on the appropriate lines the organ acquisition charges in each of the outpatient service areas. Obtain these amounts from Part I, column 2, lines 35 through 40, as appropriate.

Column 2--Enter the ratio of the outpatient costs of interns and residents not in an approved teaching program to the hospital outpatient service charges in each of the outpatient service areas. Obtain these ratios from Worksheet D-2, Part I, column 4, lines as indicated.

Column 3--Multiply the charges in column 1 by the ratios in column 2 for each cost center. Enter the sum of lines 49 through 54 on line 55.

4030. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

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

Worksheet E consists of the following two parts:

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

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

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

4030.1 Part A - Inpatient Hospital Services Under IPPS--

For SCH/MDH status change and/or geographical reclassification (see 42 CFR 412.102 *and* 103) subscript column 1 for lines *1 through 3*, 22, 28, 29, 33, 34, 41, 45, 47, and 48. If you responded "1" and "2", or "2" and "1", to Worksheet S-2, Part I, questions 26 and 27, respectively, which indicated your facility experienced a change in geographic classification status during the year, subscript column 1, and report the payments before the reclassification in column 1 and on or after the reclassification in column 1.01. *For cost reporting periods that overlap or begin on or after October 1, 2014, if you responded "Y", to Worksheet S-2, Part I, line 22.03, column 1 or 2, which indicated your facility experienced a change in geographic reclassification as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015, subscript column 1, for lines 33 and 34.*

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

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

Line Descriptions

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

Line 1.01--For cost reporting periods that overlap October 1, 2013 *and subsequent years,* enter the amount of the federal specific operating portion (DRG payments) paid for PPS discharges and transfers occurring prior to October 1. For example, a calendar year provider would include DRG payments for discharges occurring during the period of (January 1 through September 30).

Line 1.02--For cost reporting periods that *begin or* overlap October 1, 2013 *and subsequent years,* enter the amount of the federal specific operating portion (DRG payments) paid for PPS discharges and transfers occurring on or after October 1. For example, a calendar year provider would include DRG payments for discharges occurring during the period of (October 1 through December 31).

Line 1.03--Enter the amount of the federal specific operating portion (DRG payments) for Model 4 bundled payments for care improvement (BPCI) initiative, effective for discharges occurring on or after October 1, 2013. *Effective for cost reporting periods that overlap October 1, 2014 and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring prior to October 1.*

Line 1.04--Effective for cost reporting periods that begin or overlap October 1, 2014 and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring on or after October 1.

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

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

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

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

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

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

Indirect Medical Educational Adjustment Calculation for Hospitals--Calculate the IME adjustment only if you answered "yes" to line 56 on Worksheet S-2 and complete lines *5 through* 29*.01* as applicable. In addition, a hospital may be entitled to the IME adjustment if Worksheet S-2, line 56 is "no" and lines 13 and/or 14 are greater than zero. (See 42 CFR 412.105.) Hospitals that incur indirect costs for graduate medical education programs are eligible for an additional payment as defined in 42 CFR 412.105(d). This section calculates the additional payment by applying the applicable multiplier of the adjustment factor for such hospitals.

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

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

Line 6--Enter the FTE count for allopathic and osteopathic programs *that* meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e).

For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1) or (e)(3), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995, but before October 1, 2012. For *urban* hospitals that *participate in* training residents in a new program for the first time on or after October 1, 2012 *under 413.79(e)(1)*, the cap is *effective beginning with the hospital's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)). For rural hospitals that participate in training residents in a new program on or after October 1, 2012 under 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on each new program. Therefore, the rural hospital's FTE resident cap is adjusted for each new program effective with the hospital's cost reporting period that coincides with or follows the start of the sixth program year of each new program started (see 79 FR 50110 (August 22, 2014)).*

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

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

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

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

Line 8.01--Enter, as applicable, all of or a portion of the amount of the FTE cap slots the hospital was awarded under section 5503 of the ACA. The amount of the section 5503 award that is reported on this line is the amount of the section 5503 award that is being "used" in this cost reporting period. In the 5-year evaluation period following implementation of section 5503 (that is, July 1, 2011 through June 30, 2016), at least 75 percent of the slots are to be "used" for additional primary care and/or general surgery residents, while 25 percent of the amount that is reported may be (but need not be) "used" for other purposes. During the 5-year evaluation period, failure to meet the requirements at 42 CFR 413.79(n)(2) of the regulations means loss of a hospital's section 5503 slots. Therefore, do not automatically report the full amount of the section 5503 award; only enter the amount of the section 5503 award that equates to at least 75 percent of the FTEs being "used" for additional primary care and/or general surgery FTEs, and no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting period.

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

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

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

Calculation of the allowable current year FTEs:

Line 10--Enter the FTE count for allopathic and osteopathic programs in the current year from your records. Do not include residents in the initial years of the new program, which, *for urban or rural hospitals that participate in training residents in a new program under 42 CFR 413.79(e)(1) or (e)(3), prior to October 1, 2012,* means that the program has not yet completed one cycle of the program (i.e., "period of years," or the minimum accredited length of the program). (42 CFR 412.105(f)(1)(iv) and/or (f)(1)(v).) *For new programs started prior to October 1, 2012, c*ontact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. *For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012 under 42 CFR 413.79(e)(1), do not include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (i.e., the initial years, see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program(s) on or after October 1, 2012 under 42 CFR 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on that new program. Therefore, for rural hospitals, do not include FTE residents in a particular new program on this line if this cost reporting period is*

prior to the cost reporting period that coincides with or follows the start of the sixth program year of that specific new program started (see 79 FR 50110 (August 22, 2014)). For both urban and rural hospitals, report FTE residents in the initial years of the new program on line 16. Exclude FTE residents displaced by hospital or program closure that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 412.105(f)(1)(v)).

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

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

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

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

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

Line 16--Enter the number of FTE residents in the initial years of the program. (See 42 CFR 412.105(f)(1)(v).) *This line is reserved for use only by urban hospitals that do not have a previous FTE cap established on line 5 or line 6, and are first establishing an FTE cap by participating in training residents in a new allopathic or osteopathic residency program(s) for the first time in accordance with 42 CFR 413.79(e)(1). (Rural hospitals participating in training residents in new programs in accordance with 42 CFR 413.79(e)(3) would also report FTE residents in the initial years of the new program on this line). For a new program started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012 under 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program(s) on or after October 1, 2012 under 42 CFR 413.79(e)(3), include FTE residents in a particular new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of that new program (see 79 FR 50110 (August 22, 2014)).*

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

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

Line 19--Enter the current year resident to bed ratio *by dividing l*ine 18 by line 4.

Line 20--In general, enter from the prior year cost report the intern and resident to bed ratio by dividing line 12 by line 4 (divide line 3.14 by line 3 if the prior year cost report was the Form CMS-2552-96). However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e) *for a new program started prior to October 1, 2012,* add to the numerator of the prior year intern and resident to bed *ratio (i.e., line 12 of the prior cost report, which might be zero, if applicable),* the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program *(line 16)* (i.e., the period of years is the minimum accredited length of the program). *For a new program started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012 under 42 CFR 413.79(e)(1), if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, then divide line 16 of this cost report by line 4 of the prior year cost report (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program on or after October 1, 2012 under 42 CFR 413.79(e)(3), for each new program started, if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of each particular new program, then add the amount from line 12 of the prior year (if greater than zero) and line 16 of this cost report, and divide the sum by line 4 of the prior year cost report (see 79 FR 50110 (August 22, 2014)).* If the provider is participating in a Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap and current year FTE count due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator and the prior year numerator, and b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior year's numerator (see 66 *FR 39880 (*August 1, 2001*)*). If the hospital is participating in a valid emergency Medicare GME affiliation agreement under a §1135 waiver, and a portion of this cost report falls within the time frame covered by that emergency affiliation agreement, then, effective on and after October 1, 2008, enter the current

year resident to bed ratio from line 19 (see 73 *FR 48649 (*August 19, 2008*)* and 42 CFR 412.105(f)(1)(vi)). Effective for cost reporting periods beginning on or after *October 1, 2002*, if the hospital is training FTE residents in the current year that were displaced by the closure of another hospital or program, also adjust the numerator of the prior year ratio for the number of current year FTE residents that were displaced by hospital or program closure (42 CFR 412.105(a)(1)(iii)). The amount added to the prior year's numerator is the displaced resident FTE amount that you would not be able to count without a temporary cap adjustment. This is the same amount of displaced resident FTEs entered on line 17.

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

IME Add-on Payment For SCHs--Effective for cost reporting periods beginning on or after October 1, 2014, all SCHs that are subsection (d) teaching hospitals will receive an IME add on payment for discharges of Medicare Part C (managed care) patients in accordance with the 79 FR 50004 (August 22, 2014), regardless of whether the SCH is paid based on the federal rate or the hospital specific rate. For purposes of the comparison of payments based on the federal rate and the hospital specific rate, Medicare Part C patients will no longer be included as part of the federal rate payment.

Line 22--*For cost reporting periods beginning before October 1, 2014, c*alculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 21) to the .405 power) - 1} times {the sum of lines 1, 1.01, 1.02, 1.03*, 1.04,* and 3}.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 21) to the .405 power) - 1} times {the sum of lines 1.01, 1.02, 1.03, and 1.04}.

Line 22.01--Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment for managed care, as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 21) to the .405 power) - 1} times line 3.

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

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

Line 24--IME FTE Resident Count Over the Cap--Subtract line 9 from line 10 and enter the result here. If the result is zero or negative, the hospital does not need to use the 422 IME cap. Therefore, do not complete lines 25 through 28.

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

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

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

Line 28--IME Add On Adjustment--*For cost reporting periods beginning before October 1, 2014, e*nter the sum of lines 1, 1.01, 1.02, 1.03*, 1.04,* and 3, multiplied by the factor on line 27.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME add-on adjustment as follows: Enter the sum of lines 1.01, 1.02, 1.03, and 1.04, multiplied by the factor on line 27.

Line 28.01--IME Add On Adjustment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the result of line 3, multiplied by the factor on line 27.

Line 29--Total IME Payment--*E*nter the sum of lines 22 and 28.

Line 29.01--Total IME Payment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the sum of lines 22.01 and 28.01.

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

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

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

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

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

NOTE: *For cost reporting periods ending on or after October 1, 2014 and before October 1, 2016, 42 CFR 412.102 provides for a two year transition to a rural DSH payment amount from an urban DSH payment amount, for hospitals that received a geographic reclassification from urban to rural under the OMB standards for delineating statistical areas adopted by CMS in FY2015. Impacted hospitals whose DSH payment adjustment exceeds 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2015 and 1/3 of the difference between the urban and rural operating DSH for FY 2016. This affects providers that responded yes in column 1 and no in column 3 of Worksheet S-2, Part I, line 22.03. See 79 FR 49963 (August 22, 2014).*

Line 34--Multiply line 33 by line 1 for cost reporting periods ending on or before September 30, 2013. Effective for cost reporting periods that overlap October 1, 2013, enter the sum of {(line 33 times line 1.01), plus ((line 33 times the sum of lines 1.02 and 1.03) times 25 percent)}. For cost reporting periods beginning on or after October 1, 2013, multiply (line 33 times the sum of lines *1.01 through* 1.03) times 25 percent. *For cost reporting periods that overlap or begin on or after October 1, 2014, enter the sum of {((line 33 times the sum of lines 1.01 and 1.03) times 25 percent), plus ((line 33 times the sum of lines 1.02 and 1.04) times 25 percent)}.*

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

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

If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, columns 1 and 2 are "Y", do not complete lines 35 and 35.01. If Worksheet S-2, Part I, line 22.01, either column 1 or 2 is "N", complete only the column with the "N" response for lines 35 and 35.01. A response of "Y" for both questions indicates that a hospital uncompensated care payment has been pre-determined for your hospital for the applicable FFY. *For SCHs, if Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 35, column 1 is greater than or equal to 1, complete lines 35 through 35.03, columns 1 and 2, as applicable.*

NOTE: For cost reporting periods that overlap October 1, 2013, column 1 should be left blank and only column 2 should be completed. For cost reporting periods that begin on October 1, complete only column 2 (i.e., enter "N" for no in column 1 or leave column 1 blank).

Line 35--If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "N", *or Worksheet S-2, Part I, line 22, column 1 is "Y" and this is a newly merged DSH eligible hospital (Worksheet S-2, Part I, line 22.02, column 1 or 2 is "Y"),* enter in the corresponding column the full amount (for all eligible IPPS hospitals) available for uncompensated care payments for the appropriate FFY. For example, for a cost reporting period ending December 31, 2013, enter zero in column 1 for the portion of the cost reporting period that began prior to October 1, 2013, and enter the FFY14 uncompensated care payment amount in column 2. *The total uncompensated care payment amount for FFY14 is $9,046,380,143 and for FFY15 is $7,647,644,885. If this is a SCH and Worksheet S-2, Part I, line 22, column 1 is "Y", but an amount for line 35.02 was not determined by CMS for a FFY, complete this line accordingly.*

Line 35.01--If Worksheet S-2, Part I, line 22.01, column 1 or 2, is "N", enter the applicable factor 3 value determined by CMS for uncompensated care payments for the appropriate FFY in columns 1 and 2. *If this is a SCH and Worksheet S-2, Part I, line 22, column 1 is "Y", but an amount for line 35.02 was not determined by CMS for a FFY, enter the applicable factor 3 value determined by CMS for the appropriate FFY in column 1 and/or 2.* If you are a new hospital *(*Worksheet S-2, Part I, line 47, column 2 is "Y"*), or a newly merged DSH eligible hospital (Worksheet S-2, Part I, line 22.02, column 1 or 2 is "Y"),* factor 3 must be calculated. In determining factor 3, the numerator is the current year cost report Medicaid days (Worksheet S-2, Part I, line 24, sum of columns 1 through 6) plus the SSI days published for the applicable FFY, divided by the denominator which is a fixed amount obtained from the applicable FFY IPPS rule. For FFY14 the denominator is 36,429,747 *and for FFY15 the denominator is 36,484,622* (the denominator represents the total IPPS hospitals Medicaid days and SSI days for the applicable FFY). Round factor 3 to 9 decimal places.

Line 35.02--If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "Y", enter the hospital uncompensated care payment amount

determined by CMS for the appropriate FFY in columns 1 and 2. If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "N", *or Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "N", and Worksheet S-2, Part I, line 22.02, column 1 or 2 is "Y",* then CMS did not determine the hospital uncompensated care payment amount for that FFY. Compute this amount by multiplying line 35 times line 35.01, for columns 1 and 2, respectively. *If this is a SCH and Worksheet S-2, Part I, line 22, column 1 is "Y" but an amount for line 35.02 was not determined by CMS for a FFY, compute the amount by multiplying line 35 times line 35.01, for columns 1 and 2, respectively.* If Worksheet S-2, Part I, line 22, column 1 is "N" and/or line 34 above is zero, enter zero on this line.

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

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

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

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

Lines 37 through 39--Reserved for future use.

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

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

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

MS-DRGs 652, 682, 683, 684, and 685, must be included in the numerator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals.

Line 41.01--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see 69 FR *49087 (*August 11, 2004*)*) excluding MS-DRGs 652, 682, 683, 684, and 685 (see *73* FR *48520 and 48447 (*August 19, 2008*)*). The discharges on this line are associated with Medicare covered and paid hospital stays, and are included in the discharges in Worksheet S-3, Part I, column 13, line 14. These discharges are a subset of the discharges on line 41. The discharges on this line are only used to determine the ESRD add-on payment, not eligibility for the add-on payment.

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

Line 43--Enter the total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684, and 685, as applicable. The Medicare ESRD inpatient days must be included in the Medicare inpatient days reported in Worksheet S-3, Part I, column 6, line 14 and are part of a Medicare covered stay.

Line 44--Enter the average length of stay expressed as a ratio to 7 days. For cost reporting periods ending before June 30, 2014, divide line 43 by line 41, sum of columns 1 and 1.01, and divide that result by 7 days. For cost reporting periods ending on or after June 30, 2014, divide line 43 by line 41.01, sum of columns 1 and 1.01, and divide that result by 7 days.

Line 45--Enter the average weekly cost per dialysis treatment calculated by multiplying the unadjusted composite rate per treatment by 3. For example, the average weekly cost per dialysis treatment for CY 2013 is $435.60 ($145.20 times the average weekly number of treatments of 3). This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.

Line 46--For cost reporting periods ending before June 30, 2014, enter the ESRD payment adjustment (line 44, column 1 times line 45, column 1 times line 41, column 1 plus, if applicable, line 44, column 1 times line 45, column 1.01 times line 41, column 1.01). For cost reporting periods ending on or after June 30, 2014, enter the ESRD payment adjustment (line 44, column 1 times line 45, column 1 times line 41.01, column 1 plus, if applicable, line 44, column 1, times line 45, column 1.01 times line 41.01, column 1.01).

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

Line 48--Sole community hospitals are paid the highest of the federal payment rate, the hospital-specific rate (HSR) determined based on a federal fiscal year 1982 base period (see 42 CFR 412.73), the hospital-specific rate determined based on a federal fiscal year 1987 base period (*s*ee 42 CFR 412.75), for cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate determined based on a federal fiscal year 1996 base period (*s*ee 42 CFR 412.77), or for cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate determined based on a federal fiscal year 2006 base period (*s*ee 42 CFR 412.78). Medicare dependent hospitals are paid the highest of the federal payment rate, or the federal rate plus 75 percent of the amount of the excess over the federal rate of the highest rate for the 1982, 1987, or 2002 (*s*ee 42 CFR 412.79), base period hospital specific rate. For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments.

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

Additionally, for sole community hospitals only (effective for cost reporting periods beginning

on or after January 1, 2009), use the highest of the determined hospital specific rate based on federal fiscal year 1982, 1987, 1996, or 2006.

For MDH discharges occurring on or after October 1, 2006, and before April 1, 2015, an MDH can use a FFY 2002 hospital specific rate. The MDH program ends on March 31, 2015.

Line 49--For SCHs, enter the greater of line 47 or 48, *plus the amount from line 29.01*. For MDH discharges occurring on or after October 1, 2006, and before April 1, 2015, if line 47 is greater than line 48, enter the amount on line 47*, plus the amount from line 29.01*. *For MDHs if* line 48 is greater than line 47, enter the amount on line 47, plus 75 percent of the amount that line 48 exceeds line 47*, plus the amount from line 29.01*. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 47*, plus the amount from line 29.01*.

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

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

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

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

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

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

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

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

Line 56--Teaching hospitals or subproviders electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

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

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

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

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

- Workers' compensation
- No fault coverage
- General liability coverage
- Working aged provisions
- Disability provisions
- Working ESRD provisions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 70.89--Enter the Pioneer Accountable Care Organization (ACO) demonstration payment adjustment amount in accordance with ACA 2010, §3022 effective for discharges occurring on or after April 1, 2013. Obtain this amount from the PS&R.

Line 70.90--For MDH use only. Enter the hospital value-based purchasing (HVBP) adjustment amount relative to the HSP bonus payment from line 102, sum of columns 1 and 2.

Line 70.91--For MDH use only. Enter the hospital readmission reduction (HRR) adjustment amount relative to the HSP bonus payment from line 104, columns 1 and 2.

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

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

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

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

Line 70.96 through 70.98 (lines 70.96 and 70.97 are hardcoded)--Effective for discharges occurring during federal fiscal years 2011 through 2015 (discharges before April 1, 2015) (e.g., standard federal fiscal years: October 1, 2010 through September 30, 2011; October 1, 2011 through September 30, 2012; etc.), temporary improved/changed payments are mandated by §§3125 and 10314 ACA of 2010 and subsequent legislation, as addressed in 42 CFR 412.101. For cost reporting periods that are concurrent with the federal fiscal year (10/1 through 9/30), use line 70.97 only. For cost reporting periods that overlap October 1 for years 2010, 2011, 2012, 2013, 2014 and 2015 (discharges occurring before April 1, 2015), enter on lines 70.96 (Low volume adjustment (enter the corresponding federal year for the period prior to 10/1)) and line 70.97 (Low volume adjustment (enter the corresponding federal year for the period ending on or after 10/1)), and if necessary line 70.98 (low volume adjustments for additional portions of the cost reporting period, if necessary), the Medicare inpatient payment adjustment for low volume hospitals as applicable in accordance with Exhibit 4 (low volume adjustment calculation schedule and corresponding instructions).

Line 70.99--Enter the HAC program payment reduction adjustment amount effective for discharges occurring on or after October 1, 2014. Use Exhibit 5 or similar worksheet to reconcile the HAC payment adjustment amount.

Line 71--Enter the result of line 67 plus or minus lines 69, *70.90, 70.91,* 70.93, 70.94, 70.96, 70.97, 70.98, *70.99* and line 70 and its subscripts not previously identified, minus lines 68, 70.89, 70.92 and 70.95.

Line 71.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 71]. *Do not apply the sequestration calculation when gross reimbursement is less than zero.*

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

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

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

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

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

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

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

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

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

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

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

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

Hospital Specific Payment (HSP) Bonus Payment HVBP Adjustment and HRR Adjustment--The ACA 2010 §§3001 and 3025 implemented HVBP and HRR and applied special rules for MDHs through FFY13. Effective for discharges occurring on or after October 1, 2013, MDHs that receive a HSP bonus payment on the cost report are subject to a HVBP and HRR adjustment for that bonus payment amount. The HSP bonus payment amount is 75 percent of the amount that line 48 exceeds line 47. Complete lines 100 through 104 only when line 48 exceeds line 47.

NOTE: *For cost reporting periods that overlap October 1, 2013, leave column 1 blank and complete only column 2. For cost reporting periods that begin on October 1, complete only column 2.*

Line 100--If line 48 is greater than line 47, enter the pro rata share of the HSP bonus payment amount in columns 1 and 2. Enter in column 1, {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period prior to October 1 divided by the total days in the cost reporting period)}. Enter in column 2, {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after October 1 divided by the total days in the cost reporting period)}. If the hospital does not have MDH status for the entire cost reporting period, prorate accordingly.

Line 101--Enter the HVBP adjustment factor that corresponds to the portion of the cost reporting period prior to October 1 in column 1 and the HVBP adjustment factor that corresponds to the portion of the cost reporting period on or after October 1 in column 2. The HVBP adjustment factors are published annually in the IPPS final rule and posted on the CMS website.

Line 102--The HVBP adjustment amount is computed as ((HSP Bonus x HVBP adjustment factor)-HSP Bonus). Enter in column 1, the HVBP adjustment amount for the portion of the cost reporting period prior to October 1 by multiplying(column 1, line 100, times column 1, line 101), minus column 1, line 100. Enter in column 2, the HVBP adjustment amount for the portion of the cost reporting period on or after October 1 by multiplying (column 2, line 100 times column 2, line 101) minus column 2, line 100.

Line 103--Enter the HRR adjustment factor that corresponds to the portion of the cost reporting period prior to October 1 in column 1, and HRR adjustment factor that corresponds to the portion of the cost reporting period on or after October 1 in column 2. The HRR adjustment factors are published annually in the IPPS final rule and posted on the CMS website.

Line 104--The HRR adjustment amount is computed as ((HSP Bonus x HRR adjustment factor)-HSP Bonus). Enter in column 1, the HRR adjustment amount for the portion of the cost reporting period prior to October 1 by multiplying (column 1, line 100 times column 1, line 103) minus column 1, line 100. Enter in column 2, the HRR adjustment amount for the portion of the cost reporting period on or after October 1 by multiplying (column 2, line 100 times column 2, line 103) minus column 2, line 100.

Instructions for Completing Exhibit 4--

Low Volume Adjustment Calculation Schedule:

Sections 3125 and 10314 of ACA 2010 and subsequent legislation amended the low-volume hospital adjustment in §1886(d)(12) of the Social Security Act by revising, for FFYs 2011 through 2015 (discharges before April 1, 2015) the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. CMS implemented these changes to the low-volume payment adjustment in the regulations at 42 CFR 412.101 in the FFY 2011 IPPS final rule (75 FR 50238-50275 *(March 7, 2013)*).

The legislative amendments referenced in the preceding paragraph provide for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2011 through 2015 (discharges before April 1, 2015) as follows:

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

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

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

CMS provided a table listing the IPPS hospitals with fewer than 1,600 Medicare discharges and their low-volume percentage add-on, if applicable, for FFYs 2011 through 2015 (discharges before April 1, 2015). However, this list is not a list of all hospitals that qualify for the low-volume adjustment since it does not reflect whether or not the hospital meets the mileage criteria. Hospitals were required to request low-volume status in writing to their contractor and provide documentation that they met the mileage criteria.

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

NOTE: Because a hospital's eligibility for the low-volume payment adjustment and/or a hospital's applicable low-volume adjustment percentage can change during its cost reporting period (for example, a hospital with a cost report that spans the start of the FFY), it is necessary to determine the low-volume payment amount using the applicable low-volume adjustment percentage for the FFY and payment amounts listed above for a hospital's discharges that occur during the FFY for each FFY included by the hospital's cost reporting period.

After the cost report is calculated for settlement the low-volume payment adjustment must be calculated. The low-volume payment amount must be calculated by FFY. Therefore, if the cost report overlaps a FFY the information computed on Worksheet E, Part A, must be recomputed by FFY accordingly. The amounts may not be prorated but must be calculated using the appropriate information. The following payment amounts are multiplied by the low-volume payment adjustment percentage by FFY:

- Operating Federal IPPS payments;
- Operating HSR payments;
- Operating outlier payments including any Operating Outlier Reconciliation amounts;
- Operating IME payments;
- Operating IME payments for Medicare Advantage patients;
- Operating DSH payments;
- *Uncompensated care payments;*
- ESRD adjustment payments;
- Total Capital IPPS payment*;*

- New technology payments;
- *Net organ acquisition costs;*
- *Credits for replaced devices;* and
- Capital outlier reconciliation amounts (if applicable, see instructions)

Complete Exhibit 4 to compute the low-volume adjustment payment applicable to this cost reporting period. **The following Exhibit 4 is designed to simulate the Medicare cost report and must be completed after the cost report is calculated.**

Column 0--Line references are comparable to the actual line references on Worksheet E, Part A, and Worksheet L, Part I.

Column 1--Enter from Worksheet E, Part A, and Worksheet L, Part I, the amounts reported on the corresponding lines of the Medicare cost report.

Column 2--Enter amounts related to discharges occurring in the cost reporting period either pre-entitlement (discharges occurring in the cost reporting period prior to October 1) or post-entitlement (discharges occurring in the cost reporting period on or after October 1). Discharges occurring in these periods are not eligible for the low-volume adjustment.

In addition, if there are discharges occurring during FFY 2011 through 2015 (discharges before April 1, 2015) and the provider was not eligible for the low-volume adjustment for the entire eligibility period, report the information relative to those discharges in this column, for example, where a provider has a cost reporting period ending June 30, 2011, which began prior to the October 1, 2010 effective date of the provision. Or where the low-volume adjustment for discharges occurring in this cost reporting period is effective for discharges on or after October, 1, 2010; however, the provider did not request the low-volume adjustment until November 15, 2010 and the low-volume adjustment was implemented within 30 days of the request. The period of time from October 1, 2010 until the contractor notified the provider of eligibility, which should be no later than December 15, 2010, is considered a period of ineligibility.

Column 3--Enter amounts related to discharges occurring during the provider's low-volume eligibility period and prior to October 1st. If the cost reporting period is not concurrent with a federal year of October 1st through September 30th, do not include discharges occurring on or after October 1st in this column.

If the provider goes in and out of eligibility for discharges occurring prior to October 1st, add all discharges for the eligibility periods prior to October 1st and include in this column. If the provider's classification (i.e. SCH to small rural) changes during the eligibility period, use subscripted column 3.01 to accommodate the change for discharges occurring prior to October 1st.

Column 4--Enter amounts related to discharges occurring during the provider's low-volume eligibility period and on or after October 1st. If the cost reporting period is concurrent with a federal year of October 1st through September 30th, report all discharges occurring on or after October 1st in this column. If the provider goes in and out of eligibility for discharges occurring on or after October 1st, add all discharges for the eligibility periods on or after October 1st and include in this column. If the provider's classification (i.e. SCH to small rural) changes during the eligibility period, use subscripted column 4.01 to accommodate the change for discharges occurring on or after October 1st.

Columns 3, 3.01, 4, and 4.01--Use the beginning and ending dates of the applicable portion of the cost reporting period as the respective column headings.

Column 5--Subtotal columns 2 through 4 and applicable subscripts. Column 5 must equal column 1 and any resulting rounding difference must be applied to the highest value in columns 2 through 4 and applicable subscripts.

Line Descriptions

Line 1--The amount entered on this line is computed as the sum of the *f*ederal operating portion (DRG payment) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report.

Line 1.01 (Corresponds to Worksheet E, Part A, line 1.01)--Enter the DRG amounts other than outlier payments for discharges occurring prior to *October 1*, in column 3.

Line 1.02 (Corresponds to Worksheet E, Part A, line 1.02)--Enter the DRG amounts other than outlier payments for discharges occurring on or after *October 1*, in column 4.

Line 1.03 (Corresponds to Worksheet E, Part A, line 1.03)--Enter the DRG for federal specific operating payments for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report. *Effective for cost reporting periods that overlap October 1, 2014 and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring prior to October 1 in columns 2 and 3 accordingly.*

Line 1.04 (Corresponds to Worksheet E, Part A, line 1.04)--Enter the DRG for federal specific operating payments for Model 4 BPCI occurring on or after October 1, on this line. The PS&R information must be split and reported in columns 2 and 4 accordingly, and must concur with the PS&R paid through date used to calculate the cost report.

Line 2--Enter the amount of outlier payments made for PPS discharges occurring during the cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report.

Line 2.01 (Corresponds to Worksheet E, Part A, line 2.02)--Enter the outlier payment for discharges for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report.

Line 3 (Corresponds to Worksheet E, Part A, *l*ine 2.01)--For inpatient PPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line Worksheet E, Part A, line 92 for each respective period. The lump sum utility produces a claim by claim output. If the provider has two different low-volume hospital adjustment percentages during its cost reporting period, the contractor must report the operating and capital outlier reconciliation adjustment amounts for the discharges occurring in each of the federal fiscal years spanned by the cost report separately. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 2.01.

Line 4 (Corresponds to Worksheet E, Part A, line 3)--Enter the indirect medical education for managed care patients based on the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture, in conjunction with the PPS PRICER, the simulated payments. Enter the total managed care "simulated payments" from the PS&R. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report.

Line 5 (Corresponds to Worksheet E, Part A, line 21)--Enter the ratio calculated from Worksheet E, Part A, line 21, in columns 2 through 4.

Line 6 (Corresponds to Worksheet E, Part A, line 22)--*For cost reporting periods beginning before October 1, 2014, c*alculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times {the sum of line 1, 1.01, 1.02, 1.03, *1.04, and* line 4}. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 22.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times {the sum of lines 1.01, 1.02, 1.03 and 1.04}.

Line 6.01(Corresponds to Worksheet E, Part A, line 22.01)--Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment for managed care, as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times line 4.

Line 7 (Corresponds to Worksheet E, Part A, line 27)--Enter the ratio calculated from Worksheet E, Part A, line 27, in columns 2 through 4.

Line 8 (Corresponds to Worksheet E, Part A, line 28)--IME Add On Adjustment--*For cost reporting periods beginning before October 1, 2014, e*nter the sum of lines 1, 1.01, 1.02, 1.03*, 1.04,* and 4, multiplied by the factor on line 7.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME add-on adjustment as follows: Enter the sum of lines 1.01, 1.02, 1.03 and 1.04, multiplied by the factor on line 7.

Line 8.01 (Corresponds to Worksheet E, Part A, line 28.01)--IME Add On Adjustment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the result of line 4, multiplied by the factor on line 7.

Line 9 (Corresponds to Worksheet E, Part A, line 29)--Total IME Payment--Enter the sum of lines 6 and 8. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 29.

Line 9.01 (Corresponds to Worksheet E, Part A, line 29.01)--Total IME Payment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the sum of lines 6.01 and 8.01. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 29.01.

Line 10 (Corresponds to Worksheet E, Part A, line 33)--Enter the DSH percentage calculated from Worksheet E, Part A, line 33, in columns 2 through 4.

Line 11 (Corresponds to Worksheet E, Part A, line 34)--Multiply line 10 by line 1 for cost reporting periods ending on or before September 30, 2013. Effective for cost reporting periods that overlap October 1, 2013, enter the sum of {(line 10 times line 1.01), plus ((line 10 times the sum of lines 1.02 and 1.03) times 25 percent)}. For cost reporting periods beginning on or after October 1, 2013, multiply (line 10 times the sum of lines *1.01, 1.02,* and 1.03) times 25 percent. *For cost reporting periods overlapping or beginning on or after October 1, 2014, multiply (line 10 times the sum of lines 1.01, 1.02, 1.03 and 1.04) times 25 percent.* The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 34.

Line 11.01 (Corresponds to Worksheet E, Part A, line 35.03)--Enter the uncompensated care payments. For cost reporting periods that overlap or begin on or after October 1, 2013, when you are eligible for the low volume payment adjustment for the entire cost reporting period, enter in column 3, the uncompensated care payments from Worksheet E, Part A, column 1, line 35.03 and enter in column 4, the uncompensated care payments from Worksheet E, Part A, column 2, line 35.03.

For cost reporting periods that overlap or begin on or after October 1, 2013, when you are not eligible for the low volume payment adjustment for any portion of the cost reporting period, enter the uncompensated care payments as follows:

- Enter in column 3, the uncompensated care payment eligible for the low volume payment adjustment for the portion of the cost reporting period prior to October 1 (calculated as the amount from Worksheet E, Part A, column 1, line 35.03 times the ratio of the number of days prior to October 1 in the cost reporting period eligible for the low volume payment adjustment divided by the total days in the cost reporting period prior to October 1).

- Enter in column 4, the uncompensated care payment eligible for the low volume payment adjustment for the portion of the cost reporting period on and after October 1 (calculated as the amount from Worksheet E, Part A, column 2, line 35.03 times the ratio of the number of days on and after October 1 in the cost reporting period eligible for the low volume payment adjustment divided by the total days in the cost reporting period on and after October 1).

- Enter in column 2, the uncompensated care payments not eligible for the low volume payment adjustment (calculated as the total uncompensated care payment, from Worksheet E, Part A, line 35.03, sum of columns 1 and 2, minus the sum of the uncompensated care payments reported in columns 3 and 4 of this exhibit). The sum of columns 2 through 4, must equal Worksheet E, Part A, line 36.

Line 12 (Corresponds to Worksheet E, Part A, line 46)--Prorate in columns 2 through 4, the amount reported on Worksheet E, Part A, line 46, based on the ratio of days in each applicable period to total days in the cost reporting period. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 46.

Line 13 (Corresponds to Worksheet E, Part A, line 47)--Enter the sum of lines 1, 1.01, 1.02, 2, 2.01, 3, 9, 11, 11.01, and 12. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 47.

Line 14 (Corresponds to Worksheet E, Part A, line 48)--For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments. The sum of columns 2 through 4 must equal the amount reported on Worksheet E Part A, line 48. If Worksheet E, Part A, line 47 is greater than Worksheet E, Part A, line 48, do not complete this line.

Line 15 (Corresponds to Worksheet E, Part A, line 49)--Enter in column 1, the amount from Worksheet E, Part A, line 49. For SCHs, if line 13, column 1 is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, *plus the amount from line 9.01* for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 through 4, the amount reported on line 14, *plus the amount from line 9.01* for each applicable column. For MDH discharges occurring on or after October 1, 2006, and before April 1, 2015, if line 13, column 1, is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, *plus the amount from line 9.01,* for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 through 4, the amount on line 13, for each applicable column, plus 75 percent of the difference between line 14 minus line 13, *plus the amount from line 9.01*. Hospitals not qualifying as SCH or MDH providers will enter in columns 2 through 4, the amount from line 13, *plus the amount from line 9.01,* for each applicable column. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 49.

Line 16 (Corresponds to Worksheet E, Part A, line 50)--Enter in columns 2 through 4, the amounts computed from line 26, columns 2 through 4. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 50.

Line 17 (Corresponds to Worksheet E, Part A, line 54)--Enter the add-on payment for new technologies. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report.

Line 17.01 (Corresponds to Worksheet E, Part A, line 55)--For discharges on or after October 1, 2014, prorate in columns 2 through 4, the amount reported on Worksheet E, Part A, line 55, net organ acquisition costs, based on the ratio of days in each applicable period to total days in the cost reporting period. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 55.

Line 17.02 (Corresponds to Worksheet E, Part A, line 68)--For discharges on or after October 1, 2014, enter the credits for replaced devices. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report.

Line 18 (Corresponds to Worksheet E, Part A, line 93)--Enter the capital outlier reconciliation adjustment amount in columns 2 through 4 accordingly. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 93.

Line 19 Subtotal--Enter in columns 2 through 4, the sum of amounts on lines 15, 16, 17, and 18. For SCH, if the hospital specific payment amount on line 14, column 1, is greater than the federal specific payment amount on line 13, column 1, enter in columns 2 through 4, the sum of the amounts on lines 15, 16, and 17.

Line 20 (Corresponds to Worksheet L, Part I, line 1)--Enter the amount of the federal rate portion of the capital DRG payments for other than outlier during this cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 1.

Line 20.01 (Corresponds to Worksheet L, Part I, line 1.01)--Enter the Model 4 BPCI Capital DRG other than outlier payments. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 1.01.

Line 21 (Corresponds to Worksheet L, Part I, line 2)--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during this cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 2.

Line 21.01 (Corresponds to Worksheet L, Part I, line 2.01)--Enter the Model 4 BPCI Capital DRG outlier payments. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid through date used to calculate the cost report. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 2.01.

Line 22 (Corresponds to Worksheet L, Part I, line 5)--Enter the ratio calculated from Worksheet L, Part I, line 5 in all applicable columns.

Line 23 (Corresponds to Worksheet L, Part I, line 6)--Multiply line 22 by the sum of lines 20 and 20.01. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 6.

Line 24 (Corresponds to Worksheet L, Part I, line 10)--Enter the percentage calculated from Worksheet L, Part I, line 10 in all applicable columns.

Line 25 (Corresponds to Worksheet L, Part I, line 11)--Multiply line 24 by the sum of lines 20 and 20.01 and enter the result. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 11.

Line 26 (Corresponds to Worksheet L, Part I, line 12)--Enter the sum of lines 20, 20.01, 21, 21.01, 23 and 25. Transfer this amount to line 16. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 12.

Low-volume payment adjustment--Effective for discharges occurring during FFYs 2011 through 2015 (discharges before April 1, 2015), compute the amount of the low-volume adjustment as follows:

Line 27--Low-volume adjustment factor--Enter the appropriate adjustment factor in columns 3 and 4.

Line 28 (Corresponds to Worksheet E, Part A, line 70.96 discharges prior to October 1st)--Multiply line 19 by line 27. Transfer this amount to the cost report, Worksheet E, Part A, line 70.96.

Line 29 (Corresponds to Worksheet E, Part A, line 70.97 discharges on or after October 1st)--Multiply line 19 by line 27. Transfer this amount to the cost report, Worksheet E, Part A, line 70.97.

EXHIBIT 4

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE

LOW VOLUME CALCULATION EXHIBIT 4	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____

		Wkst. E, *Pt.* A., line	(Amt. from *Wkst.* E, Pt. A)	Pre/Post Entitlement	Prior to 10/1	On and after 10/1	*Total (col. 2 through 4)*	
		(0)	(1)	(2)	(3)	(4)	(5)	
1	DRG Amounts Other than Outlier Payments	1						1
1.01	DRG amounts other than outlier payments for discharges occurring prior to *October 1*	1.01						1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after *October 1*	1.02						1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI *occurring prior to October 1*	1.03						1.03
1.04	*DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1*	*1.04*						*1.04*
2	Outlier payments for discharges (see instructions)	2						2
2.01	Outlier payment for discharges for Model 4 BPCI	2.02						2.01
3	Operating outlier reconciliation	2.01						3
4	Managed Care Simulated Payments	3						4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E, Part A, line 21 (see instructions)	21						5
6	IME payment adjustment (see instructions)	22						6
6.01	*IME payment adjustment for managed care (see instructions)*	*22.01*						*6.01*
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	*IME payment adjustment factor* (see instructions)	27						7
8	IME *add-on adjustment* amount (see instructions)	28						8
8.01	*IME payment adjustment add-on for managed care (see instructions)*	*28.01*						*8.01*
9	Total IME payment (sum of lines 6 and 8)	29						9
9.01	*Total IME payment for managed care (sum of lines 6.01 and 8.01)*	*29.01*						*9.01*
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage (see instructions)	33						10
11	Disproportionate share adjustment (see instructions)	34						11
11.01	Uncompensated care payments	*35.03*						11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment (see instructions)	46						12
13	Subtotal (see instructions)	47						13
14	Hospital specific payments *(completed* by SCH and MDH, small rural hospitals only.*)* (see instructions)	48						14
15	Total payment for inpatient operating *costs* (see instructions)	49						15
16	Payment for inpatient program *capital*	50						16
17	Special add-on payments for new technologies	54						17
17.01	*Net organ acquisition cost*	*55*						*17.01*
17.02	*Credits received from manufacturers for replaced devices for applicable MS-DRGs*	*68*						*17.02*
18	Capital outlier reconciliation adjustment amount (see instructions)	93						18
19	**SUBTOTAL**							19
		Wkst. L, line	(*Amt.* from *Wkst.* L)					
		(0)	(1)	(2)	(3)	(4)	(5)	
20	Capital DRG other than outlier	1						20
20.01	Model 4 BPCI Capital DRG other than outlier	1.01						20.01
21	Capital DRG outlier payments	2						21
21.01	Model 4 BPCI Capital DRG outlier payments	2.01						21.01
22	Indirect medical education percentage (see instructions)	5						22
23	Indirect medical education adjustment *(see instructions)*	6						23
24	Allowable disproportionate share percentage (see instructions)	10						24
25	Disproportionate share adjustment *(see instructions)*	11						25
26	Total prospective capital payments *(see instructions)*	12						26
		Wkst. E, *Pt.* A., line	(*Amt.* to *Wkst.* E., *Pt.* A)					
		(0)	(1)	(2)	(3)	(4)	(5)	
27	**Low volume adjustment factor**							27
28	Low volume adjustment (transfer amount to Wkst. E, *Pt.* A, line 70.96) (prior to 10/1)							28
29	Low volume adjustment (transfer amount to *Wkst.* E, *Pt.* A, line 70.97) (on and after 10/1)							29

Instructions for Completing Exhibit 5--

Adjustment to Hospital Payments for Hospital Acquired Conditions (HAC) Calculation Schedule:

Section 3008 of ACA 2010 establishes the HAC Reduction Program, beginning in FFY 2015 (discharges occurring on or after October 1, 2014), for IPPS hospitals to improve patient safety. HACs are medical errors or serious infections that patients contract while in the hospital. Under the HAC Reduction Program, a 1 percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specific fiscal year. For SCHs and MDHs, the HAC reduction percentage applies to either the federal payment rate or the HSP rate, whichever results in a greater operating IPPS payment. See 2015 IPPS final rule (79 FR 50087-50104 (August 22, 2014)).

Applicable IPPS hospitals subject to the HAC reduction adjustment for discharges occurring during FFY 2015 (i.e., discharges occurring on or after October 1, 2014 through September 30, 2015) are listed in Table 17 of the FY 2015 IPPS final rule. Consult the appropriate CMS final rule for the table listing IPPS hospitals subject to the HAC reduction adjustment. The HAC reduction adjustment amount is calculated after all IPPS per discharge payments, which includes adjustment for DSH (including the uncompensated care payment (UCP)), IME payments, outliers, new technology, net organ acquisition costs, credits for replace devices, readmissions, HVBP, and capital payments. The HAC reduction adjustment calculated by the IPPS Pricer is an interim payment amount and is subject to adjustment during cost report settlement if any of the payment amounts upon which the HAC reduction adjustment is based are also recalculated at cost report settlement (for example, payments for DSH, IME, Low volume adjustment, or federal rate versus HSP rate payments for SCHs and MDHs).

After the cost report is calculated for settlement, the HAC reduction adjustment must be calculated by FFY. If the cost report overlaps a FFY, the information computed on Worksheet E, Part A, must be recomputed by FFY accordingly. The amounts are not prorated (except where noted), but must be calculated using the appropriate information. The following payment amounts are required to calculate the HAC reduction adjustment by FFY:

- *Operating Federal IPPS payments;*
- *Operating HSR payments;*
- *Operating Outlier payments including any Operating Outlier Reconciliation amounts;*
- *Operating IME payments;*
- *Operating IME payments for Medicare Advantage patients;*
- *Operating DSH payments;*
- *Uncompensated care payments;*
- *ESRD adjustment payments;*
- *Total capital IPPS payment;*
- *New technology payments;*
- *Net organ acquisition costs;*
- *Credits for replaced devices;*
- *Low volume adjustment;*
- *HVBP payment adjustment;*
- *HRR adjustment; and*
- *Capital outlier reconciliation amounts (if applicable, see instructions)*

Complete Exhibit 5 to compute the HAC reduction adjustment applicable to this cost reporting period. ***The following Exhibit 5 is designed to simulate the Medicare cost report and must be completed after the cost report is calculated.***

Column 0--Line references are comparable to the actual line references on Worksheet E, Part A, and Worksheet L, Part I.

Column 1--Enter from Worksheet E, Part A, and Worksheet L, Part I, the amounts reported on the corresponding lines of the Medicare cost report.

Column 2--Enter amounts related to discharges occurring during the applicable provider's HAC reduction period prior to October 1st. If the cost reporting period is not concurrent with a federal year (October 1st through September 30th), do not include discharges occurring on or after October 1st in this column. If the provider's classification (i.e. SCH to small rural) changes during the HAC reduction period, use subscripted column 2.01 to accommodate the change for discharges occurring prior to October 1st.

Column 3--Enter amounts related to discharges occurring during the applicable provider's HAC reduction period on or after October 1st. If the cost reporting period is concurrent with a federal year (October 1st through September 30th), report all discharges occurring on or after October 1st in this column. If the provider's classification (i.e. SCH to small rural) changes during the HAC reduction period, use subscripted column 3.01 to accommodate the change for discharges occurring prior to October 1st.

When a hospital with a cost reporting period that is not concurrent with a FFY is subject to the HAC reduction adjustment for only part of the cost reporting period, complete both columns 2 and 3. If Worksheet S-2, Part I, line 40, column 1 is "N" do not complete the HAC reduction program adjustment amount in column 2, line 32. If Worksheet S-2, Part I, line 40, column 2, is "N" do not complete the HAC reduction program adjustment amount in column 3, line 32.

Columns 2 and 3--Use the beginning and ending dates of the applicable portion of the cost reporting period as the respective column headings.

Column 4--Sum of columns 2 and 3. Column 4 must equal column 1 and any resulting rounding difference must be applied to the highest value in column 2 or column 3.

Line Descriptions

Line 1--Do not use this line.

Line 1.01 (Corresponds to Worksheet E, Part A, line 1.01)--Enter the DRG amounts other than outlier payments for discharges occurring prior to October 1 in column 2.

Line 1.02 (Corresponds to Worksheet E, Part A, line 1.02)--Enter the DRG amounts other than outlier payments for discharges occurring on or after October 1st in column 3.

Line 1.03 (Corresponds to Worksheet E, Part A, line 1.03)--Enter the DRG for federal specific operating payments for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. Effective for cost reporting periods that overlap October 1, 2014 and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring prior to October 1 in column 2.

Line 1.04 (Corresponds to Worksheet E, Part A, line 1.04)--Enter the DRG for federal specific operating payments for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 2--Enter the amount of outlier payments made for PPS discharges occurring during the cost reporting period. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 2.01 (Corresponds to Worksheet E, Part A, line 2.02)--Enter the outlier payment for discharges for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 3 (Corresponds to Worksheet E, Part A, line 2.01)--For inpatient PPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line Worksheet E, Part A, line 92, for each respective period. The lump sum utility produces a claim-by-claim output. If the provider has two different low-volume hospital adjustment percentages during its cost reporting period, the contractor must report the operating and capital outlier reconciliation adjustment amounts for the discharges occurring in each of the federal fiscal years spanned by the cost report separately. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 2.01.

Line 4 (Corresponds to Worksheet E, Part A, line 3)--Enter the IME for managed care patients based on the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture, in conjunction with the PPS PRICER, the simulated payments. Enter the total managed care simulated payments from the PS&R. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 5 (Corresponds to Worksheet E, Part A, line 21)--Enter the ratio calculated from Worksheet E, Part A, line 21, in columns 2 and 3.

Line 6 (Corresponds to Worksheet E, Part A, line 22)--For cost reporting periods that overlap October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times {the sum of lines 1.01, 1.02, 1.03, 1.04 and line 4}. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 22.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times {the sum of lines 1.01, 1.02, 1.03 and 1.04}. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 22.

Line 6.01 (Corresponding to Worksheet E, Part A, line 22.01)--Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment for managed care, as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times line 4.

Line 7 (Corresponds to Worksheet E, Part A, line 27)--Enter the ratio calculated from Worksheet E, Part A, line 27, in columns 2 and 3.

Line 8 (Corresponds to Worksheet E, Part A, line 28)--IME Add On Adjustment--For cost reporting periods that overlap October 1, 2014, enter the sum of lines 1.01, 1.02, 1.03, 1.04 and 4, multiplied by the factor on line 7.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME add-on adjustment as follows: Enter the sum of lines 1.01, 1.02, 1.03 and 1.04, multiplied by the factor on line 7.

Line 8.01 (Corresponding to Worksheet E, Part A, line 28.01)--Total IME Add On Adjustment for Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the result of line 4, multiplied by the factor on line 7.

Line 9 (Corresponds to Worksheet E, Part A, line 29)--Total IME Payment--Enter the sum of lines 6 and 8. The sum of columns 2 and3 must equal the amount reported on Worksheet E, Part A, line 29.

Line 9.01 (Corresponding to Worksheet E, Part A, line 29.01)--Total IME Payment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the sum of lines 6.01 and 8.01. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 29.01.

Line 10 (Corresponds to Worksheet E, Part A, line 33)--Enter the DSH percentage calculated from Worksheet E, Part A, line 33, in columns 2 and 3.

Line 11 (Corresponds to Worksheet E, Part A, line 34)--Multiply (line 10 times the sum of lines 1.01, 1.02 1.03 and 1.04) times 25 percent. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 34.

Line 11.01 (Corresponds to Worksheet E, Part A, line 35.03)--Enter the uncompensated care payments. For cost reporting periods that overlap October 1st, enter in column 2, the uncompensated care payments from Worksheet E, Part A, column 1, line 35.03, and enter in column 3, the uncompensated care payments from Worksheet E, Part A, column 2, line 35.03.

Line 12 (Corresponds to Worksheet E, Part A, line 46)--Prorate in columns 2 and 3 the amount reported on Worksheet E, Part A, line 46, based on the ratio of days in each applicable period to total days in the cost reporting period. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 46.

Line 13 (Corresponds to Worksheet E, Part A, line 47)--Enter the sum of lines 1.01, 1.02, 2, 2.01, 3, 9, 11, 11.01, and 12. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 47.

Line 14 (Corresponds to Worksheet E, Part A, line 48)--For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments. The sum of columns 2 and 3 must equal the amount reported on Worksheet E Part A, line 48. If Worksheet E, Part A, line 47, is greater than Worksheet E, Part A, line 48, do not complete this line.

Line 15 (Corresponds to Worksheet E, Part A, line 49)--Enter in column 1, the amount from Worksheet E, Part A, line 49. For SCHs, if line 13, column 1 is greater than line 14, column 1, enter in columns 2 and 3, the amount reported on line 13, plus the amount from line 9.01 for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 and 3, the amount reported on line 14, plus the amount from line 9.01, for each applicable column. For MDH discharges occurring on or before April 1, 2015, if line 13, column 1, is greater than line 14, column 1, enter in columns 2 and 3, the amount reported on line 13, plus the amount from line 9.01, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 and 3, the amount on line 13, for each column, plus 75 percent of the difference between line 14 minus line 13, plus the amount from line 9.01. Hospitals not qualifying as SCH or MDH providers will enter in columns 2 and 3, the amount from line 13, plus the amount from line 9.01, for each column. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 49.

Line 16 (Corresponds to Worksheet E, Part A, line 50)--Enter in columns 2 and 3, the amounts computed from line 26, columns 2 and 3. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 50.

Line 17 (Corresponds to Worksheet E, Part A, line 54)--Enter the add-on payment for new technologies. The PS&R information must be split and reported in columns 2 and 3 and must concur with the PS&R paid-through date used to calculate the cost report .

Line 17.01 (Corresponds to Worksheet E, Part A, line 55)--Prorate in columns 2 and 3, the amount reported on Worksheet E, Part A, line 55, net organ acquisition costs, based on the ratio of days in each applicable period to total days in the cost reporting period. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 55.

Line 17.02 (Corresponds to Worksheet E, Part A, line 68)--Enter the credits for replaced devices. The PS&R information must be split and reported in columns 2 and 3 and must concur with the PS&R paid-through date used to calculate the cost report.

Line 18 (Corresponds to Worksheet E, Part A, line 93)--Enter the capital outlier reconciliation adjustment amount in columns 2 and 3. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 93.

Line 19 Subtotal--Enter in columns 2 and 3, the sum of amounts on lines 15, 16, 17, and 18. For SCH, if the hospital specific payment amount on line 14, column 1, is greater than the federal specific payment amount on line 13, column 1, enter in columns 2 and 3, the sum of the amounts on lines 15, 16, and 17.

Line 20 (Corresponds to Worksheet L, Part I, line 1)--Enter the amount of the federal rate portion of the capital DRG payments other than outlier during this cost reporting period. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 1.

Line 20.01 (Corresponds to Worksheet L, Part I, line 1.01)--Enter the Model 4 BPCI Capital DRG other than outlier payments. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 1.01.

Line 21 (Corresponds to Worksheet L, Part I, line 2)--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during this cost reporting period. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 2.

Line 21.01 (Corresponds to Worksheet L, Part I, line 2.01)--Enter the Model 4 BPCI Capital DRG outlier payments. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 2.01.

Line 22 (Corresponds to Worksheet L, Part I, line 5)--Enter the ratio calculated from Worksheet L, Part I, line 5 in all applicable columns.

Line 23 (Corresponds to Worksheet L, Part I, line 6)--Multiply line 22 by the sum of lines 20 and 20.01. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 6.

Line 24 (Corresponds to Worksheet L, Part I, line 10)--Enter the percentage calculated from Worksheet L, Part I, line 10, in applicable columns.

Line 25 (Corresponds to Worksheet L, Part I, line 11)--Multiply line 24 by the sum of lines 20 and 20.01, and enter the result. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 11.

Line 26 (Corresponds to Worksheet L, Part I, line 12)--Enter the sum of lines 20, 20.01, 21, 21.01, 23, and 25. Transfer this amount to line 16 of this exhibit. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 12.

Line 27--Do not use. This line was left blank to maintain line number consistency between the low volume and HAC adjustment worksheets.

Line 28 (Corresponds to Worksheet E, Part A, line 70.96 discharges prior to October 1st)--Enter the amount from Worksheet E, Part A, line 70.96 in column 2.

Line 29 (Corresponds to Worksheet E, Part A, line 70.97 discharges on or after October 1st)--Enter the amount from Worksheet E, Part A, line 70.97 in column 3.

Line 30 (Corresponds to Worksheet E, Part A, line 70.90 plus 70.93)--Enter the HVBP payment adjustment amount. The PS&R information for Worksheet E, Part A, line 70.90 must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The amount from Worksheet E, Part A, line 70.93, must be split using the amount reported on Worksheet E, Part A, line 102, columns 1 and 2, and reported in columns 2 and 3, accordingly. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, sum of lines 70.90 and 70.93.

Line 31 (Corresponds to Worksheet E, Part A, line 70.91 plus 70.94)--Enter the HRR adjustment amount. The PS&R information for Worksheet E, Part A, line 70.91 must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The amount from Worksheet E, Part A, line 70.94, must be split using the amount reported on Worksheet E, Part A, line 104, columns 1 and 2, and reported in columns 2 and 3, accordingly. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, sum of lines 70.91 and 70.94.

Line 32 (Corresponds to Worksheet E, Part A, line 70.99)--Enter the HAC reduction adjustment amount. If you responded "N" on Worksheet S-2, Part I, line 40, column 1, do not complete the HAC reduction adjustment in column 2. If you responded "N" on Worksheet S-2, Part I, line 40, column 2, do not complete the HAC reduction adjustment in column 3. Enter in column 2 the sum of lines 19, 28, 30, and 31, times 1 percent. For cost reporting periods that overlap October 1, 2014, enter zero in column 2. Enter in column 3 the sum of lines 19, 29, 30, and 31, times 1 percent. Enter in column 4, the sum of columns 2 and 3. Transfer the amount in column 4 to the cost report calculated settlement, Worksheet E, Part A, line 70.99.

EXHIBIT 5

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION SCHEDULE

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	PROVIDER CCN: _____	PERIOD: FROM:_____ TO:_____

		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)	Prior to 10/1	On or after 10/1	Total (cols. 2 and 3)	
		(0)	(1)	(2)	(3)	(4)	
1	DRG Amounts Other than Outlier Payments	1					1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01					1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02					1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03					1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04					1.04
2	Outlier payments for discharges (see instructions)	2					2
2.01	Outlier payment for discharges for Model 4 BPCI	2.02					2.01
3	Operating outlier reconciliation	2.01					3
4	Managed Care Simulated Payments	3					4
	Indirect Medical Education Adjustment						
5	Amount from Worksheet E, Part A, line 21 (see instructions)	21					5
6	IME payment adjustment (see instructions)	22					6
6.01	IME payment adjustment for managed care (see instructions)	22.01					6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7	IME payments adjustment factor (see instructions)	27					7
8	IME add-on adjustment amount (see instructions)	28					8
8.01	IME payment adjustment add-on for managed care (see instructions)	28.01					8.01
9	Total IME payment (sum of lines 6 and 8)	29					9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01					9.01
	Disproportionate Share Adjustment						
10	Allowable disproportionate share percentage (see instructions)	33					10
11	Disproportionate share adjustment (see instructions)	34					11
11.01	Uncompensated care payments	35.03					11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12	Total ESRD additional payment (see instructions)	46					12
13	Subtotal (see instructions)	47					13
14	Hospital specific payments (completed by SCH and MDH, small rural hospitals only) (see instructions)	48					14
15	Total payment for inpatient operating costs (see instructions)	49					15
16	Payment for inpatient program capital	50					16
17	Special add-on payments for new technologies	54					17
17.01	Net organ acquisition cost	55					17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68					17.02
18	Capital outlier reconciliation adjustment amount (see instructions)	93					18
19	SUBTOTAL						19
		Wkst. L, line	(Amt. from Wkst. L)				
		(0)	(1)	(2)	(3)	(4)	
20	Capital DRG other than outlier	1					20
20.01	Model 4 BPCI Capital DRG other than outlier	1.01					20.01
21	Capital DRG outlier payments	2					21
21.01	Model 4 BPCI Capital DRG outlier payments	2.01					21.01
22	Indirect medical education percentage (see instructions)	5					22
23	Indirect medical education adjustment (see instructions)	6					23
24	Allowable disproportionate share percentage (see instructions)	10					24
25	Disproportionate share adjustment (see instructions)	11					25
26	Total prospective capital payments (see instructions)	12					26
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		(0)	(1)	(2)	(3)	(4)	
27							27
28	Low volume adjustment prior to October 1	70.96					28
29	Low volume adjustment on or after October 1	70.97					29
30	HVBP payment adjustment (see instructions)	70.90 plus 70.93					30
31	HRR adjustment (see instructions)	70.91 plus 70.94					31
						(Amt. to Wkst. E, Pt. A)	
32	HAC Reduction Program adjustment (see instructions)	70.99					32

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

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

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

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

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

Line 39.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R.

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

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

Line 40--Enter the result of line 37, plus or minus line 39 and its subscripts not previously identified (excluding line 39.98 that is for informational purposes only), minus lines 38*, 39.50* and 39.99.

Line 40.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 40]. *Do not apply the sequestration calculation when gross reimbursement (line 40) is less than zero.*

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

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

Line 44--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying *a* reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

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

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

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

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

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

Line 93--Enter the time value of money.

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

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

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

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

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

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

The column headings designate two categories of payments:

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

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

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

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

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

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

Line 1--As defined in ARRA, §4102, transfer the total hospital discharges from Worksheet S-3, Part I, column 15, line 14.

Line 2--Transfer the Medicare days from Worksheet S-3, Part I, column 6, sum of line 1 and lines 8 through 12.

Line 3--Transfer the Medicare HMO days from Worksheet S-3, Part I, column 6, line 2.

Line 4--Transfer the total inpatient days from Worksheet S-3, Part I, column 8, sum of line 1 and lines 8 through 12.

Line 5--Transfer the hospital charges from Worksheet C, Part I, column 8, line 200.

Line 6--Transfer the hospital charity care charges from Worksheet S-10, column 3, line 20.

Line 7--CAHs only, transfer the reasonable costs to purchase certified HIT technology from Worksheet S-2, Part I, line 168.

Line 8--Calculate and enter the HIT payment in accordance with ARRA, §4102 as indicated below. This line can be overridden by the contractor in instances where the provider's circumstances require a customized HIT calculation.

For CAHs, if Worksheet S-2, lines 105 and 167 are both "Y" for yes, enter the result of {(H1)/(line 4 x H2)}*rounded to 4 decimal places* + .20 times the amount on Worksheet S-2, Part I, **line 168**. (Note: the result of {(H1)/(line 4 x H2)} + .20 cannot exceed 100 percent.) The resulting amount must be fully expensed in the current reporting period. H1 = Line 2 plus line 3. H2 = Total charges from Worksheet C, Part I, column 8, line 200 minus charity care charges from Worksheet S-10, column 3, line 20 divided by Worksheet C, Part I, column 8, line 200.

OR

For acute care IPPS hospitals (§1886(d) of the Act), if Worksheet S-2, line 105 is "N" for no and line 167 is "Y" for yes, enter the result of {($2,000,000.00 + H1) x {(H2)/(line 4 x H3)}*rounded to 4 decimal places* x H4}. If line 1 is less than 1,150 discharges then H1 equals 0 (zero). If line 1 equals 1,150 through 23,000 discharges, then H1 equals the result of line 1 minus 1,149 times $200. If line 1 is greater than or equal to 23,000 discharges then H1 = $4,370,200 [that is: 23,000 minus 1,149 times $200]. H2 = Line 2 plus line 3. H3 = Total charges from Worksheet C, Part I, column 8, line 200 minus charity care charges from Worksheet S-10, column 3, line 20 divided by Worksheet C, Part I, column 8, line 200. H4 = The transition factor from Worksheet S-2, Part I, line 169.

Line 9--If the EHR reporting period ending date on Worksheet S-2, line 170, column 2 is on or after April 1, 2013, enter the sequestration adjustment amount as follows: [2 percent times line 8].

Line 10--Calculate and enter the HIT payment after application of the sequestration adjustment by entering the result of line 8 minus line 9.

Lines 11 through 29--Reserved for future use.

Inpatient Hospital Services Under IPPS & CAH--

Line 30--Enter the initial (first) payment received for HIT assets for this cost reporting period. This initial payment is a single payment for the cost reporting period rather than a series of periodic interim payments during the period. This line must be completed by the providers for standard cost reporting periods and by the contractors for nonstandard cost reporting periods.

Line 31--Enter the sum of all additional initial payment adjustments, as applicable for this cost reporting period. Enter a positive amount on this line if the sum of the initial payment adjustments represents an increase to the initial payment. Enter a negative amount on this line if the sum of the initial payment adjustments represents a decrease to the initial payment.

Line 32--Balance Due Provider/(Program)--Calculate and enter the result of line 8 minus the sum of lines 30 and 31. Effective for cost reporting periods that overlap or begin on or after April 1, 2013, calculate and enter the result of line 10 minus the sum of lines 30 and 31. Transfer this amount to Worksheet S, Part III, column 4, line 1.

4032. WORKSHEET E-2 - CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

This worksheet provides for the reimbursement calculation for swing bed services rendered to program patients under titles V, XVIII, and XIX. It provides for an accumulation of reimbursable costs determined on various worksheets within the cost report package. It also provides (under Part B) for the computation of the lesser of 80 percent of reasonable cost after deductibles or reasonable cost minus coinsurance and deductibles. These worksheets have been designed so that components must prepare a separate worksheet for swing bed-SNF title XVIII, Parts A and B, and separate worksheets for swing bed-NF for title V and title XIX. Use column 1 only on the worksheets for title V and title XIX. Indicate the use of each worksheet by checking the appropriate boxes.

Lines 1 through 9--Enter in the appropriate column on lines 1 through 7 the indicated costs for each component of the health care complex.

Line 1--Post-hospital swing beds in rural hospitals (other than CAHs) are paid in accordance with SNF PPS. Enter the total PPS payments in column 1 or 2, as applicable, from the provider's books and records or the PS&R. (See 42 CFR 413.114(a)(2)) For CAHs, transfer 101 percent of the cost of swing-bed SNF inpatient routine services from Worksheet D-1, Part II, line 66.

Do not use lines 2 and 3, column 1 for swing bed SNF PPS providers.

Line 2--Enter the cost of swing bed-NF inpatient routine services from Worksheet D-1, Part II, line 69 (titles V and XIX only). Make no entry on line 2 when Worksheet E-2 is used for swing bed-SNF.

Line 3--Enter the amount of ancillary services provided by swing bed-SNFs for vaccines that are cost reimbursed in column 2. CAHs transfer for title XVIII services 101 percent of the amounts from the applicable worksheets and for swing bed-SNF services that are cost reimbursed transfer 100 percent of the amount from the applicable worksheet:

Title V	from	Worksheet D-3, col. 3, line 200
Title XVIII, Part A	from	Worksheet D-3, col. 3, line 200
Title XVIII, Part B	from	The sum of Worksheet D, Part V, columns 6 and 7, line 202
Title XIX	from	Worksheet D-3, col. 3, line 200

Enter title XVIII, Part B amounts only in column 2. Enter all other amounts in column 1.

Line 4--Enter (in column 1 for titles V and XIX and in column 2 for title XVIII) the per diem cost for interns and residents not in an approved teaching program transferred from Worksheet D-2, Part I, column 4, line 2.

Line 5--For title XVIII, enter in column 1 the total number of days in which program swing-bed SNF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 10 and 11. For titles V or XIX, enter in column 1 the total number of days in which program swing bed-NF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 12 and 13. For title XVIII, enter in column 2 the total number of days in which Medicare swing bed beneficiaries were inpatients and had Medicare Part B coverage. Determine such days without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days.

The following reconciliation format is recommended:

Part A Inpatient Days	Plus	Part B Only Days	Minus	Part A Coverage But No Part B Days Coverage	Equals	Medicare Part B Days

NOTE: See §4026.1.

Line 6--Enter the amount on line 4 multiplied by the number of days recorded on line 5. Also, if the hospital qualifies for the exception for graduate medical education payments in 42 CFR 413.77 (d)(1), enter the amount transferred from Worksheet D-2, Part II, column 7, line 30.

Line 7--If Worksheet E-2 is completed for a certified SNF, enter the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees applicable to the SNF.

Line 8--Enter the sum of lines 1 through 3, plus lines 6 and 7 for each column.

Line 9--Enter any amounts paid and/or payable by workers' compensation and other primary payers. (See instructions for Worksheet E, Part A, line 60, in §4030.1 for further clarification.)

Line 10--Line 8 minus line 9.

Line 11--Enter the deductible billed to program patients. DO NOT INCLUDE deductible applicable to physician professional services. Obtain this amount from your records.

Line 12--Enter line 10 minus line 11.

Line 13--Enter from your records the amounts billed to program patients for coinsurance. DO NOT INCLUDE coinsurance billed to program patients for physician professional services.

Line 14--In column 2, enter 80 percent of the amount on line 12.

Line 15--Enter the lesser of line 12 less line 13, or line 14.

Line 16--Enter any other adjustments.

Line 16.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R.

Line 17--When Worksheet E-2 is completed for Medicare, enter the amount of bad debts (net of bad debt recoveries) for billed deductibles and coinsurance (excluding bad debts for physician professional services and bad debts arising from covered services paid under a reasonable charge-based methodology or a fee-schedule) for Part A services in column 1 and for Part B services in column 2. If recoveries exceed the current year's bad debts, line 17 will be negative.

Line 17.01--For cost reporting periods that begin prior to October 1, 2012, enter the amount on line 17. For cost reporting periods that begin on or after October 1, 2012, calculate this line as follows: [((line 17 - line 18) * 65 percent) + (line 18 * 88 percent)]. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: [((line 17 - line 18) * 65 percent) + (line 18 * 76 percent)]. For cost reporting periods that begin on or after October 1, 2014, multiply the amount on line 17 by 65 percent.

Line 18--Enter the gross allowable bad debts for dual eligible beneficiaries. For cost reporting periods that begin prior to October 1, 2012, this amount is reported for statistical purposes only. This amount must also be reported on line 17.

Line 19--For title XVIII, Part A, enter in column 1 the sum of lines 15 and 17.01 plus or minus line 16 *and minus line 16.50.* For title XVIII, Part B, enter in column 2 the sum of lines 15 and 17.01 plus or minus line 16 *and minus line 16.50.* For titles V and XIX, enter in column 1 the sum of line 15, plus or minus line 16 *and minus line 16.50.*

Line 19.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 19]. *Do not apply the sequestration calculation when gross reimbursement (line 19) is less than zero.*

Line 20--For title XVIII, enter in column 1 the amount from the appropriate Worksheet E-1, column 2, line 4, and enter in column 2 the amount from the appropriate Worksheet E-1, column 4, line 4. For contractor final settlement, report on line 21 the amount from line 5.99 for columns 2 and 4. For titles V and XIX, enter interim payments from your records.

Line 22--Enter the amount recorded on line 19 minus the sum of the amounts on lines 19.01, 20, and 21. This amount shows the balance due provider or the program. Transfer this amount to Worksheet S, Part III, columns as appropriate, lines 5 or 6 for the swing bed-SNF or the swing bed-NF, respectively.

Line 23--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the non-allowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the supporting details and computations for this line.

Line 17--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc., enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 17.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 17.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R.

Line 18--Enter the sum of lines 14, 15, and 16 plus or minus line 17 *and minus line 17.50.*

Line 18.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 18]. *Do not apply the sequestration calculation when gross reimbursement (line 18) is less than zero.*

Line 19--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 20 the amount on line 5.99.

Line 20--Contractor use only: Report the amount from Worksheet E-1, column 2, line 5.99.

Line 21--Enter line 18 minus the sum of lines 18.01, 19 and 20. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 22--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

4033.2 Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS--Use Worksheet E-3, Part II to calculate Medicare reimbursement settlement under IPF PPS for hospitals and subproviders. (See 42 CFR 412, subpart N.)

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

Line Descriptions

Line 1--Enter the net Federal IPF PPS payment. This amount excludes payments for outliers, electroconvulsive therapy (ECT), and the teaching adjustment. Obtain this information from the PS&R and/or your records.

Line 2--Enter the net IPF outlier payment. Obtain this from the PS&R and/or your accounting books records.

Line 3--Enter the net IPF payments for ECT. Obtain this from the PS&R and/or your accounting books and records.

NOTE: Complete only line 4 or line 5, but not both.

Line 4--For providers that trained residents in the most recent **cost reporting period filed on or before November 15, 2004** (response on Worksheet S-2, Part I, line 71, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period filed on or before November 15, 2004. See *69* FR *66922 (*November 4, 2004*)* for a detailed explanation.

Line 4.01--For IPFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment under 42 CFR 412.424(d)(1)(iii)(F)(1) or (2).

Line 5--If the response to Worksheet S-2, Part I, line 71, column 2 is "Y" and your facility did not train residents in the most recent cost report filed before November 15, 2004, but qualifies to receive a cap adjustment under 42 CFR 412.424(d)(1)(iii)(D) enter the new program cap adjustment on this line. Do not complete this line until the new program growth period has ended using the method described in 42 CFR 413.79(e)(1)(i) and (ii). *For new programs started prior to October 1, 2012, i*f your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the cap adjustment accordingly. *For facilities that participate in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), complete this line effective beginning with the facility's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)).*

Line 6--Enter the current year unweighted FTE resident count excluding FTEs in the new program growth period *as determined using the method described in 42 CFR 413.79(e)(1)(i) and (ii).* FTEs in the new program growth period are reported on line 7. *For new programs started prior to October 1, 2012, i*f your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly. *For facilities that began participating in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started*

(i.e., the initial years, see 79 FR 50110 (August 22, 2014)). Continue to report FTE residents on this line in subsequent cost reporting periods.

Line 7--Enter the current year unweighted FTE count for residents in the new program growth period. Complete this line only during the new program growth period of the first new program's existence. *For new programs started prior to October 1, 2012, i*f your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly. *For facilities that began participating in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)).*

Line 8--For providers that completed line 4, enter the lower of the FTE count on line 6 or the sum of the cap amounts on lines 4 and 4.01.

For providers that qualify to receive a cap adjustment under 42 CFR 412.424(d)(1)(iii)(D) during the new program growth period of the first new program's existence, enter the FTE count from line 7.

*For new programs started prior to October 1, 2012, b*eginning with the program year following the new program growth period of the first new program's existence, enter the lower of the FTE count on line 6 or the FTE count on line 5. Add to this count the FTEs on line 7 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program. *For new programs started on or after October 1, 2012, effective beginning with the facility's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, enter the lower of the FTE count on line 6 or the FTE count on line 5.*

Line 9--Enter the total IPF patient days divided by the number of days in the cost reporting period (Worksheet S-3, Part I, column 8, line 1 (independent/freestanding) or 16 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 10--Enter the teaching adjustment factor by adding 1 to the ratio of line 8 to line 9. Raise that result to the power of .5150. Subtract 1 from this amount to calculate the teaching adjustment factor. This is expressed mathematically as {(1 + (line 8 / line 9)) to the .5150 power - 1}.

Line 11--Enter the teaching adjustment by multiplying line 1 by line 10.

Line 12--Enter the adjusted net IPF PPS payments by entering the sum of lines 1, 2, 3, and 11.

Line 13--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable. Only complete this line if your facility is a freestanding/independent non-IPPS hospital that does not complete Worksheet E, Part A.

Line 14--DO NOT USE THIS LINE.

Line 15--Teaching IPFs or IPF subproviders participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

Line 16--Enter the sum of lines 12, 13, 14, and 15.

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

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 17. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

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

Do not enter on line 17 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 18--Enter line 16 minus line 17.

Line 19--Enter the Part A deductibles.

Line 20--Enter line 18 minus line 19.

Line 21--Enter the Part A coinsurance.

Line 22--Enter the result of subtracting line 21 from line 20.

Line 23--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year’s bad debts, lines 23 and 24 will be negative.

Line 24--Multiply the amount (including negative amounts) from line 23 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 25--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 23.

Line 26--Enter the sum of lines 22 and 24.

Line 27--Enter the amount from Worksheet E-4, line 49 for the hospital component (freestanding IPF) only. Do not complete this line for an IPF unit.

Line 28--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility or line 40 for the IPF subprovider. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

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

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

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

Line 30.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R.

Line 31--Enter the sum of lines 26 through 28 plus or minus lines 29 *and* 30, *and minus line 30.50.*

Line 31.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 31]. *Do not apply the sequestration calculation when gross reimbursement (line 31) is less than zero.*

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

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

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

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

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

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

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

Line 53--Enter the time value of money.

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

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

Line Descriptions

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

In accordance with the *78* FR *47869 (*August 6, 2013), effective for IRF discharges rendered on or after October 1, 2013, the IRF LIP adjustment factor is updated. Subscript column 1 for lines 1 and 3 for cost reporting periods that overlap October 1, 2013. Enter the net federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2013 in column 1 and the net federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2013 in column 1.01 to facilitate the calculation of the LIP adjustment on line 3, columns 1 and 1.01, respectively. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013.

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

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

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

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

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

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

Line 5.01--For IRFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment in accordance with 76 *FR 47846 (*August 5, 2011*)*.

Line 6--If the response to Worksheet S-2, Part I, line 76, column 2 is "Y" and your facility did not train residents in the most recent cost reporting period ending on or before November 15, 2004, and qualifies to receive a cap adjustment (see *70* FR *47929 (*August 15, 2005) enter the new cap adjustment on this line. Do not complete this line until the new program growth period has ended using the method described in 42 CFR 413.79(e)(1)(i) and (ii). *For new programs started prior to October 1, 2012, i*f your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the cap adjustment accordingly. *For facilities that participate in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), complete this line effective beginning with the facility's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)).*

Line 7--Enter the current year unweighted FTE resident count excluding FTEs in the new program growth period *as determined using the method described in 42 CFR 413.79(e)(1)(i) and (ii)*. FTEs in the new program growth period are reported on line 8. If your fiscal year end does not correspond to the program year end and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly. *For facilities that began participating in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (i.e., the initial years, see 79 FR 50110 (August 22, 2014)). Continue to report FTE residents on this line in subsequent cost reporting periods.*

Line 8--Enter the current year unweighted FTE count for residents in the new program growth period. Complete this line only during the new program growth period of the first new program's existence. *For new programs started prior to October 1, 2012, i*f your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly. *For facilities that began participating in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)).*

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

For providers that qualify to receive a cap adjustment (see 70 *FR 47929 (*August 15, 2005*)*), during the new program growth period of the first new program's existence enter the FTE count from line 8.

*For new programs started prior to October 1, 2012, b*eginning with the program year following the new program growth period of the first new program's existence, enter the lower of the FTE count on line 7 or the FTE count on line 6. Add to this count the FTEs on line 8 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program. *For new programs started on or after October 1, 2012, effective beginning with the facility's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, enter the lower of the FTE count on line 7 or the FTE count on line 6.*

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

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

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

In accordance with the 78 *FR 47869 (*August 6, 2013*)*, effective for IRF discharges rendered on or after October 1, 2013, the teaching adjustment factor is updated. For cost reporting periods that overlap October 1, 2013, subscript column 1.

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

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

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

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

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

Line 15--DO NOT USE THIS LINE.

Line 16--Teaching IRFs or IRF subproviders participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

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

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

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

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

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

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

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

Line 19--Enter line 17 minus line 18.

Line 20--Enter the Part A deductibles.

Line 21--Enter line 19 less line 20.

Line 22--Enter the Part A coinsurance.

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

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

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

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

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

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

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

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

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

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

Line 31.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R.

Line 32--Enter the sum of lines 27, 28, and 29 plus or minus lines 30*, and* 31, *and minus line 31.50.*

Line 32.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 32]. *Do not apply the sequestration calculation when gross reimbursement (line 32) is less than zero.*

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

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

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

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

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

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

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

Line 53--Enter the time value of money.

This page is reserved for future use.

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

Line Descriptions

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

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

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

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

Line 5--DO NOT USE THIS LINE.

Line 6--Teaching hospitals participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

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

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

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

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

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

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 8 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 8 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 9--Enter line 7 minus line 8.

Line 10--Enter the Part A deductibles.

Line 11--Enter line 9 less line 10.

Line 12--Enter the Part A coinsurance.

Line 13--Enter the result of subtracting line 12 from line 11.

Line 14--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year’s bad debts, lines 14 and 15 will be negative.

Line 15--Multiply the amount (including negative amounts) from line 14 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 16--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 14.

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

Line 18--Enter the amount from Worksheet E-4, line 49 for the hospital.

Line 19--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 20--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

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

Enter on line 21.99, the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See *CMS* Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 21.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R.

Line 22--Enter the sum of lines 17, 18, and 19, plus or minus lines 20, *and* 21, *and minus line 21.50.*

Line 22.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 22]. *Do not apply the sequestration calculation when gross reimbursement (line 22) is less than zero.*

Line 23--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 24 the amount on line 5.99.

Line 25--Enter line 22 minus the sum of lines 22.01, 23, and 24. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 26--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

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

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

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 3, §150.26 - §150.28.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, chapter 3, §150.26 - §150.28)

Line 53--Enter the time value of money.

Computation of Reimbursement Settlement

Line 18--New children's or new cancer hospitals enter the amount from Worksheet E-4, line 49. CAHs do not complete this line.

Line 19--Enter the sum of lines 6 and 17.

Line 20--Enter the Part A deductibles billed to Medicare beneficiaries.

Line 21-- Enter the amount from line 16. If you are a nominal charge provider, enter zero.

Line 22--Enter line 19 minus lines 20 and 21.

Line 23--Enter from PS&R or your records the coinsurance billed to Medicare beneficiaries.

Line 24--Enter line 22 minus line 23.

Line 25--Enter from your records program allowable bad debts net of recoveries. If recoveries exceed the current year's bad debts, lines 25 and 26 will be negative.

Line 26--No reduction is required for *CAHs* for cost reporting periods beginning prior to October 1, 2012, enter the amount from line 25.

Multiply the amount from line 25 (including negative amounts) by 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 27--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 25.

Line 28--Enter the sum of lines 24 and 26.

Line 29--Enter any other adjustments. For example, if you change the recording of vacation pay from cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 29.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 29.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R.

Line 30--Enter line 28, plus or minus line 29*, and minus line 29.50.*

Line 30.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 30]. *Do not apply the sequestration calculation when gross reimbursement (line 30) is less than zero.*

Line 31--Enter interim payments from Worksheet E-1, column 2, line 4. For contractor final settlement, report on line 32 the amount from line 5.99.

Line 33--Enter line 30 minus the sum of lines 30.01, 31, and 32. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 34--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

4033.6 Part VI - Calculation of Reimbursement Settlement - Title XVIII Part A PPS SNF Services-- For title XVIII SNFs reimbursed under PPS, complete this part for settlement of Part A services. For Part B services, all SNFs complete Worksheet E, Part B.

When this part is completed for a component, show both the hospital and component numbers.

Computation of Net Costs of Covered Services

Line Descriptions

Prospective Payment Amount

Line 1--Compute the sum of the following amounts obtained your books and records or from the PS&R:

- The Resource Utilization Group (RUG) payments made for PPS discharges during the cost reporting period, and
- The RUG payments made for PPS transfers during the cost reporting period.

Line 2--Enter the amount from Worksheet D, Part III, column 9, line 44.

Line 3--Enter the amount from Worksheet D, Part IV, column 11, line 200.

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

Line 5--Do not use this line as vaccine costs are included on line 1 of Worksheet E, Part B. Line 5 is shaded on Worksheet E-3, Part VI.

Line 6--Enter any deductible amounts imposed.

Line 7--Enter any coinsurance amounts.

Line 8--Enter from your records program allowable bad debts for deductibles and coinsurance net of bad debt recoveries. If recoveries exceed the current year's bad debts, *line* 8 will be negative.

Line 9--Enter *the allowable* bad debts *for deductibles and coinsurance* for dual eligible beneficiaries*, net of recoveries of bad debts for dual eligible beneficiaries*. This amount *is included in the amount* reported on line 8. *If recoveries of bad debts for dual eligible beneficiaries exceed the current year's bad debts for dual eligible beneficiaries, line 9 will be negative.*

Line 10--SNF Bad Debt--Calculate this line as follows for cost reporting periods beginning prior to October 1, 2012: [((line 8 - line 9) * 70 percent) + line 9]. This is the adjusted SNF reimbursable bad debt in accordance with *the Deficit Reduction Act (*DRA*)* 2005, section 5004.

In accordance with DRA 2005 SNF Bad Debt as amended by section 3201(b) of the Middle Class Tax Relief and Job Creation Act of 2012, calculate this line as follows: for cost reporting periods beginning on or after October 1, 2012, calculate this line as follows: [((line 8 - line 9) * 65 percent) + (line 9 * 88 percent)]. For cost reporting periods beginning on or after October 1, 2013, calculate this line as follows: [((line 8 - line 9) * 65 percent) + (line 9 * 76 percent)]. For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 8 by 65 percent.

Line 11--Enter the title XVIII reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include on this line the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, Part III, line 85.

Line 12--Enter the result of line 4 plus line 5 minus the sum of lines 6 and 7 plus lines 10 and 11.

Line 13--Enter the amounts paid or payable by *workers'* compensation and other primary payers where program liability is secondary to that of the primary payer for inpatient services. Enter only the primary payer amounts applicable to Part A routine and ancillary services.

Line 14--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc., enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 14.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See *CMS* Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 14.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R.

Line 15--Enter the result of line 12, plus or minus *line* 14, minus line*s* 13*, and 14.50.*

Line 15.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 15]. *Do not apply the sequestration calculation when gross reimbursement (line 15) is less than zero.*

Line 16--For title XVIII, enter the total interim payments from Worksheet E-1, column 2, line 4.

Line 17--For contractor final settlement, report the amount from Worksheet E-1, column 2, line 5.99.

Line 18--Enter line 15 minus the sum of the amounts on lines 15.01, 16 and 17. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 19--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

4033.7 Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services--This worksheet calculates reimbursement for titles V or XIX services for hospitals, subproviders, other nursing facilities and ICF/MRs.

Use a separate copy of this part for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of this part to indicate the component and program for which it is used. When this part is completed for a component, show both the hospital and component numbers. Enter check marks in the appropriate spaces to indicate the applicable reimbursement method for inpatient services (e.g., TEFRA, OTHER).

Computation of Net Costs of Covered Services

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs.

Cost Reimbursement

Hospital/CAH or Subprovider - Worksheet D-1, Part II, line 49
Skilled Nursing Facility, Other Nursing Facility, ICF/MR - Worksheet D-1, Part III, line 86.
If Worksheet S-2, line 92 is answered "yes", and multiple Worksheets D-1 are prepared, add the multiple Worksheets D-1 and enter the result.

TEFRA

Hospital or Subprovider - Worksheet D-1, Part II, line 63

NOTE: If you are a new provider reimbursed under TEFRA, use Worksheet D-1, Part II, line 49.

Line 2--Enter the cost of outpatient services for titles V or XIX which is the sum of Worksheet D, Part V, columns 6 and 7 and subscripts where applicable.

Line 3--For titles V and XIX, enter in column 1 the amount paid or payable by the State program for organ acquisition.

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

Line 5--Enter in column 1 the amounts paid or payable by *workers'* compensation and other primary payers where program liability is secondary to that of the primary payer for inpatient services for titles V and XIX.

Line 6--Enter in column 2 the primary payer amounts applicable to outpatient services for titles V and XIX.

Line 7--Enter line 4 minus the sum of lines 5 and 6.

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

Line Descriptions

Lines 8 *through* 11--These lines provide for the accumulation of charges which relate to the reasonable cost on line 4.

Line 2--Enter the unweighted resident FTE count for allopathic and osteopathic programs that meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1)) or (e)(3), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995, but before October 1, 2012. For *urban* hospitals that *participate in* training residents in a new program for the first time on or after October 1, 2012 *under 42 CFR 413.79(e)(1)*, the cap is effective beginning with the *cost reporting period that coincides with or follows the start of the* sixth program year *of the first new program started* (see *(79 FR 50110 (August 22, 2014)*). *For rural hospitals that participate in training residents in a new program on or after October 1, 2012 under 42 CFR 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on each new program. Therefore, the rural hospital's FTE resident cap is adjusted for each new program effective with the hospital's cost reporting period that coincides with or follows the start of the sixth program year of each new program started (see 79 FR 50110 (August 22, 2014)).* For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited or begun on or after January 1, 1995, and before August 6, 1997 is reported on this line and is effective in the fourth program year of each of those new programs (see 66 FR August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 1. Do not report new program FTEs during the time frame prior to the effective date of the hospital's FTE cap on this line. New program FTEs during the time frame prior to the effective date of the hospital's FTE cap are reported on line 15. For urban hospitals that already have an FTE cap on line 1 but start a rural track program in accordance with 42 CFR 413.75(k), enter the unweighted allopathic or osteopathic FTE count for residents in all years of the rural track program that meet the criteria for an add-on to the cap under 42 CFR 413.79(k). (If the rural track program is a new program under 42 CFR 413.79(l) and the hospital qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (e)(3), do not report FTE residents in the rural track program on this line during the time frame prior to the effective date of the hospital's FTE cap*)*.

Line 3--Enter the section 422 reduction amount to the direct GME cap as specified under 42 CFR 13.79(c)(3).

Line 3.01--Enter the section 5503 reduction amount to the direct GME cap as specified under 42 CFR 413.79(m). If this cost report straddles July 1, 2011, then calculate the prorated section 5503 reduction amount off the cost report and enter the result on this line. (Prorate the cap reduction amount by multiplying it by the ratio of the number of days from July 1, 2011, to the end of the cost reporting period to the total number of days in the cost reporting period). Otherwise enter the full cap reduction amount.

Line 4--Enter the adjustment (increase or decrease) for the unweighted resident FTE count for allopathic or osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(f), and (63 FR 26336 *(*May 12, 1998), and 67 FR 50069 *(*August 1, 2002).

Line 4.01--Enter, as applicable, all or a portion of the amount of the FTE cap slots the hospital was awarded under section 5503 of ACA. The amount of the section 5503 award that is reported on this line is the amount of the section 5503 award that is being "used" in this cost reporting period. In the 5-year evaluation period following implementation of section 5503 (that is, July 1, 2011 through June 30, 2016), at least 75 percent of the slots are to be "used" for additional primary care and/or general surgery residents, while 25 percent of the amount that is reported may be (but need not be) "used" for other purposes. During the 5-year evaluation period, failure to meet the requirements at 42 CFR 413.79(n)(2) of the regulations means loss of a hospital's section 5503 slots. Therefore, do not automatically report the full amount of the section 5503 slots; only enter the amount of the section 5503 award that equates to at least 75 percent of the FTEs being "used" for additional primary care and/or general surgery FTEs, and no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with

receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting period. If the amount reported on Worksheet S-2, Part I, line 61.02, column 3, is less than the amount on line 61.01, column 3, then report 0 on this line.

Line 4.02--Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. Further subscript this line (lines 4.03 through 4.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to determine the effective date of the cap increase. If the section 5506 award is phased in over more than one effective date, only report the portions of the section 5506 award as they become effective. If the effective date of the cap increase is not the same as your fiscal year *beginning* date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period.)

Line 5--Enter the result of line 1 plus line 2 minus line 3 minus line 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus subscripts as applicable. However, if the resulting cap is less than zero, enter zero on this line.

Line 6--Enter the unweighted resident FTE count for allopathic or osteopathic programs for the current year from your records, other than those in the initial years of the program , i.e., the program has not yet completed one cycle of the program (the "period of years" or the minimum accredited length of the program. The residents in programs within the "period of years" are exempt from the rolling average rules. (42 CFR 413.79(d)(5) and (e).) Contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or greater than 3 years. Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)).

Line 7--Enter the lesser of lines 5 or 6.

Line 8--Enter in column 1, the weighted FTE count for primary care physicians and OB/GYN residents in an allopathic or osteopathic program for the current year. Enter in column 2, the weighted FTE count for all other physicians in an allopathic or osteopathic program for the current year. *Exclude FTE residents in the initial period of years of the new program, which for urban or rural hospitals that began training residents in a new program under 42 CFR 413.79(e)(1) or (e)(3), prior to October 1, 2012, means that the program has not yet completed one cycle of the program (i.e., "period of years," or minimum accredited length of the program.* (42 CFR 413.79(d)(5) and (e)). *For new programs started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012 under 42 CFR 413.79(e)(1), do not include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (i.e., the initial years, see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program on or after October 1, 2012 under 42 CFR 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on each new program. Therefore, for rural hospitals, do not include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of each individual new program started (see 79 FR 50110 (August 22, 2014)). For both urban and rural hospitals, report FTE residents in the initial years of the new program on line 15.* Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)). Enter in column 3, the sum of columns 1 and 2.

Line 9--If line 6 is less than or equal to line 5, enter the amounts from line 8, columns 1 and 2, in columns 1 and 2 of this line. Otherwise, multiply the amount in each column of line 8 by (line 5/line 6). Enter in column 3 the sum of columns 1 and 2. (42 CFR 413.79(c)(2)(iii).)

Line 10--Enter in column 2 the weighted dental and podiatric resident FTE count for the current year.

Line 11--Enter in column 1, the amount from column 1, line 9. Enter in column 2, the sum of the amounts in column 2, lines 9 and 10.

Line 12--Enter in column 1, the weighted FTE count for primary care residents for the prior year, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific primary care *(or OB/GYN)* program included in Form *CMS*-2552-96, Worksheet E-3, Part IV, line 3.22 or Form *CMS*-2552-10, Worksheet E-4, *from* line 15 of the prior year's cost report. If subject to the cap in the prior year Form *CMS*-2552-96 cost report, report the result of Worksheet E-3, Part IV, line 3.07 times (line 3.04/line 3.05). If subject to the cap in the prior year Form *CMS*-2552-10 cost report, report the result of Worksheet E-4, column 1, line 8 times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the prior year, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific nonprimary care program included in Form *CMS*-2552-96, Worksheet E-3, Part IV, line 3.16 or Form *CMS*-2552-10, Worksheet E-4, *from* line 15 of the prior year's cost report. If subject to the cap in the prior year Form *CMS*-2552-96 cost report, report the result of Worksheet E-3, Part IV, line 3.08 times (line 3.04/line 3.05) plus line 3.11. If subject to the cap in the prior year Form *CMS*-2552-10 cost report, report the result of Worksheet E-4, column 2, line 8 times (line 5/line 6) plus line 10.

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

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

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

Line 15--Enter the weighted number of FTE residents in the initial years of a program in column 1 for primary care *and OB/GYN* and in column 2 for nonprimary care FTEs. *For a new program started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012 under 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program(s) on or after October 1, 2012 under 42 CFR 413.79(e)(3), include FTE residents in a particular new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of that new program (see 79 FR 50110 (August 22, 2014)).*

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

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

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

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

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

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

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

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

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

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

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

Line Descriptions

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

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

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

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

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

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

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

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

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

Line Descriptions

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

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

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

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

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

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

Line Descriptions

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

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

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

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

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

- PPS hospital and/or subproviders - Worksheet E, Part A, line 60;
- TEFRA hospital and/or subproviders - Worksheet E-3, Part I, line 5;
- IPF PPS hospital and/or subproviders - Worksheet E-3, Part II, line 17;
- IRF PPS hospital and/or subproviders - Worksheet E-3, Part III, line 18;
- LTC PPS hospital - Worksheet E-3, Part IV, line 8;
- Cost reimbursed hospital and/or subproviders - Worksheet E-3, Part V, line 5;
- Hospital-based HHAs - Each Worksheet H-4, Part I, column 1, line 9;
- Swing Bed SNF and/or NF - Worksheet E-2, column 1, line 9; and
- Hospital-based PPS SNF - Worksheet E-3, Part VI, column 1, line 13.

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

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

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

Line 44--Enter line 42 minus line 43

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

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

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

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

Line Descriptions

Line 48--Enter the amount from line 31.

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

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

SECTIONS 4035 THROUGH 4039 ARE RESERVED FOR FUTURE USE.

This page is reserved for future use.

NOTE: The sum of visits reported in columns 6 and 7 must equal the corresponding amounts on Worksheet S-4, column 5, lines 21, 23, 25, 27, 29, and 31. These visits are reported for episodes completed during the fiscal year.

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

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

Visits by CBSA--Lines 8 through 14--HHAs are paid for home health services under title XVIII on the basis of the geographic location at which the service is furnished. Enter for each discipline the CBSA code of the location where the home health service was furnished. Subscript each discipline line to accommodate multiple CBSAs serviced by your home health agency.

Column Descriptions

Column 1--Enter the CBSA code in which the corresponding HHA visits were rendered for each discipline on lines 8 through 13.

Columns 2 and 3--Enter the visit count for each of the corresponding disciplines for each CBSA.

Column 4, lines 8 through 14--These lines are shaded to prevent data input.

Line 14--Enter the total program visits for each discipline by adding lines 8 through 13 and subscripts, and enter this total on line 14.

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

Column 1--Enter the facility costs in column 1, lines 15 and 16, from Worksheet H-2, Part I, column 28, lines 8 and 9, respectively.

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

Columns 3 through 5--In column 3, enter the sum total of columns 1 and 2 on lines 15 and 16, respectively. Enter in column 4, lines 15 and 16, respectively, the total charges for such services in accordance with the instructions in §4041, lines 12 and 13. Develop a ratio of total cost (column 3) to total charges (column 4) (from your records), and enter this ratio in column 5.

Columns 6 through 8--Enter in the appropriate column the program charges for drugs and medical supplies charged to patients subject to cost reimbursement. The actual vaccine/drug cost for pneumococcal, influenza, hepatitis B and osteoporosis are cost reimbursed.

Do not enter charges for drugs and medical supplies subject to reimbursement on the basis of a fee schedule.

Line Descriptions for Columns 6 through 8

Line 15--Columns 6 through 11 are shaded to prevent the input of medical supplies charged to patients as all medical supplies are covered under the HHA PPS benefit. *Effective for cost reporting periods ending on or after October 1, 2014, enter in columns 6 through 11, medical supplies covered under the HHA PPS benefit. This information is captured for statistical purposes only.*

Line 16--This line represents pneumococcal, influenza, and hepatitis B vaccine costs and injectable osteoporosis drugs, but not the administration of these medications. Enter the program covered charges for drugs charged to patients for items not reimbursed on the basis of a fee schedule or OPPS. Enter in column 7 the program charges for pneumococcal vaccine and influenza vaccine exclusive of their respective administration costs. Enter in column 8 the program charges for hepatitis B vaccine and injectable osteoporosis drugs exclusive of their respective administration costs.

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

Columns 7 and 10--To determine the Medicare Part B cost, multiply the Medicare charges (column 7) by the ratio (column 5) for each line. Enter the product in column 10.

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

4044.2 Part II - Apportionment of Cost of HHA Services Furnished by Shared Hospital Departments.--Use this part only where the hospital complex maintains a separate department for any of the cost centers listed on lines 1 through 5 of this part of the worksheet, and these departments provide services to patients of the hospital's HHA. Subscript lines 1 *through* 5, as applicable, if subscripted on Worksheet C, Part I.

Column 1--Where applicable, enter in column 1 the cost to charge ratio from Worksheet C, Part I, column 9, lines as indicated.

Column 2--Where hospital departments provide services to the HHA, enter on the appropriate lines the charges applicable to the hospital-based home health agency.

Column 3--Multiply the amounts in column 2 by the ratios in column 1, and enter the result in column 3. Transfer the amounts in column 3 to Worksheet H-3, Part I as indicated. If lines 1 *through* 5 are subscripted, transfer the aggregate of each line.

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

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

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

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

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

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

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

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

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

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

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

Line 30.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R.

Line 31--Enter the result of line 29 plus or minus line 30*, and minus line 30.50.*

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

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

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

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

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

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

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

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

Line Descriptions

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

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

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

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

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

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

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

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

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

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

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

Line 25.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R.

Line 26--Enter the result of line 24 plus or minus line 25*, and minus line 25.50.*

Line 26.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 26]. *Do not apply the sequestration calculation when gross reimbursement (line 26) is less than zero.*

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

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

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

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

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

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

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

Line Descriptions

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

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

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

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

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

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

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

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

Line 7--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet J-3, line 26 less the amount on line 26.01.

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

4064. WORKSHEET L - CALCULATION OF CAPITAL PAYMENT

Worksheet L, Parts I through III, calculate program settlement for PPS inpatient hospital capital-related costs in accordance with the final rule for payment of capital-related costs on a prospective payment system pursuant to 42 CFR 412, Subpart M. (See *56 FR 43449 (*August 30, 1991*)*) Only provider components paid under IPPS complete this worksheet.

Worksheet L consists of the following three parts:

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

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

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

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

Line Descriptions

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

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

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

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

Indirect Medical Education Adjustment

Lines 3 - 6

Line 3--Enter the result of dividing the sum of total patient days (Worksheet S-3, Part I, column 8, lines 14 and 30) by the number of days in the cost reporting period (365 or 366 in case of leap year). *Effective for cost reporting periods beginning on or after October 1, 2013, also include in total patient days, the labor and delivery days from Worksheet S-3, Part I, column 8, line 32.* Do not include statistics associated with an excluded unit (subprovider).

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

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

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

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

Capital Disproportionate Share Adjustment

Lines 7 - 11

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

Line 7--Enter the percentage of SSI recipient patient days (from your contractor or your records) to Medicare Part A patient days. *Transfer t*his amount from Worksheet E, Part A, line 30.

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

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

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

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

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

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

Line Descriptions

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

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

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

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

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

Column 5--Divide the cost of each cost center in column 3 by the total patient days in column 4 for each line to determine the per diem cost capital cost for extraordinary circumstances. Enter the resultant per diem cost in column 5.

Column 6--Enter the program inpatient days for the corresponding cost centers from Worksheet D, Part I, column 6.

Column 7--Multiply the per diem in column 5 by the inpatient program days in column 6 to determine the program's share of capital costs for extraordinary circumstances applicable to inpatient routine services, as applicable, and enter the result.

4065.3 Part III - Computation of Program Inpatient Ancillary Service Capital Costs For Extraordinary Circumstances.--This part computes the program inpatient ancillary capital costs for extraordinary circumstances for titles V, XVIII, Part A, and XIX. Complete a separate copy of this part for the hospital and each subprovider for titles V, XVIII, Part A, and XIX, as applicable. In this case, enter the subprovider component number in addition to showing the provider number.

Make no entries on this worksheet for any costs centers with a negative balance on Worksheet B, Part I, column 26.

Column 1--Enter on each line the capital-related costs for each cost center as appropriate. Obtain this amount from Worksheet L-1, Part I, column 26.

NOTE: Compute capital costs for extraordinary circumstances relating to non-distinct observation bed units. To compute extraordinary circumstances relating to non-distinct observation bed units, develop a ratio of total observation bed costs to total general routine costs. Compute this ratio, rounded to six decimal places, by dividing the amount from Worksheet L-1, Part I, column 26, line 30 by the amount on Worksheet D-1, line 37. Then multiply this ratio by the general routine capital costs for extraordinary circumstances from Supplemental Worksheet L-1, Part I, column 26, line 30 to obtain the capital costs for extraordinary circumstances relating to non-distinct observation bed units for line 92, column 1. Transfer distinct part observation bed unit costs from Worksheet L-1, Part I, the appropriate subscript of column 26, line 92.

Column 2--Enter on each line the charges applicable to each cost center as shown on Worksheet C, Part I, column 6.

Column 3--Divide the cost of each cost center in column 1 by the charges in column 2 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to 032151. Enter the resultant departmental ratios in column 3.

Column 4--Enter on each line the appropriate titles V, XVIII, Part A, or XIX inpatient charges. Transfer these charges from the corresponding lines of Worksheet D, Part II, column 4.

Column 5--Multiply the ratio in column 3 by the charges in column 4 to determine the program's share of capital costs for extraordinary circumstances applicable to titles V; XVIII, Part A; or XIX inpatient ancillary services, as appropriate.

4066. WORKSHEET M-1 - ANALYSIS OF *HOSPITAL*-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Use this worksheet only if you operate a certified rural health clinic (RHC) or federally qualified health center (FQHC). Use only those cost centers that represent services for which the facility is certified. If you have more than one provider-based RHC and/or FQHC, complete separate worksheets for each RHC and FQHC facility, unless the facility has received prior contractor approval to file a consolidated cost report (see CMS Pub. 100-4, chapter 9, §30).

This worksheet is for the recording of direct RHC and FQHC costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. The worksheet also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations.

Column Descriptions

Columns 1 through 3--The expenses listed in these columns must be in accordance with your accounting books and records. If the cost elements of a cost center are maintained separately on your books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained by you and are subject to review by your contractor.

Enter on the appropriate lines in columns 1 through 3 the total expenses incurred during the reporting period. Detail the expenses as Salaries (column 1) and Other (column 2). The sum of columns 1 and 2 must equal column 3.

Column 4--Enter any reclassifications among the cost center expenses listed in column 3 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. See §4014 for examples of reclassifications that may be needed. Submit with the cost report copies of any work papers used to compute the reclassifications reported in this column.

The net total of the entries in column 4 must equal zero on line 30 if no reclassifications were reported on *Worksheet* A, column 4, of the appropriate line 88 and/or 89.

Column 5--Add column 4 to column 3, and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 30, if no reclassifications were reported on *Worksheet* A, column 4, of the appropriate line 88 and/or 89.

Column 6--In accordance with 42 CFR 413.9(c)(3), enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §4016.) Submit with the cost report copies of any work papers used to compute the adjustments reported in this column.

NOTE: The allowable cost of the services furnished by National Health Service Corp (NHSC) personnel may be included in your facility's costs. Obtain this amount from your contractor, and include this as an adjustment to the appropriate lines on column 6.

Column 7--Adjust the amounts in column 5 by the amounts in column 6, and extend the net balance to column 7. The total facility costs on line 32 must equal the net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center.

Line Descriptions

Lines 1 through 9--Enter the costs of your health care staff.

Line 10--Enter the sum of the amounts on lines 1 through 9.

Line 11--Enter the cost of physician medical services furnished under agreement.

Line 12--Enter the expenses of physician supervisory services furnished under agreement.

Line 14--Enter the sum of the amounts on lines 11 through 13.

Lines 15 through 20--Enter the expenses of other health care costs.

Line 20--If you answered yes on Worksheet S-8, line 15 report on this line the amount of reimbursable graduate medical education costs from Worksheet B, Part I, sum of columns 21 and 22, lines 88 (RHC) and/or 89 (FQHC), as applicable. To claim GME the RHC/FQHC must have provided a "substantial amount" toward the cost of the intern and residents.

For cost reporting periods ending on or after October 1, 2014, do not complete this line. The regulations at 42 CFR 413.78(a) state that the GME payment to the hospital includes all residents working in the hospital complex in determining the amount due. Therefore, no separate payment is made to the hospital-based RHC or hospital-based FQHC for GME costs.

Line 21--Enter the sum of the amounts on lines 15 through 20. *For cost reporting periods ending on or after October 1, 2014, enter the sum of the amounts on lines 15 through 19.*

Line 22--Enter the sum of the amounts on lines 10, 14, and 21. Reduce that result by the amount reported on line 20 if you are entitled to claim GME costs on line 20. Transfer this amount to Worksheet M-2, line 10.

Lines 23 through 27--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 27--If you have incurred non-allowable costs associated with graduated medical education, report on line 26 the non-allowable costs.

For cost reporting periods ending on or after October 1, 2014, do not complete this line. Since no separate payment is made to the hospital-based RHC or hospital-based FQHC for GME costs, any unallowable GME costs are included in the hospitals' total unallowable GME costs, and are not reported separately.

Line 28--Enter the sum of the amounts on lines 23 through 27. *For cost reporting periods ending on or after October 1, 2014, enter the sum of the amounts on lines 23 through 26.* Transfer the total amount in column 5 to Worksheet M-2, line 11.

Line 29--Enter the overhead expenses directly costed to the facility. These expenses may include rent, insurance, interest on mortgage or loans, utilities, depreciation of buildings and fixtures, depreciation of equipment, housekeeping and maintenance expenses, and property taxes. Submit with the cost report supporting documentation to detail and compute the facility costs reported on this line.

Line 30--Enter the expenses related to the administration and management of the RHC/FQHC that are directly costed to the facility. These expenses may include office salaries, depreciation of office equipment, office supplies, legal fees, accounting fees, insurance, telephone service, fringe benefits, and payroll taxes. Submit with the cost report supporting documentation to detail and compute the administrative costs reported on this line.

Line 31--Enter the sum of the amounts on lines 29 and 30. Transfer the total amount in column 5 to Worksheet M-2, line 14.

Line 32--Enter the sum of the amounts on lines 22, 28, and 31. Do not include the amount reported on line 20 for GME. This is the total facility cost. This amount should agree with the amount reported for RHC and FQHC on Worksheet A, column 7 reduced by any amounts claimed on line 20 above.

4067. WORKSHEET M-2 - ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

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

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

Column descriptions

Column 1--Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility's practice. (See CMS Pub. 100-04, chapter 9, §40.3 for a definition of FTEs).

Column 2--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2463(a) defining a visit.

Column 3--Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each non-physician practitioner. You are not subject to the productivity standards if you answered "Yes" to question 12 of Worksheet S-8. If so, then enter the revised standards established by you and your contractor.

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

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

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

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

Line descriptions

Line 1--Enter the number of FTEs and total visits furnished to facility patients by staff physicians working at the facility on a regular ongoing basis. Also include on this line, physician data (FTEs and visits) for services furnished to facility patients by staff physicians working under contractual agreement with you on a regular ongoing basis in the RHC/FQHC facility. These physicians are subject to productivity standards. (See 42 CFR 405.2468(d)(2)(v).)

Line 4--Enter the total of lines 1 through 3 for columns 1, 2 and 4.

Line 5--Enter the number of FTEs and total visits furnished to facility patients by visiting nurses working at the facility. Visiting nurses provide skilled nursing services to the homebound for services which require the skills of a nurse based on the complexity of the service, e.g., intravenous or intramuscular injections or insertions of catheters. (See CMS Pub. 100-02, chapter 13, §180).

Line 6--Enter the number of FTEs and total visits furnished to facility patients by clinical psychologists working at the facility. Clinical psychologist services may include the diagnosis, treatment and consultation of a patient. (See CMS Pub. 100-02, chapter 13, §140).

Line 7--Enter the number of FTEs and total visits furnished to facility patients by clinical social worker working at the facility. Clinical social worker services may include the diagnosis, treatment and consultation of a patient. (See CMS Pub. 100-02, chapter 13, §140).

Line 7.01--Enter the number of FTEs for registered dieticians or nutritional professionals and total visits furnished to FQHC patients for medical nutrition therapy (MNT) services provided in FQHCs. MNT services apply to FQHCs only. (See CMS Pub. 100-02, chapter 13, §210.2.4).

Line 7.02--Enter the number of FTEs for registered dieticians or nutritional professionals and total visits furnished to FQHC patients for diabetes self-management training (DSMT) services provided in FQHCs. DSMT services apply to FQHCs only. (See CMS Pub. 100-02, chapter 13, §210.2.4).

Line 8--Enter the total of lines 4 through 7 (and subscripts).

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

Determination of Total Allowable Cost Applicable To RHC/FQHC Services.--Lines 10 through 18 determine the amount of the overhead costs incurred by both the parent provider and the facility which apply to RHC or FQHC services.

Line 10--Enter the cost of health care services from Worksheet M-1, column 7, line 22.

Line 11--Enter the total nonreimbursable costs from Worksheet M-1, column 7, line 28.

Line 12--Enter the sum of lines 10 and 11 for the cost of all services (excluding overhead).

Line 13--Enter the percentage of RHC or FQHC services. This percentage is determined by dividing the amount on line 10 (the cost of health care services) by the amount on line 12 (the cost of all services, excluding overhead).

Line 14--Enter the total facility overhead costs incurred from Worksheet M-1, column 7, line 31.

Line 15--Enter the overhead costs incurred by the parent provider allocated to the RHC/FQHC. This amount is the difference between the total costs after cost allocation on Worksheet B, Part I, column 26 and Worksheet B, Part I, column 0. If GME costs are claimed on line 20 of Worksheet M-1, do not include the GME costs allocated to the RHC/FQHC in columns 21 and 22 of Worksheet B, Part I.

Line 16--Enter the sum of lines 14 and 15 to determine the total overhead costs related to the RHC/FQHC.

Line 17--If you are claiming allowable GME cost (line 20 of Worksheet M-1 completed), divide the total intern and resident visits reported on Worksheet S-8, line 15, column 5 by the total visits for the facility (sum of lines 8 and 9, column 5 above), multiply the result by line 16 above, and enter that amount. If you are not claiming GME enter -0-.

For cost reporting periods ending on or after October 1, 2014, do not complete this line. The regulations at 42 CFR 413.78(a) state that the GME payment to the hospital includes all

residents working in the hospital complex in determining the amount due. Therefore, no separate payment is made to the hospital-based RHC or hospital-based FQHC for GME costs.

Line 18--Subtract the amount on line 17 from line 16 and enter the result. *For cost reporting periods ending on or after October 1, 2014, enter the amount from line 16*.

Line 19--Enter the overhead amount applicable to RHC/FQHC services. It is determined by multiplying the amount on line 13 (the ratio of RHC/FQHC services to total services) by the amount on line 18 (total overhead costs).

Line 20--Enter the total allowable cost of RHC/FQHC services, the sum of line 10 (cost of RHC/FQHC health care services) and line 19 (overhead costs applicable to RHC/FQHC services).

4068. WORKSHEET M-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

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

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

Line descriptions

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

Line 2--Report vaccine costs on this line from Worksheet M-4.

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

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

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

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

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

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

Lines 8 and 9--The limits are updated every January 1. However, the possibility exists that limits may also be updated other than on January 1. Complete columns 1, 2 and 3, if applicable (add a column 3 for lines 8 *through* 14 if the cost reporting overlaps 3 limit update periods) of lines 8 and 9 to identify costs and visits affected by different payment limits for a cost reporting period that overlaps January 1. If only one payment limit is applicable during the cost reporting period (calendar year reporting period), complete column 2 only.

Line 8--Enter the per visit payment limit. Obtain this amount from CMS Pub. 100-04, §20.6 or from your contractor.

NOTE: If you are based in a small rural hospital with less than 50 beds (the bed count is based on the same calculation used on Worksheet E, Part A, line 4), in accordance with 42 CFR 412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2.

NOTE: RHCs that are based in a small urban hospital with less than 50 beds (as calculated above) will also be exempt from the per visit limit.

For RHCs based in small urban hospitals transfer the adjusted cost per visit (line 7) to line 9, column 1 and/or 2.

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

Calculation of Settlement.--Complete lines 10 through 29 to determine the total program payment due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period. Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

Line descriptions

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

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

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

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

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

NOTE: Section 4104 of ACA eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. RHCs and FQHCs must provide detailed HCPCS coding for preventive services to ensure coinsurance and deductible are not applied. Providers must maintain this documentation to apply the appropriate reductions on lines 16.03 and 16.04.

Line 15--Enter the amount of GME pass through costs determined by dividing the program intern and resident visits reported on Worksheet S-8, line 15 by the total visits reported on Worksheet S-8, line 15, column 5. Multiply that result by the allowable GME costs equal to the sum of Worksheet M-1, column 7, line 20 and Worksheet M-2, line 17. For cost reporting periods that overlap January 1, 2011 prorate the result using a ratio of days prior to and on or after January 1, 2011 for each column. For cost reporting periods beginning on or after January 1, 2011, do not use column 1 and enter the result in column 2.

For cost reporting periods ending on or after October 1, 2014, do not complete this line. The regulations at 42 CFR 413.78(a) state that the GME payment to the hospital includes all residents working in the hospital complex in determining the amount due. Therefore, no separate payment is made to the hospital-based RHC or hospital-based FQHC for GME costs.

Line 16--For cost reporting periods that overlap January 1, 2011, enter in column 1 the sum of lines 11 *and* 14, column 1 and in column 2, the sum of lines 11 *and* 14, column 2. For cost reporting periods beginning on or after January 1, 2011, do not use column 1 and enter the total program cost in column 2. This is equal to the sum of the amounts in columns 1 and 2, respectively (and 3 if applicable), lines 11 *and* 14.

Line 16.01--Enter the total program charges from the contractor's records (PS&R). For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in column 2.

Line 16.02--Enter the total program preventive charges from the provider's records. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program preventive charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in column 2.

Line 16.03--Enter the total program preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16, column 2.

Line 16.04.--Enter the total program non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program non- preventive costs ((line 16 minus lines 16.03 and 18) times .80) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program non- preventive costs ((line 16, column 2, minus lines 16.03 and 18, column 2) times .80) in column 2.

Line 16.05--Enter the total program costs. For cost reporting periods that overlap January 1, 2011, enter total program costs (line 16 times .80) for services rendered prior to January 1, 2011 in column 1, and enter the sum of lines 16.03 and 16.04, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the sum of lines 16.03 and 16.04, in column 2.

Line 17--Enter the primary payer amounts from your records.

Line 18--Enter the amount credited to the RHC's program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the contractor from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the contractor. FQHCs enter zero on this line as deductibles do not apply.

Line 19--Enter the coinsurance amount applicable to the RHC or FQHC for program patient visits on lines 10 and 12 as recorded by the contractor from clinic bills processed during the reporting period. This line captures data for informational and statistical purposes only. This line does not impact the settlement calculation.

Line 20--Enter the net program costs, excluding vaccines. For cost reporting periods that overlap January 1, 2011, enter the result of subtracting the amount on line 17 from the amount on line 16.05, columns 1 and 2. For cost reporting beginning on or after January 1, 2011, enter the result of subtracting the amount on line 17 from the amount on line 16.05, column 2.

Line 21--Enter the amount from Worksheet M-4, line 16.

Line 22--Enter the total allowable Medicare cost, sum of the amounts on lines 20 and 21.

Line 23--Enter your total allowable bad debts, net of recoveries, from your records. If recoveries exceed the current year's bad debts, line 23 will be negative.

Line 23.01--Enter the result of line 23 (including negative amounts) times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 24--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 23.

Line 25--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see *CMS* Pub. 15-1, *chapter 21, §2146*.4), enter the adjustment. Specify the adjustment in the space provided.

Line 25.50--Enter the Pioneer ACO demonstration payment adjustment amount.

Line 26--Enter the sum of lines 22 and 23 plus or minus line 25*, and minus line 25.50.* For cost reporting periods beginning on or after October 1, 2012, enter the sum of lines 22 and 23.01 plus or minus line 25 *and minus line 25.50.*

Line 26.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 26]. *Do not apply the sequestration calculation when gross reimbursement is less than zero.*

Line 27--Enter the total interim payments from Worksheet M-5 made to you for covered services furnished to program beneficiaries during the reporting period (from contractor records).

Line 28--For contractor use only, enter the on line 5.99 of Worksheet M-5.

Line 29--Enter the total amount due to/from the program (line 26 minus lines 26.01, 27, and 28). Transfer this amount to Worksheet S, Part III, column 3, line 10 and/or 11 as applicable.

Line 30--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-1, chapter 1, §115.2.) A schedule showing the supporting details and computations must be attached.

4069. WORKSHEET M-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

To accommodate vaccines other than the seasonal influenza vaccines covered by Medicare, subscript column 2 (add column 2.01 and 2.02, if necessary). The data entered in all columns (1, 2, and applicable subscripts) for lines 4, 11, and 13 are mutually exclusive. That is, the vaccine costs, the total number of vaccines administered, and the total number of Medicare covered vaccines shall only be represented one time in the appropriate column.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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