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 8 **Date: September 18, 2015**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents	40-1 - 40-4 (4 pp.)	40-1 - 40-4 (4 pp.)
4000 - 4000.2 (Cont.)	40-7 - 40-10 (4 pp.)	40-7 - 40-10 (4 pp.)
4001 (Cont.) - 4001 (Cont.)	40-15 - 40-16 (2 pp.)	40-15 - 40-16 (2 pp.)
4002.1 - 4004.1 (Cont.)	40-23 - 40-33.1 (14 pp.)	40-23 - 40-33.1 (14 pp.)
4004.1 (Cont.) - 4004.2 (Cont.)	40-33.4 - 40-42 (12 pp.)	40-33.4 - 40-42 (12 pp.)
4005.1 - 4005.2	40-55 - 40-58.2 (6 pp.)	40-55 - 40-58.2 (6 pp.)
4005.2 (Cont.) - 4005.2 (Cont.)	40-61 - 40-62 (2 pp.)	40-61 - 40-62 (2 pp.)
4005.5 - 4006 (Cont.)	40-65.8 - 40-68 (4 pp.)	40-65.8 - 40-68 (4 pp.)
4008 - 4009	40-71 - 40-72 (2 pp.)	40-71 - 40-72 (2 pp.)
4011.2 - 4012 (Cont.)	40-75 - 40-78 (4 pp.)	40-75 - 40-78 (4 pp.)
4013 (Cont.) - 4013 (Cont.)	40-85 - 40-86 (2 pp.)	40-85 - 40-86 (2 pp.)
4013 (Cont.) - 4013 (Cont.)	40-89 - 40-92 (4 pp.)	40-89 - 40-92 (4 pp.)
4013 (Cont.) - 4013 (Cont.)	40-95 - 40-96 (2 pp.)	40-95 - 40-96 (2 pp.)
4014 - 4015.2	40-99 - 40-102 (4 pp.)	40-99 - 40-102 (4 pp.)
4017 - 4018 (Cont.)	40-107 - 40-110 (4 pp.)	40-107 - 40-110 (4 pp.)
4019.4 - 4021 (Cont.)	40-113 - 40-124 (12 pp.)	40-113 - 40-124 (12 pp.)
4023.1 - 4024.5 (Cont.)	40-127 - 40-138 (12 pp.)	40-127 - 40-138 (12 pp.)
4025 - 4025.4	40-141 - 40-152 (12 pp.)	40-141 - 40-152 (12 pp.)
4026.1 (Cont.) - 4028.2	40-155 - 40-162 (8 pp.)	40-155 - 40-162 (8 pp.)
4030.1 - 4030.1 (Cont.)	40-169 - 40-170 (2 pp.)	40-169 - 40-170 (2 pp.)
4030.1 (Cont.) - 4030.1 (Cont.)	40-171 - 40-176.10 (18 pp.)	40-171 - 40-176.10 (18 pp.)
4030.1 (Cont.) - 4030.1 (Cont.)	40-176.13 - 40-176.18 (6 pp.)	40-176.13 - 40-176.18 (6 pp.)
4030.2 (Cont.) - 4033.2 (Cont.)	40-179 - 40-194 (16 pp.)	40-179 - 40-194 (16 pp.)
4033.3 (Cont.) - 4033.3 (Cont.)	40-197 - 40-198 (2 pp.)	40-197 - 40-198 (2 pp.)
4033.3 (Cont.) - 4033.4	40-199.2 - 40-200 (2 pp.)	40-199.2 - 40-200 (2 pp.)
4033.5 - 4034	40-203 - 40-212 (10 pp.)	40-203 - 40-212 (10 pp.)
4034 (Cont.) - 4034 (Cont.)	40-215 - 40-216.2 (4 pp.)	40-215 - 40-216.2 (4 pp.)
4040.3 - 4041	40-223 - 40-226 (4 pp.)	40-223 - 40-226 (4 pp.)
4041 (Cont.) - 4042	40-229 - 40-230 (2 pp.)	40-229 - 40-230 (2 pp.)
4042 (Cont.) - 4045.1 (Cont.)	40-233 - 40-240 (8 pp.)	40-233 - 40-240 (8 pp.)
4053.2 - 4055 (Cont.)	40-253 - 40-256 (4 pp.)	40-253 - 40-256 (4 pp.)
4057 - 4057 (Cont.)	40-259 - 40-260 (2 pp.)	40-259 - 40-260 (2 pp.)
4058 - 4058 (Cont.)	40-263 - 40-264 (2 pp.)	40-263 - 40-264 (2 pp.)
4061 (Cont.) - 4067	40-269 - 40-282 (16 pp.)	40-269 - 40-282 (14 pp.)
4090 (Cont.)	40-503 - 40-512 (10 pp.)	40-503 - 40-512 (10 pp.)
	40-517 - 40-518 (2 pp.)	40-517 - 40-518 (2 pp.)
	40-569 - 40-578 (10 pp.)	40-569 - 40-578 (10 pp.)
	40-589 - 40-590 (2 pp.)	40-589 - 40-590 (2 pp.)
	40-595 - 40-598 (4 pp.)	40-595 - 40-598 (4 pp.)
	40-615 - 40-616 (2 pp.)	40-615 - 40-616 (2 pp.)
	40-619 - 40-620 (2 pp.)	40-619 - 40-620 (2 pp.)
	40-629 - 40-630 (2 pp.)	40-629 - 40-630 (2 pp.)
	40-645 - 40-646 (2 pp.)	40-645 - 40-646 (2 pp.)

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4095 (Cont.)	40-705 - 40-706 (2 pp.)	40-705 - 40-706 (2 pp.)
	40-719.2 - 40-720 (2 pp.)	40-719.2 - 40-720 (2 pp.)
	40-729 - 40-729.1 (2 pp.)	40-729 - 40-729.1 (2 pp.)
	40-733 - 40-738 (6 pp.)	40-733 - 40-738 (6 pp.)
	40-743 - 40-744 (2 pp.)	40-743 - 40-744 (2 pp.)
	40-771 - 40-771.1 (2 pp.)	40-771 - 40-771.1 (2 pp.)
	40-773 - 40-774 (2 pp.)	40-773 - 40-774 (2 pp.)
	40-793 - 40-794 (2 pp.)	40-793 - 40-794 (2 pp.)
	40-803 - 40-804 (2 pp.)	40-803 - 40-804 (2 pp.)
	40-815 - 40-818 (4 pp.)	40-815 - 40-818 (4 pp.)
	40-822.1 - 40-822.2 (2 pp.)	40-822.1 - 40-822.2 (2 pp.)
	40-825 - 40-836 (12 pp.)	40-825 - 40-836 (12 pp.)
	40-839 - 40-842 (4 pp.)	40-839 - 40-842 (4 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Ending on or After June 30, 2015.

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 instructions for line 22.01 for cost reporting periods that overlap two federal years.
  - Clarified instructions for line 22.03.
  - Clarified instructions for lines 71 and 76.
  - Added question 87 to identify hospitals classified as “subclause (II)” long term care hospitals (LTCHs)) as described at 42 CFR 412.526(c).
  - Modified the instructions for line 145 to identify a hospital dialysis facility with no Medicare utilization.
  - Added question 168.01 to identify critical access hospitals that qualify for a hardship exception under 42 CFR 413.70(a)(6)(ii).
- Worksheet S-3:
  - Added instructions for column 14, lines 3 and 4, to capture title XIX HMO discharges.
- Worksheet A-8-2:
  - Updated reasonable compensation equivalent limits for cost reporting periods beginning on or after January 1, 2015.
- Worksheet D-1, Part II:
  - Modified instructions for lines 54 through 63 to calculate the reimbursement for “subclause (II)” LTCHs in accordance with 42 CFR 412.526(c).
- Worksheet E, Part A:
  - Modified instructions for lines 35 through 35.03 for cost reporting periods that overlap two federal years.
- Exhibit 4:
  - Modified instructions for lines 20 and 20.01 for hospitals that experience a geographic redesignation.
- Exhibit 5:
  - Modified instructions for lines 20 and 20.01 for hospitals that experience a geographic redesignation.
  - Modified instructions for lines 30, 31, and 32, and added lines 30.01 and 31.01, for the hospital value-based purchasing payment and the hospital readmission reduction adjustment amounts relative to the hospital specific payment bonus payment amount.

- Worksheet E-3, Part I:
  - Modified usage and instructions to include calculation of Medicare reimbursement settlement under TEFRA for "subclause (II)" LTCHs.
- Worksheet E-1, Part II:
  - Clarified instructions for the health information technology incentive payment calculation on line 8.
- Worksheet E-3, Part V:
  - Modified instructions for line 6 for a CAH that is not a meaningful user of electronic health record technology for cost reporting periods beginning in FFY 2015 and subsequent years (cost reporting periods beginning on or after October 1, 2014).
- Worksheet L, Part I:
  - Modified instructions for lines 1 and 1.01 for hospitals that experience a geographic redesignation.
- Worksheet M-1:
  - Added instructions for a federally qualified health center (FQHC) filing as part of the hospital healthcare complex that, effective for cost reporting periods beginning on or after October 1, 2014, the FQHC must complete the new FQHC cost reporting worksheets when the worksheets are available.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after June 30, 2015.

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

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

Section

Section

Section

4000. GENERAL

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

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

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

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

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

o Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop C5-03-03
Baltimore, MD 21244-1855

o The Office of Information and Regulatory Affairs
Office of Management and Budget
Washington, DC 20503

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Round to 9 decimal places:
   a. Uncompensated care *F*actor 3

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

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

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

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

Step	Worksheet	Instructions
12	D-1, Parts III & IV	Read §§4025, 4025.3 and 4025.4. Only the hospital-based SNF and hospital-based NF must complete Part III, lines 70 through 86. All providers must complete Part IV.
13	D-2, Parts I through III	Read §§4026-4026.3. Complete only those parts that are applicable. Do not complete Part III unless both Parts I and II are completed.
14	L, Parts I through III	Read §4064. Complete applicable parts.
15	D-5, Parts I and II, or Parts III and IV	Read §§4029-4029.4. Complete applicable parts.
16	D-4, Parts I through IV	Read §§4028-4028.4. Complete only if hospital is a certified transplant center.
17	E-4	Read §§4034. Complete entire worksheet, if applicable.

Part III - Calculation and Apportionment of Hospital-Based Facilities

A. Title XVIII - For SNF Only Reimbursed Under PPS.--

Step	Worksheet	Instructions
1	E-3, Part VI	Read §4033.6. If applicable, complete lines 1 through 15 for title XVIII SNF PPS services.
2	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-3, Part VI.
3	E-3, Part VI	Complete the remainder of this worksheet, lines 16 through 19.

B. Titles V and XIX - For Hospital, Subprovider(s), NF and ICF/*IID*s.--

Step	Worksheet	Instructions
4	E-3, Part VII	Read §4033.7. If applicable, complete entire worksheet for titles V and XIX services. Use a separate worksheet for each title.

C. Title XVIII - For Swing-Bed SNF and Titles V and XIX - For Swing-Bed NF.--

Step	Worksheet	Instructions
5	E-2	Read §4032. Complete a separate copy of this worksheet (lines 1 through 19) for each applicable health care program for each applicable provider component. Only entries applicable to title XVIII are made in column 2. Complete lines 9, 13, and 17 of column 1 for titles V and XIX and columns 1 and 2 for title XVIII.
6	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-2 title XVIII swing-bed SNF only.
7	E-2	Complete the remainder of this worksheet, lines 20 through 23.

4002. SEQUENCE OF ASSEMBLY

The following examples of assembly of worksheets are provided so all providers are consistent in the order of submission of their annual cost report. All providers using Form CMS-2552-10 must adhere to this sequence. If worksheets are not completed because they are not applicable, do not include blank worksheets in the assembly of the cost report.

4002.1 Sequence of Assembly for Hospital Health Care Complex Participating in Medicare.-- Cost report worksheets are assembled in alpha-numeric sequence starting with the "S" series, followed by A, B, C, etc.

Form CMS	Work-sheet	Part	Health Care Program (Title)	Component
2552-10	S	I - III		
2552-10	S-2	I & II		
2552-10	S-3	I - V		
2552-10	S-4		XVIII	Hospital-Based HHA
2552-10	S-5		XVIII	Renal Dialysis Dept
2552-10	S-6		XVIII	Hospital-Based CMHC
2552-10	S-7		XVIII	Hospital-Based SNF
2552-10	S-8		XVIII	Hospital-Based RHC/FQHC
2552-10	S-9		XVIII	Hospital-Based Hospice
2552-10	S-10		XVIII	Hospital & CAH
2552-10	A			
2552-10	A-6			
2552-10	A-7	I - III		
2552-10	A-8			
2552-10	A-8-1			
2552-10	A-8-2			
2552-10	A-8-3	I - VI		
2552-10	B	I		
2552-10	B	II		
2552-10	B-1			
2552-10	B-2			
2552-10	C	I		Hospital
2552-10	C	II	V	Hospital
2552-10	C	II	XIX	Hospital
2552-10	D	I	V	Hospital
2552-10	D	II	V	Hospital
2552-10	D	III	V	Hospital
2552-10	D	IV	V	Hospital
2552-10	D	V	V	Hospital
2552-10	D	II	V	Subprovider
2552-10	D	V	V	Subprovider
2552-10	D	I	XVIII	Hospital
2552-10	D	II	XVIII	Hospital
2552-10	D	III	XVIII	Hospital
2552-10	D	IV	XVIII	Hospital
2552-10	D	V	XVIII	Hospital
2552-10	D	II	XVIII	Subprovider
2552-10	D	III	XVIII	Subprovider

Form CMS	Work-sheet	Part	Health Care Program (Title)	Component
2552-10	D	V	XVIII	Subprovider
2552-10	D	III	XVIII	Swing-Bed SNF
2552-10	D	III	XVIII	SNF
2552-10	D	I	XIX	Hospital
2552-10	D	II	XIX	Hospital
2552-10	D	III	XIX	Hospital
2552-10	D	IV	XIX	Hospital
2552-10	D	V	XIX	Hospital
2552-10	D	II	XIX	Subprovider
2552-10	D	V	XIX	Subprovider
2552-10	D-1	I, II, & IV	V	Hospital
2552-10	D-1	I, II, & IV	V	Subprovider
2552-10	D-1	I & III	V	SNF
2552-10	D-1	I & III	V	NF, ICF/*IID*
2552-10	D-1	I, II, & IV	XVIII	Hospital
2552-10	D-1	I, II, & IV	XVIII	Subprovider
2552-10	D-1	I & III	XVIII	SNF
2552-10	D-1	I, II, & IV	XIX	Hospital
2552-10	D-1	I, II, & IV	XIX	Subprovider
2552-10	D-1	I & III	XIX	SNF
2552-10	D-1	I & III	XIX	NF, ICF/*IID*
2552-10	D-2	I	V, XVIII, & XIX	
2552-10	D-2	II	XVIII	
2552-10	D-2	III	XVIII	
2552-10	D-3		V	Hospital
2552-10	D-3		V	Subprovider
2552-10	D-3		V	Swing-Bed SNF
2552-10	D-3		V	Swing-Bed NF
2552-10	D-3		V	SNF
2552-10	D-3		V	NF, ICF/*IID*
2552-10	D-3		XVIII	Hospital
2552-10	D-3		XVIII	Subprovider
2552-10	D-3		XVIII	Swing-Bed SNF
2552-10	D-3		XIX	Hospital
2552-10	D-3		XIX	Subprovider
2552-10	D-3		XIX	Swing-Bed SNF
2552-10	D-3		XIX	Swing-Bed NF
2552-10	D-3		XIX	SNF
2552-10	D-3		XIX	NF, ICF/*IID*
2552-10	D-4	I - IV	XVIII	
2552-10	D-5	I	V, XVIII, & XIX	
2552-10	D-5	II	V, XVIII, & XIX	Hospital
2552-10	D-5	II	V, XVIII, & XIX	Subprovider
2552-10	E	A	XVIII	Hospital
2552-10	E	B	XVIII	Hospital
2552-10	E-1	Part I	XVIII	Hospital
2552-10	E-1	Part I	XVIII	IPF-Subprovider
2552-10	E-1	Part I	XVIII	IRF-Subprovider
2552-10	E-1	Part I	XVIII	Subprovider
2552-10	E-1	Part I	XVIII	Swing-Bed SNF
2552-10	E-1	Part I	XVIII	SNF

Form CMS	Work-sheet	Part	Health Care Program (Title)	Component
2552-10	E-1	II	HIT	Hospital and CAH
2552-10	E-2		V	Swing-Bed SNF
2552-10	E-2		V	Swing-Bed NF
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	*II & III*	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*	*Subprovider - IPF*
2552-10	*E-3*	*VII*	*V & XIX*	*Subprovider - IRF*
2552-10	E-3	VII	V & XIX	NF, ICF/*IID*
2552-10	E-3	VII	V & XIX	SNF
2552-10	G			
2552-10	G-1			
2552-10	G-2			
2552-10	G-3			
2552-10	H			Hospital-based HHA
2552-10	H-1	I & II		Hospital-based HHA
2552-10	H-2	I & II		Hospital-based HHA
2552-10	H-3	I & II	V, XVIII, & XIX	Hospital-based HHA
2552-10	H-4	I & II	V, XVIII, & XIX	Hospital-based HHA
2552-10	H-5		XVIII	Hospital-based HHA
2552-10	I-1 - I-5			Renal Dialysis
2552-10	I-1 - I-5			Home Program Dialysis
2552-10	J-1 - J-2	I & II		CMHC
2552-10	J-3		V, XVIII, & XIX	CMHC
2552-10	J-4		XVIII	CMHC
2552-10	K			Hospital-based Hospice
2552-10	K-1			Hospital-based Hospice
2552-10	K-2			Hospital-based Hospice
2552-10	K-3			Hospital-based Hospice
2552-10	K-4	I & II		Hospital-based Hospice
2552-10	K-5	I - III		Hospital-based Hospice
2552-10	K-6		XVIII, XIX	Hospital-based Hospice
2552-10	L	I - III	V, XVIII, & XIX	Hospital
2552-10	L	I - III	V, XVIII, & XIX	Subprovider
2552-10	L-1	I		Hospital
2552-10	L-1	II	V, XVIII, & XIX	Hospital
2552-10	L-1	III	V, XVIII, & XIX	Hospital
2552-10	L-1	III	V, XVIII, & XIX	Subprovider
2552-10	M-1		V, XVIII, &XIX	Hospital-based RHC/FQHC
2552-10	M-2		V, XVIII, &XIX	Hospital-based RHC/FQHC
2552-10	M-3		V, XVIII, &XIX	Hospital-based RHC/FQHC
2552-10	M-4		V, XVIII, &XIX	Hospital-based RHC/FQHC
2552-10	M-5		V, XVIII, &XIX	Hospital-based RHC/FQHC

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 *CMS* Pub. 15-2, chapter 1, *§*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.

4003.3 Part III - Settlement Summary.--Enter the balance due to or due from the applicable program for each applicable component of the complex. Transfer settlement amounts as follows:

		FROM			
Hospital/ Hospital Component	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX
Hospital	Wkst. E-3, Part VII, line 42	Wkst. E, Part A, line 74 or Wkst. E-3, Part I, line 21 *or Wkst. E-3, Part II, line 34 or Wkst. E-3, Part III, line 35* or Wkst. E-3, Part IV, line 25 or Wkst. E-3, Part V, line 33	Wkst. E, Part B, line 43	Wkst. E-1, Part II, line 32	Wkst. E-3, Part VII, line 42
Subprovider-IPF	Wkst. E-3, Part VII, line 42	Wkst. E-3, Part II, line 34	Wkst. E Part B, line 43		Wkst. E-3, Part VII, line 42
Subprovider-IRF	Wkst. E-3 Part VII, line 42	Wkst. E-3, Part III, line 35	Wkst. E Part B, line 43		Wkst E-3, Part VII line 42
Subprovider-Other	Wkst. E series as applicable.				
Swing-Bed SNF	Wkst. E-2, col. 1, line 22	Wkst. E-2, col. 1, line 22	Wkst. E-2, col. 2, line 22		Wkst. E-2, col. 1, line 22
Swing-Bed NF	Wkst. E-2, col. 1, line 22	N/A	N/A		Wkst. E-2 col. 1, line 22
SNF	Wkst. E-3, Part VII, Line 42	Wkst. E-3, Part VI, line 18	Wkst. E, Part B, line 43		Wkst. E-3, Part VII, line 42
NF, ICF/*IID*	Wkst. E-3, Part VII, Line 42	N/A	N/A		Wkst. E-3, Part VII line 42

FROM_____

Hospital/ Hospital Component	Title V	Title XVIII Part A	Title XVIII Part B	Title XIX
Home Health Agency	Wkst. H-4, Part II, sum of cols. 1&2, line 34	Wkst. H-4, Part II, col. 1, line 34	Wkst. H-4, Part II, col. 2, line 34	Wkst. H-4, Part II, sum of cols. 1 & 2, line 34
Outpatient Rehabilitation Providers	Wkst. J-3, line 29	N/A	Wkst. J-3, line 29	Wkst. J-3, line 29
Rural Health Clinic/ Federally Qualified Health Clinic	Wkst. M-3 line 29	N/A	Wkst. M-3 line 29	Wkst. M-3 line 29

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

This worksheet consists of two parts:

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

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

Line Descriptions

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

Lines 3 through 17--Enter on the appropriate lines and columns indicated the component names, CMS certification numbers (CCN), core based statistical area (CBSA) codes (non-CBSA (rural) codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the State of Maryland the non-CBSA code is 99921), provider type, and certification dates of the hospital and its various components, if any. Indicate for each health care program (titles V, XVIII, or XIX), the payment system applicable to the hospital and its various components by entering P, T, O, or N in the appropriate column to designate PPS, TEFRA, OTHER, or NOT APPLICABLE, respectively. *The "PPS" payment systems include the Inpatient Prospective Payment System (IPPS), the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS), the Long Term Care Hospital Prospective Payment System (LTCH PPS) and the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). The "TEFRA" payment system includes long term care hospitals (LTCH) classified under subclause (II) of subsection (d)(1)(B)(iv) of the Act (referred to as "subclause (II)" LTCHs), children's hospitals and cancer hospitals.* The "OTHER" payment system includes critical access hospitals (CAHs) and cost reimbursed providers such as new TEFRA providers exempt from the rate of increase limits.

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

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

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

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

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

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

Line 4--The distinct part *IPF* is a portion of a general hospital which has been issued a subprovider CCN because it offers a clearly different type of service from the remainder of the hospital with such services reimbursed under inpatient psychiatric PPS. (See 42 CFR 412.25.)

Line 5--The distinct part *IRF* is a portion of a general hospital which has been issued a subprovider CCN because it offers a clearly different type of service from the remainder of the hospital with such services reimbursed under inpatient rehabilitation PPS. (See 42 CFR 412.25)

Line 6--This is a portion of a general hospital defined as non-Medicare certified not included in lines 4 through 18 which offers a clearly different type of service from the remainder of the hospital. *The data on this line cannot be used for Medicare reimbursement.*

Line 7--Medicare swing-bed services are paid under the SNF PPS system (indicate payment system as "P"). CAHs are reimbursed on a cost basis for swing-bed services and should indicate "O" as the payment system. Rural hospitals with fewer than 100 beds may be approved by CMS to use these beds interchangeably as hospital and skilled nursing facility beds with payment based on the specific care provided, as authorized by §1883 of the Act. (See CMS Pub. 15-1, chapter 22, §§2230-2230.6.)

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

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

Line 10--This is a distinct part nursing facility which has been issued a separate identification number and which meets the requirements of §1905 of the Act. (*See 42 CFR 441.400* for standards for other nursing facilities, for other than facilities for *individuals with intellectual disabilities*, and for facilities for *individuals with intellectual disabilities*.) If your State recognizes only one level of care, i.e., skilled, do not complete any lines designated as NF and report all activity on the SNF line for all programs. The NF line is used by facilities having two levels of care, i.e., either 100 bed facility all certified for NF and partially certified for SNF or 50 beds certified for SNF only and 50 beds certified for NF only. The contractor will reject a cost report attempting to report more than one nursing facility.

If the facility operates an *i*ntermediate *c*are *f*acility *for individuals with intellectual disabilities* (ICF/*IID*), subscript line 10 to 10.01 and enter the data on that line. Note: Subscripting is allowed only for the purpose of reporting an ICF/*IID*.

Line 11--This is any other hospital-based *long term care* facility not listed above. The beds in this unit are not certified for titles V, XVIII, or XIX. *The data on this line cannot be used for Medicare reimbursement. Treat this as a non-reimbursable cost center since it is not part of the Medicare certified hospital.*

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

Line 13--This is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and which meets the conditions for coverage in 42 CFR 416, Subpart B. The ASC operated by a hospital must be a separately identifiable entity which is physically, administratively, and financially independent and distinct from other operations of the hospital. (See 42 CFR 416.30(f).) Under this restriction, hospital outpatient departments providing ambulatory surgery (among other services) are not eligible. (See 42 CFR 416.120(a).)

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

Lines 15 and 16--Enter the applicable information for rural health clinics (RHCs) on line 15, and for federally qualified health centers (FQHCs) on line 16. These lines are used by RHCs and/or FQHCs which have been issued a provider number and meet the requirements of §1861(aa) of the Act. If you have more than one RHC, report them on subscripts of line 15. If you have more than one FQHC, report them on subscripts of line 16. Report the required information in the appropriate column for each. RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-04 (Medicare Claims Processing Manual), chapter 9, §30.8. Do not subscript this line if you elect to file under the consolidated cost reporting method. See §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 *(DSH)* 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, *enter "N" for no in column 1 and* complete column 2*; however, when the cost reporting period begins on October 1 and overlaps October 1 of the subsequent year, complete column 1 for the first period (October 1 through September 30) and complete column 2 for the remainder of the cost reporting period*.

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 *at least* 100, *but not more than 499* beds *(as counted* 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, *small rural* hospital (MDH), enter the number of periods within this cost reporting period that MDH status was in effect.

Line 38--*If line 37 is 1, e*nter the beginning and ending date of MDH status during this cost reporting period. Subscript *this* line if *line 37 is greater than 1 and enter the applicable beginning and ending dates accordingly.*

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 *2017*:

- 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 *graduate medical education* (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 *full time equivalent (*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 72139-72140 (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--*For column 1, i*f 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. *For column 2, i*s 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: 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.) *For new programs that began before October 1, 2012, 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 3 year new program growth period of the first new program, enter "N" in column 2. For new programs that began on or after October 1, 2012, if your fiscal year end does not correspond to the program year end, and this cost reporting includes the beginning of the program year following the 5 year new program growth period of the first new program, enter "N" in column 2. For column 3, i*f column 2 is yes, *indicate which program year began in this cost reporting period. For new programs that began before October 1, 2012,* 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. For new program*s that began* on or after October 1, 2012 (see 42 CFR 413.79(e)(1)), *enter 1, 2, 3, 4, or 5 to correspond to the I&R academic year in the first 5 years of the first new program's existence that began during the current cost reporting period.*

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 *or* "N" for no.

Line 76--*For column 1, i*f 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. *For column 2, i*f the facility is training residents in new teaching programs in accordance with 70 FR 47929 (August 15, 2005), enter in column 2, "Y" for yes *or* "N" for no. (Note: if column 1 is "Y", then column 2 must be "N" and vice versa; columns 1 and 2 cannot be "Y" simultaneously, and, columns 1 and 2 can be "N" simultaneously.) *For new programs that began before October 1, 2012, if your fiscal year end does not correspond to the program year end, and this cost reporting includes the beginning of the program year following the 3 year new program growth period of the first new program, enter "N" in column 2. For new programs that began on or after October 1, 2012, if your fiscal year end does not correspond to the program year end, and this cost reporting includes the beginning of the program year following the 5 year new program growth period of the first new program, enter "N" in column 2. For column 3, i*f column 2 is yes, *indicate which program year began in this cost reporting period. For new programs that began before October 1, 2012,* 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. For *new programs that began* on or after October 1, 2012 (see 42 CFR 413.79(e)(1)), *enter 1, 2, 3, 4, or 5 to correspond to the I&R academic year in the first 5 years of the first new program's existence that began during the current cost reporting period.*

Lines 77 through 79--Reserved for future use.

Line 80--Are you a freestanding LTCH? Enter in column 1 "Y" for yes *or* "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--Is this hospital a LTCH classified under section 1886(d)(1)(B)(iv)(II) (referred to as "subclause (II)" LTCHs)? Enter "Y" for yes or "N" for no.

Line 8*8 and* 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/*IID* 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 *are* excluded from deductible and coinsurance amounts and *are not* included on *Worksheet* 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 costs for renal *dialysis* services *are claimed* on Worksheet A, line 74, are *the costs for* inpatient services only? Enter "Y" for yes or "N" for no *in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.* If *column 1 is* yes *or column 2 is no*, do not complete Worksheet S-5 *or* the Worksheet I series *for renal dialysis services*.

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. *A CAH that is not a meaningful user beginning in FFY 2015 is subject to a payment adjustment as defined in 42 CFR 413.70(a)(6)(i). A CAH may, on a case-by-case basis, be granted an exception from this adjustment if CMS or its Medicare contractor determines, on an annual basis, that a significant hardship exists, such as in the case of a CAH in a rural area without sufficient internet access. However, in no case may a CAH be granted an exception for more than 5 years.*

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 168.01--If this provider is a CAH (line 105 is "Y") and is not a meaningful user (line 167 is "N"), does this provider qualify for a hardship exception under 42 CFR 413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. If no, the CAH is subject to a payment adjustment. The CAH's reasonable costs in providing inpatient services are adjusted as defined in 42 CFR 413.70(a)(6)(i) for cost reporting periods that begin in or after FFY 2015. Specifically, sections 1814(l)(4)(A) and (B) of the Act provide that, if a CAH does not demonstrate meaningful

use of certified EHR technology for an applicable EHR reporting period, then for a cost reporting period beginning in FFY 2015, the CAHs reasonable costs shall be adjusted from 101 percent to 100.66 percent. For a cost reporting period beginning in FFY 2016, the CAH's reasonable costs shall be adjusted to 100.33 percent. For a cost reporting period beginning in FFY 2017 and each subsequent FFY, the CAH's reasonable costs shall be adjusted to 100 percent.

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 44458-44460 (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 *or* "N" for no.

4004.2 Part II - Hospital and Hospital Health Care Complex Reimbursement Questionnaire.--The information required on Part II of this worksheet (formerly Form CMS-339) must be completed by all hospitals submitting cost reports to the Medicare contractor under Title XVIII of the Social Security Act (hereafter referred to as "The Act"). Its purpose is to assist you in preparing an acceptable cost report, to minimize the need for direct contact between you and your contractor, and to expedite review and settlement of cost reports. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost reports and to gather information necessary to support certain financial and statistical entries on the cost report. The questionnaire is a tool used in arriving at a prompt and equitable settlement of your cost report.

Where the instructions for this worksheet direct you to submit documentation/information, mail or otherwise transmit to the contractor immediately after submission of the ECR. The contractor has the right under §§1815(a) and 1883(e) of the Act to request any missing documentation required to complete the desk review.

To the degree that the information in the questionnaire constitutes commercial or financial information which is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act. If there is any question about releasing information, the contractor should consult with the CMS Regional Office.

Line Descriptions

NOTE: The responses on all lines are Yes or No unless otherwise indicated. If, in accordance with the following instructions, you are requested to submit documentation, indicate the line number for each set of documents you submit.

Lines 1 through 21 are required to be completed by all hospitals.

Line 1--Indicate whether the hospital has changed ownership immediately prior to the beginning of the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2--Indicate whether the hospital has terminated participation in the Medicare program. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date of termination in column 2, and "V" for voluntary or "I" for involuntary in column 3.

Line 3--Indicate whether the hospital is involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter "Y" for yes or "N" for *no. If "Y",* submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

Note: A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See *CMS* Pub. 15-1, *c*hapter 10, and 42 CFR §413.17.)

Line 4--Indicate whether the financial statements were prepared by a Certified Public Accountant. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "A" for audited, "C" for compiled, or "R" for reviewed in column 2. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report enter the date they will be available in column 3.

If you answer no in column 1, submit a copy of the financial statements you prepared, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5--Indicate whether the total expenses and total revenues reported on the cost report differ from those on the filed financial statements. Enter "Y" for yes or "N" for *no . If "Y",* submit a reconciliation with the cost report.

Line 6--Indicate whether costs were claimed for *n*ursing *s*chool. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "Y" for yes or "N" for no in column 2 to indicate whether the provider is the legal operator of the program.

Line 7--Indicate whether costs were claimed for *a*llied *h*ealth programs. Enter "Y" for yes or "N" for *no. If "Y",* submit a list of the program(s) with the cost report and annotate for each whether the provider is the legal operator of the program.

Note: For purposes of lines 6 and 7, the provider is the legal operator of a nursing school and/or allied health *program* if it meets the criteria in 42 CFR §413.85(f)(1) or (f)(2).

Line 8--Indicate whether approvals and/or renewals were obtained during the cost reporting period for *n*ursing *s*chool and/or *a*llied *h*ealth programs. Enter "Y" for yes or "N" for *no. If "Y",* submit a list of the program(s), and copies of the approvals and/or renewals with the cost report.

Line 9--Indicate whether *costs for i*nterns *and r*esidents *in approved GME programs* were claimed on the current cost report. Enter "Y" for yes or "N" for *no. If "Y",* submit the current year Intern-Resident Information System (IRIS) with the cost report *in a password-encrypted file on a CD or flash drive, or by a contractor-approved means such as electronic mail or a secure website*.

Line 10--Indicate whether *i*ntern *and r*esident *approved GME* program(s) have been initiated or renewed during the cost reporting period. Enter "Y" for yes or "N" for *no. If "Y",* submit copies of the certification(s)/program approval(s) with the cost report. (See 42 CFR §413.79(l) for the definition of a new program.)

Line 11--Indicate whether *GME* costs were directly assigned to cost centers other than the Intern-Resident Services in an Approved Teaching Program on Worksheet A. Enter "Y" for yes or "N" for *no. If "Y",* submit a listing of the cost centers and amounts with the cost report.

Line 12--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries. (See 42 CFR §413.89ff and CMS Pub. 15-1, chapter 3, §§*306-324,* for the criteria for an allowable bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a completed Exhibit 2 or internal schedules duplicating the documentation requested on Exhibit 2 to support the bad debts claimed. If you are claiming bad debts for inpatient and outpatient services, complete a separate Exhibit 2 or internal schedule for each category.

Exhibit 2 requires the following documentation:

Columns 1, 2, 3 - Patient Names, Health Insurance Claim (HIC) Number, Dates of Service (From - To)--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, health insurance claim number and dates of service that correlate to the filed bad debt. (See CMS Pub. 15-1, chapter 3, §314, and 42 CFR §413.89.)

Column 4--Indigency/Welfare Recipient--If the patient included in column 1 has been deemed indigent, place a check in this column. If the patient in column 1 has a valid Medicaid number, also include this number in this column. See the criteria in CMS Pub. 15-1, chapter 3, §§312 and 322, and 42 CFR §413.89 for guidance on the billing requirements for indigent and welfare recipients.

Columns 5 & 6--Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased--This information should be obtained from the provider's files and should correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2, and 3 of this exhibit. The dates in column 6 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by an outside entity, ceased and there is no likelihood of recovery of the unpaid account. (See CFR 413.89(f), and CMS Pub. 15-1, chapter 3, §§308, 310 and 314.)

Column 7--Remittance Advice Dates--Enter in this column the remittance advice dates that correlate with the beneficiary name, HIC No., and dates of service shown in columns 1, 2, and 3 of this exhibit.

Columns 8 & 9--Deductibles & Coinsurance--Record in these columns the beneficiary's unpaid deductible and coinsurance amounts that relate to covered services.

Column 10--Total Medicare Bad Debts--Enter on each line of this column, the sum of the amounts in columns 8 and 9. Calculate the total bad debts by summing up the amounts on all lines of *c*olumn 10. This "total" must agree with the bad debts claimed on the cost report. Attach additional supporting schedules, if necessary, for bad debt recoveries.

Line 13--Indicate whether your bad debt collection policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a copy of the policy with the cost report.

Line 14--Indicate whether patient deductibles and/or coinsurance amounts are waived. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, ensure that they are not included on the bad debt listings (i.e., Exhibit 2 or your internal schedules) submitted with the cost report.

Line 15--Indicate whether total available beds have changed from the prior cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, provide an analysis of available beds and explain any changes that occurred during the cost reporting period.

NOTE: For purposes of line 15, available beds are provider beds that are permanently maintained for lodging inpatients. They must be available for use and housed in patient rooms or wards (i.e., do not include beds in corridors or temporary beds). (See CMS Pub. 15-1, chapter 22, §2200.2.C., Pub. 15-2, chapter 40, §4005.1, and CFR §412.105(b).)

Line 16--Indicate whether the cost report was prepared using the Provider Statistical & Reimbursement Report (PS&R) only. Use columns 1 and 2 for Part A and columns 3 and 4 for Part B. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y" enter the paid-through date of the PS&R in columns 2 and/or 4. Also, submit a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 17--Indicate whether the cost report was prepared using the PS&R for totals and provider records for allocation. Use columns 1 and 2 for Part A and columns 3 and 4 for Part B. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and/or 4. Also, submit a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must show dollars by cost center and include which revenue codes were allocated to each cost center. The total revenue on the cost report must match the total charges on the PS&R (as appropriately adjusted for unpaid claims, etc.) to use this method. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records. If the contractor does not find the documentation sufficient, the PS&R will be used in its entirety.

Line 18--If you entered "Y" on either line 16 or 17, columns 1 and/or 3, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", include a schedule which supports any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R, and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 19--If you entered "Y" on either line 16 or 17, columns 1 and/or 3, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", submit a detailed explanation and documentation which provides an audit trail from the PS&R to the cost report.

Line 20--If you entered "Y" on either line 16 or 17, columns 1 and/or 3, indicate whether other adjustments were made to the PS&R data. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", include a description of the other adjustments and documentation which provides an audit trail from the PS&R to the cost report.

Line 21--Indicate whether the cost report was prepared using provider records only. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

4005. WORKSHEET S-3 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA AND HOSPITAL WAGE INDEX INFORMATION

This worksheet consists of five parts:

Part I	-	Hospital and Hospital Health Care Complex Statistical Data
Part II	-	Hospital Wage Index Information
Part III	-	Hospital Wage Index Summary
Part IV	-	Hospital Wage Related Costs
Part V	-	Hospital Contract Labor and Benefit Costs

4005.1 Part I - Hospital and Hospital Health Care Complex Statistical Data.--This part collects statistical data regarding beds, days, FTEs, and discharges.

Column Descriptions

Column 1--Enter the Worksheet A line number that corresponds to the Worksheet S-3 component line description.

Column 2--Refer to 42 CFR 412.105(b) and *69 FR 49093-49098 (August 11, 2004)* to determine the facility bed count. Indicate the number of beds available for use by patients at the end of the cost reporting period.

A bed means an adult bed, pediatric bed, portion of inpatient labor/delivery/postpartum (LDP) room (also referred to as birthing room) bed when used for services other than labor and delivery, or newborn ICU bed (excluding newborn bassinets) maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in post-anesthesia, post-operative recovery rooms, outpatient areas, emergency rooms, ancillary departments (however, see exception for labor and delivery department), nurses' and other staff residences, and other such areas that are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes. (See CMS Pub. 15-1, chapter 22, §2205.)

For cost reporting periods beginning prior to October 1, 2012, beds in distinct ancillary labor and delivery rooms and the proportion of LDP room (birthing room) beds used for labor and delivery services are not a bed for these purposes. (See *68 FR 45420 (August 1, 2003)*.)

For cost reporting periods beginning on or after October 1, 2012, in accordance with *77 FR 53411-53413 (August 31, 2012)*, beds in distinct labor and delivery rooms, 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 in accordance with 42 CFR 412.105(b) and are to be reported on line 32. Furthermore, the proportion of the inpatient LDP room (birthing room) beds used for ancillary labor and delivery services is considered part of the hospital's available bed count.

Column 3--Enter the total bed days available. Bed days are computed by multiplying the number of beds available throughout the period in column 2 by the number of days in the reporting period. If there is an increase or decrease in the number of beds available during the period, multiply the number of beds available for each part of the cost reporting period by the number of days for which that number of beds was available.

Column 4--CAHs accumulate the aggregate number of hours all CAH patients spend in each category on lines 1 and 8 through 12. This data is for informational purposes only.

Columns 5 through 7--Enter the number of inpatient days or visits, where applicable, for each component by program. Do not include HMO days except where required (lines 2 through 4, columns 6 and 7; line 13, column 7), organ acquisition, or observation bed days in these

columns. Nursery days (all the days during which a newborn infant occupies a nursery) are reported on line 13, column 7, and include the in-state paid Medicaid days; in-state Medicaid eligible but unpaid days; out-of-state Medicaid paid days; out-of-state Medicaid eligible but unpaid days paid; and Medicaid HMO paid and eligible but unpaid days. Observation bed days are reported in columns 7 (title XIX) and 8 (total), line 28. For LTCH, enter in column 6, on the applicable line, the number of covered Medicare days (from the PS&R) and enter in column 6, line 33, the number of non-covered days (from provider's books and records) for Medicare patients.

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

NOTE: Medicaid days for Medicaid recipients who are members of an HMO as well as out-of-state days, Medicaid secondary payer patient days, Medicaid eligible days for which no payment was received, and nursery days are reported on lines 2, 3, 4, or 13, in accordance with 42 CFR 412.106(b)(4)(ii). Therefore, Medicaid patient days reported on line 1, column 7, do not include days for Medicaid patients who are also members of an HMO, out-of-State Medicaid days, Medicaid secondary payer patient days, Medicaid eligible days for which no payment was received, and nursery days.

Column 8--Enter the number of inpatient days for all classes of patients for each component. Include organ acquisition and HMO days in this column. This amount will not equal the sum of columns 5 through 7, when the provider renders services to other than titles V, XVIII, or XIX patients.

Column 9--Enter the number of intern and resident *FTEs* in an approved program, determined in accordance with 42 CFR 412.105(f), for the indirect medical education adjustment. The FTE residents reported by an IPF PPS facility or an IRF PPS facility (whether freestanding or a unit reported on line 16 or 17, respectively, of an IPPS hospital's cost report) shall be determined in accordance with 42 CFR 412.424(d)(1)(iii) for IPFs, and in accordance with the *70 FR 47929-47930 (*August 15, 2005*)* for IRFs.

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

Columns 12 through 14--Enter the number of discharges including deaths (excluding newborn and DOAs) for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.) Enter the title XVIII Medicare Advantage (MA) discharges in column 13, line 2. For cost reporting periods ending on or after June 30, 2014, enter the title XIX managed care discharges in column 14, line 2. For columns 13 and 14, line 2 is a subset of column 15, line 1. *For cost reporting periods ending on or after October 1, 2014, enter the title XIX managed care discharges in column 14, lines 3 and 4, for the IPF and IRF subproviders. For column 14, lines 3 and 4 are subsets of column 15, line 16 and 17, respectively. Lines 2 through 4, column 14, are collected for informational purposes only.*

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

Line Descriptions

Line 1--For cost reporting periods beginning before October 1, 2012, exclude from column 2 the portion of LDP room (birthing room) beds used for ancillary labor and delivery services, but include on this line beds used for routine adult and pediatric services (postpartum). In accordance with the instructions in *68 FR 45420 (*August 1, 2003*)*, compute this proportion (off the cost report) by multiplying the total number of occupied and unoccupied available beds in the LDP room by the percentage of time these beds were used for ancillary labor and delivery services. An example of how to calculate the "percentage of time" would be for a hospital to determine the number of hours for the cost reporting period during which each LDP room maternity patient received labor and delivery services and divide the sum of those hours for all such patients by the sum of the total hours (for both, ancillary labor and delivery services and for routine postpartum services) that all maternity patients spent in the LDP room during that cost reporting period. Alternatively, a hospital could calculate an average percentage of time maternity patients received ancillary labor and delivery services in an LDP room during a typical month.

For cost reporting periods beginning on or after October 1, 2012, include all the available LDP room (birthing room) beds in the available bed count in column 2. (See 77 *FR 53411-53413 (*August 31, 2012*)*.) The proportion of available LDP room beds related to the ancillary labor and delivery services must not be excluded from column 2 for those cost reporting periods.

In columns 5, 6, 7 and 8, enter the number of adult and pediatric hospital days excluding the SNF and NF swing-bed, observation bed, and hospice days. In columns 6 and 7, also exclude HMO days. **Do not include in column 6 Medicare Secondary Payer/Lesser of Reasonable Cost (MSP/LCC) days**. Include these days only in column 8. However, do not include employee discount days in column 8.

Labor and delivery days (as defined in the instructions for Worksheet S-3, Part I, line 32) must not be included on this line.

Line 2--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans (§1876 of the Act). Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 1, column 7.

Line 3--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans (§1876 of the Act) that pertain to IPF subprovider patients. Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 16, column 7.

Line 4--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans (§1876 of the Act) that pertain to IRF subprovider patients. Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 17, column 7.

Line 5--Enter the Medicare covered swing-bed days (which are considered synonymous with SNF swing-bed days) for all title XVIII programs where applicable. (See 42 CFR 413.53(a)(2).) Exclude all MA days from column 6, include the MA days in column 8.

Line 6--Enter the non-Medicare covered swing-bed days (which are considered synonymous with NF swing-bed days) for all programs where applicable. (See 42 CFR 413.53(a)(2).)

Line 7--Enter the sum of lines 1, 5, and 6.

Lines 8 through 13--Enter the appropriate statistic applicable to each discipline for all programs.

Line 14--Enter the sum of lines 7 through 13 for columns 2 through 8, and for columns 12 through 15, enter the amount from line 1. For columns 9 through 11, enter the total for each from your records. Labor and delivery days (as defined in the instructions for Worksheet S-3, Part I, line 32) must not be included on this line.

Line 15--Enter the number of outpatient visits for CAHs by program and total. An outpatient CAH visit is defined in 42 CFR 413.70(b)(3)(iii).

Line 16--Enter the applicable data for the IPF subprovider.

Line 17--Enter the applicable data for the IRF subprovider.

Line 18--Enter the applicable data for other than IPF or IRF subproviders. If you have more than one subprovider, subscript this line. *Treat this area as a nonreimbursable cost center for Medicare since it is not part of the Medicare certified hospital.*

Line 19--If your State recognizes one level of care, complete this line for titles V, XVIII, and XIX, however, do not complete line 20. If you answered yes to line 92 of Worksheet S-2, Part I, complete all columns.

Line 20--Enter nursing facility days if you have a separately certified nursing facility for title XIX or you answered yes to line 92 of Worksheet S-2, Part I. Make no entry if your State recognizes only SNF level of care. If you operate an ICF/*IID*, subscript this line to 20.01 and enter the ICF/*IID* days. Do not report any nursing facility data on line 20.01.

Line 21--Enter data for an other long term care facility. *Treat this area as a nonreimbursable cost center for Medicare since it is not part of the Medicare certified hospital.*

Line 22--If you have more than one hospital-based HHA, subscript this line.

Line 23--Enter data for an ASC. If you have more than one ASC, subscript this line.

Line 24--Enter days applicable to hospice patients in a distinct part hospice.

Line 24.10--Effective for cost reporting periods beginning on or after October 1, 2011, enter in column 8, the days applicable to hospice patients currently under a valid hospice election who occupy general inpatient routine beds under a contractual arrangement between the hospital and hospice to provide general inpatient hospice and/or respite care services.

Line 25--CMHCs enter the number of partial hospitalization days as applicable. For reporting of multiple facilities follow the same format used on Worksheet S-2, Part I, line 17.

Line 26--Enter the number of outpatient visits for FQHC and RHC. If you have both or multiples of one, subscript the line. If the RHC/FQHC is approved to file a consolidated cost report all data is reported in aggregate as a single provider and must use either line 26 with no subscripting or must use a single subscript of line 26 representing the consolidated RHC/FQHC. If a consolidated RHC and FQHC cost reports exists, each consolidated cost report will use a separate line.

Line 28--Enter the total observation bed days in column 8. Divide the total number of observation bed hours by 24 and round up to the nearest whole day. These total hours should include the hours for observation of patients who are subsequently admitted as inpatients but only the hours up to the time of admission as well as the hours for observation of patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge from the facility. Observation bed days only need to be computed if the observation bed patients are placed in a routine patient care area. The bed days are needed to calculate the cost of observation beds since it cannot be separately costed when the routine patient care area is used. If, however, you have a distinct observation bed area, it must be separately costed (as are all other outpatient cost centers), and this computation is not needed.

Line 29--Enter in column 6, the total number of ambulance trips, as defined by §4531(a)(1) of the BBA. Do not subscript this line.

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 77 *FR* 53411-53413 *(August 31, 2012)*, 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 78 *FR* 50730-50733 *(August 19, 2013)*.)

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 74 *FR* 43899-43901 *(August 27, 2009)*.)

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 *PPS*. 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 *the* 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:

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

Line 16--Enter from your records the salaries and wage-related costs for Part A teaching physicians' from the home office allocation and/or related organizations. Also report on this line Part A teaching *physicians'* salaries under contract.

Lines 17 through 25--In general, the amount reported for wage-related costs must meet the "reasonable cost" provisions of Medicare. For pension and executive deferred compensation costs see the instructions below in Part IV.

For those wage-related costs that are not covered by Medicare reasonable cost principles, a hospital shall use generally accepted accounting principles (GAAP). For example, for purposes of the wage index, disability insurance cost should be developed using GAAP. Hospitals are required to complete Worksheet S-3, Part IV, a reconciliation worksheet to aid hospitals and contractors in implementing GAAP when developing wage-related costs. Upon request by the contractor or CMS, hospitals must provide a copy of the GAAP pronouncement, or other documentation, showing that the reporting practice is widely accepted in the hospital industry and/or related field as support for the methodology used to develop the wage-related costs. If a hospital does not complete Worksheet S-3, Part IV, or, the hospital is unable, when requested, to provide a copy of the standard used in developing the wage-related costs, the contractor may remove the cost from the hospital's Worksheet S-3 due to insufficient documentation to substantiate the wage-related cost relevant to GAAP.

NOTE: All costs for any related organization must be shown as the cost to the related organization. (For Medicare cost reporting principles, see CMS Pub. 15-1, chapter 10, §1000. For GAAP, see FASB 57.) If a hospital's consolidation methodology is not in accordance with GAAP or if there are any amounts in the methodology that cannot be verified by the contractor, the contractor may apply the hospital's cost-to-charge ratio to reduce the related party expenses to cost.

NOTE: All wage-related costs, including FICA, workers compensation, and unemployment compensation taxes, associated with physician services are to be allocated according to the services provided; that is, those taxes and other wage-related costs attributable to Part A administrative services must be placed on line 22, to Part A teaching services must be placed on line 22.01, and to Part B (patient care services) must be placed on line 23. Line 17 must not include wage-related costs that are associated with physician services.

Line 17--Enter the core wage-related costs from Worksheet S-3, Part IV, line 24. (See note below for costs that are not to be included on line 17). Only the wage-related costs reported on Worksheet S-3, Part IV, line 24, are reported on this line. (Wage-related costs are reported in column 2, not column 1, of Worksheet A.)

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 9 and 10. Instead, these costs are reported on line 19. Also, do not include the wage-related costs for physicians Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel. (See lines 14, 15, and 20 through 25.)

Health Insurance and Health-Related Wage Related Costs:

The following are the allowable health insurance and health-related costs for the wage index.

1) Purchased Health Insurance:
- Premium costs.
- Costs paid to external organizations for plan administration.

2) Self (or Self-Funded) Health Insurance:
- Costs paid to external organizations for plan administration.
- Without a Third-Party Administrator (TPA).
  - Costs the hospital incurs in providing services under the plan to its employees. (Domestic claim charges must be reduced to cost. Costs must also exclude any copayments and deductibles paid by employees.) Employee withholdings and contributions are employee costs, not hospital costs. Hospitals are not permitted to treat as hospital wage-related costs the amounts that their employees incur for their health insurance benefits.
  - Hospital's payment to unrelated health care providers for services rendered, under the plan, to hospital's employees.
- With a TPA.
  - Amount the TPA pays to the hospital or other health care providers for services rendered under the plan. (For domestic claims, the hospital must provide documentation from its TPA to demonstrate that payments for services rendered to employees are based on a discount from full charges. Also, the payments must be reasonable; that is, the costs included for domestic claims must not exceed the amount that commercial insurers pay the hospital for the same services rendered to nonemployees.) Employee withholdings and contributions are employee costs, not hospital costs. Hospitals are not permitted to treat as hospital wage-related costs the amounts that their employees incur for their health insurance benefits.

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

3) Health-Related Services: Inpatient and outpatient health services that are not covered under the hospital's health insurance plan, but are provided to employees at no cost or at a discount, for example, employee physicals, flu shots, smoking cessation, and weight control programs, are to be included as a core wage-related cost. (Domestic claim charges must be reduced to cost. Costs must also exclude any copayments and deductibles paid by employees.)

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

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

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

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

(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 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 PPS* effective for home health services rendered on or after October 1, 2000.

The statistics required on this worksheet pertain to home health services furnished on or after October 1, 2000. The data to be maintained, depending on the services provided by the agency, includes the number of aggregate program visits furnished in each episode of care payment category for each covered discipline, the corresponding aggregate program charges imposed in each episode of care payment category for each covered discipline, total visits and total charges for each episode of care payment category, total number of episodes and total number of outlier episodes for each episode of care payment category, and total medical supply charges for each episode of care payment category.

HHA Visits--See *CMS* Pub. 15-2, chapter 32, §3205, for the definition of an HHA visit.

Episode of Care--Under home health PPS the 60 day episode is the basic unit of payment where *the episode* payment is specific to one individual beneficiary. Beneficiaries are covered for an unlimited number of non-overlapping episodes. The duration of a full length episode will be 60 days. An episode begins with the start of care date and must end by the 60th day from the start of care.

Less than a full Episode of Care--When *four* or fewer visits are provided by the HHA in a 60 day episode period, the result is a low utilization payment adjustment (LUPA). In this instance, the HHA will be reimbursed based on a standardized per visit payment.

An episode may end before the 60th day in the case of a beneficiary elected transfer, or a discharge and readmission to the same HHA (including for an intervening inpatient stay). This type of situation results in a partial episode payment (PEP) adjustment.

Use lines 21 through 32 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 33 and 35 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 36 identifies the total number of episodes completed for each episode payment category. Line 37 identifies the total number of outlier episodes completed for each episode payment category. Outlier episodes do not apply to 1) Full Episodes without Outliers and 2) LUPA Episodes. Line 38 identifies the total medical supply charges incurred for each episode payment category. Column 5 displays the sum total of data for columns 1 through 4. The statistics and data required on this worksheet are obtained from *the PS&R* report.

When an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all statistical data (i.e., cost, charges, counts, etc…) associated with that episode of care will appear on the PS&R of the fiscal year in which the episode of care is concluded. Similarly, all data required in the cost report for a given fiscal year must only be associated with services rendered during episodes of care that conclude during the fiscal year. Title XVIII visits reported on this worksheet will not agree with the title XVIII visits reported on Worksheet H-3, sum of columns 2 and 3, line 14.

Columns 1 through 4--Enter data pertaining to title XVIII patients only. Enter, as applicable, in the appropriate columns 1 through 4, lines 21 through 32, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episode of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only Episodes) will not include any visit counts and corresponding charges that appear in column 3 (LUPA Episodes) and vice versa. This is true for all episode of care payment categories in columns 1 through 4.

Line 33--Enter in columns 1 through 4 for each episode of care payment *category, the* sum total of visits from lines 21, 23, 25, 27, 29 and 31.

Line 34--Enter in columns 1 through 4 for each episode of care payment *category, the* charges for services paid under PPS and not identified on any previous lines.

Line 35--Enter in columns 1 through 4 for each episode of care payment *category, the* sum total of visit charges from lines 22, 24, 26, 28, 30, 32 and 34.

Line 36--Enter in columns 1 through 4 for each episode of care payment *category, the* total number of episodes (standard/non-outlier) of care rendered and concluded in the provider's fiscal year.

Line 37--Enter in columns 2 and 4 for each episode of care payment category *identified, the* total number of outlier episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

NOTE: Lines 36 and 37 are mutually exclusive.

Line 38--Enter in columns 1 through 4 for each episode of care payment *category, the* total non-routine medical supply charges for services rendered and concluded in the provider's fiscal year.

Column 5--Enter on lines 21 through *37, the* sum total of amounts from columns 1 through 4.

4008. WORKSHEET S-6 - HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to hospital-based community mental health centers (CMHCs), comprehensive outpatient rehabilitation facilities (CORFs), outpatient rehabilitation facilities (ORFs) which generally furnishes outpatient physical therapy (OPT), outpatient occupational therapy (OOT), or outpatient speech pathology (OSP). If you have more than one hospital-based component, complete a separate worksheet for each facility.

Additionally, only CMHCs are required to complete the corresponding Worksheet J series. However, all CMHCs, CORFs, ORFs, OPTs, OOTs, and OSPs must complete the applicable Worksheet A cost center for the purpose of overhead allocation.

This worksheet provides statistical data related to the human resources of the community mental health center. FTE data is required by employee staff, contracted staff, and total. The human resources statistics are required for each of the job categories specified on lines 1 through 17. Enter any additional categories needed on line 18.

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

Report in column 1, *the FTE employees* on the CMHC or outpatient rehabilitation provider's payroll. These are staff for which an IRS Form W-2 was issued.

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

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

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

4009. WORKSHEET S-7 - PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. Public Law 105-33 (Balanced Budget Act of 1997) requires that all SNFs be reimbursed under PPS for cost reporting periods beginning on and after July 1, 1998.

Line 1--If this facility contains a hospital-based SNF, if all patients were covered under managed care or if there was no Medicare utilization, enter "Y" for yes. If the response is yes, do not complete the rest of this worksheet.

Line 2--Does this hospital have an agreement under either section 1883 or 1913 of the Act for swing-beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter arrangement date (mm/dd/yyyy) in column 2.

Column Descriptions for Lines 3 Through 200

Column 1--The case mix resource utilization group (RUGs) designations are already entered in this column.

Column 2--Enter the number of days associated with SNF services. All SNF payment data will be reported as a total amount paid under the RUG PPS payment system on Worksheet E-3, Part VI, line 1 and will be generated from the PS&R or your records.

Column 3--Enter the number of days associated with the swing-beds. All swing-bed SNF payment data will be reported as a total amount paid under the RUG PPS payment system on Worksheet E-2, line 1, and will be generated from the PS&R or your records.

Column 4--Enter the sum total of columns 2 and 3.

Line 201--Enter in column 1, the CBSA code in effect at the beginning of the cost reporting period. Enter in column 2, the CBSA code in effect on or after October 1 of the current cost reporting period, if applicable.

Lines 202 through 206--A notice published in the *68* FR *46036-46072 (August 4, 2003)* provided for an increase in RUG payments to hospital based SNFs for payments on or after October 1, 2003. Congress expects this increase to be used for direct patient care and related expenses. Lines 202 through 206 are *identified* as *follows*: 202 - Staffing, 203 - Recruitment, 204 - Retention of Employees, 205 - Training, and 206 - Other. Enter in column 1, the direct patient care expenses and related expenses in accordance with the *68 FR 46036-46072 (August 4, 2003)*. Enter in column 2, the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. For each line, indicate in column 3 whether the increased RUG payments received reflects increases associated with direct patient care and related expenses by responding "Y" for yes. Indicate "N" for no if there was no increase in spending in any of these areas. If the increased spending is in an area not previously identified in areas one through four, identify on the "Other (Specify)" line(s), the cost center(s) description and the corresponding information as indicated above.

Column 5--Enter in column 5 only the days applicable to the four types of care for all other non-Medicare or Medicaid hospice patients. Enter on line 5 the total unduplicated days.

Column 6--Enter the total days for each type of care, (i.e., sum of columns 1, 2 and 5). The amount entered in column 6, line 5, should represent the total days provided by the hospice.

NOTE: Convert continuous home care hours into days so that column 6, line 5, reflects the actual total number of days provided by the hospice.

4011.2 Part II - Census Data.--

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

Line 6--Enter the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source.

The total under this line should equal the actual number of patients served during the cost reporting period for each program. Thus, if a patient's total stay overlapped two reporting periods, the stay should be counted once in each reporting period. The patient who initially elects the hospice benefit, is discharged or revokes the benefit, and then elects the benefit again within a reporting period is considered to be a new admission with a new election and should be counted twice.

A patient transferring from another hospice is considered to be a new admission and would be included in the count. If a patient entered a hospice under a payer source other than Medicare and then subsequently elects Medicare hospice benefit, count the patient once for each pay source.

The difference between line 6 and line 9, is that line 6 should equal the actual number of patients served during the reporting period for each program, whereas under line 9, patients are counted once, even if their stay overlaps more than one reporting period.

Line 7--Enter the total title XVIII Unduplicated Continuous Care hours billable to Medicare. When computing the Unduplicated Continuous Care hours, count only one hour regardless of number of services or therapies provided simultaneously within that hour.

Line 8--Enter the average length of stay for the reporting period. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payer source other than Medicare and Medicaid is not limited to the number of days under a hospice election. Line 5 divided by Line 6.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then reelects the Medicare hospice benefits for an additional 45 days, under a new benefit period and dies (patient B).

Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D was admitted with private insurance for 27 days, then their private insurance ended and Medicaid covered an additional 92 days. Patient E, with private insurance, received hospice care for 87 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the cost reporting period) is computed as follows:

Medicare Days (90 & 45 & 29) Patient (A, B & C)	164 days
Medicare Patients	/3

Average LOS Medicare	54.67 Days
Medicaid Days Patient D (92)	92 Days
Medicaid Patient	1
Average LOS Medicaid	92 Days
Other (Insurance) Days (87 & 27)	114 Days
Other Payments (D & E)	2
Average LOS (Other)	54 Days
All Patients (90+45+29+92+87+27)	370 Days
Total number of patients	6
Average LOS for all patients	61.67 Days

Enter the hospice's average length of stay, without regard to payer source, in column 6, line 8.

Line 9--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (See CMS Pub. *100-02, chapter 9, §20*). However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and should be counted twice.

The total under this line should equal the unduplicated number of patients served during the reporting period for each program. Thus, you would not include a patient if their stay was counted in a previous cost reporting period. If a patient enters a hospice source other than Medicare and subsequently becomes eligible for Medicare and elects the Medicare hospice benefit, then count that patient only once in the Medicare column, even though he/she may have had a period in another payer source prior to the Medicare election. A patient transferring from another hospice is considered to be a new admission and is included in the count.

4012. Worksheet S-10 - Hospital Uncompensated and Indigent Care Data--Section 112(b) of the Balanced Budget Refinement Act (BBRA) requires that short-term acute care hospitals (§1886(d) of the Act) submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated. Charity care charge data, as referenced in section 4102 of American Recovery and Reinvestment Act of 2009, may be used to calculate the EHR technology incentive payments made to §1886(d) hospitals *and CAHs*. CAHs, as well as §1886(d) hospitals, are required to complete this worksheet. Note that this worksheet does not produce the estimate of the cost of treating uninsured patients required for disproportionate share payments under the Medicaid program.

Definitions:

Uncompensated care--Defined as charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances or discounts given to patients.

Charity care--Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. (Additional guidance provided in the instruction for line 20.)

Non-Medicare bad debt--Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim. (Additional guidance provided in the instruction for line 25.)

Non-reimbursable Medicare bad debt--The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are **not** reimbursed by Medicare under the requirements of §413.89 of the regulations and of *CMS Pub. 15-1, c*hapter 3. (Additional guidance provided in the instruction for line 25.)

Net revenue--Actual payments received or expected to be received from a payer (including co-insurance payments from the patient) for services delivered during this cost reporting period. Net revenue will typically be charges (gross revenue) less contractual allowance. (Applies to lines 2, 9, and 13.)

Instructions:

Cost-to-charge ratio:

Line 1--Enter the cost-to-charge ratio resulting from Worksheet C, Part I, line 202, column 3, divided by Worksheet C, Part I, line 202, column 8.

For all inclusive rate *no-charge-structure* providers that do not complete Worksheet C, Part I, enter *your ratio* as calculated in accordance with CMS Pub. 15-1, *chapter 22, §*2208.

Medicaid

NOTE: The amount on line 18 should not include the amounts on lines 2 and 5. That is, the amounts on lines 2 and 5 are mutually exclusive from the amount on line 18.

Line 2--Enter the inpatient and outpatient payments received or expected for *t*itle XIX covered services delivered during this cost reporting period. Include payments for an expansion SCHIP program, which covers recipients who would have been eligible for coverage under *t*itle XIX. Include payments for all covered services except physician or other professional services, and include payments received from Medicaid managed care programs. If not separately identifiable,

disproportionate share (DSH) and supplemental payments should be included in this line. For these payments, report the amount received or expected for the cost reporting period, net of associated provider taxes or assessments.

Line 3--Enter "Y" for yes if you received or expect to receive any DSH or supplemental payments from Medicaid relating to this cost reporting period. Otherwise enter "N" for no.

Line 4--If you answered yes to question 3, enter "Y" for yes if all of the DSH or supplemental payments you received from Medicaid are included in line 2. Otherwise enter "N" for no and complete line 5.

Line 5--If you answered no to question 4, enter the DSH or supplemental payments the hospital received or expects to receive from Medicaid relating to this cost reporting period that were not included in line 2, net of associated provider taxes or assessments.

Line 6--Enter all charges (gross revenue) for *t*itle XIX covered services delivered during this cost reporting period. These charges should relate to the services for which payments were reported on line 2.

Line 7--Calculate the Medicaid cost by multiplying line 1 times line 6.

Line 8--Enter the difference between net revenue and costs for Medicaid by subtracting the sum of lines 2 and 5 from line 7. If line 7 is less than the sum of lines 2 and 5, then enter zero.

State Children's Health Insurance Program:

Line 9--Enter all payments received or expected for services delivered during this cost reporting period that were covered by a stand-alone SCHIP program. Stand-alone SCHIP programs cover recipients who are not eligible for coverage under Title XIX. Include payments for all covered services except physician or other professional services, and include any payments received from SCHIP managed care programs.

Line 10--Enter all charges (gross revenue) for services delivered during this cost reporting period that were covered by a stand-alone SCHIP program. These charges should relate to the services for which payments were reported on line 9.

Line 11--Calculate the stand-alone SCHIP cost by multiplying line 1 times line 10.

Line 12--Enter the difference between net revenue and costs for stand-alone SCHIP by subtracting line 9 from line 11. If line 11 is less than line 9, then enter zero.

Other state or local indigent care program:

Line 13--Enter all payments received or expected for services delivered during this cost reporting period for patients covered by a state or local government indigent care program (other than Medicaid or SCHIP), where such payments and associated charges are identified with specific patients and documented through the provider's patient accounting system. Include payments for all covered services except physician or other professional services, and include payments from managed care programs.

Line 14--Enter all charges (gross revenue) for services delivered during this cost reporting period for patients covered by a state or local government program, where such charges and associated payments are documented through the provider's patient accounting system. These charges should relate to the services for which payments were reported on line 13.

Under certain circumstances, costs associated with minor equipment are considered capital-related costs. See CMS Pub. 15-1, *chapter 1,* §106 for three methods of writing off the cost of minor equipment. Amounts treated as expenses under method (a) are not capital-related costs because they are treated as operating expenses. Amounts included in expense under method (b) are capital-related costs because such amounts represent the amortization of the cost of tangible assets over a projected useful life. Amounts determined under method (c) are capital-related costs because method (c) is a method of depreciation.

Section 1886(g) of the Act, as implemented by 42 CFR, Part 412, Subpart M, requires that the reasonable cost-based payment methodology for hospital inpatient capital-related costs be replaced with an inpatient prospective payment methodology for hospitals paid under *the* IPPS, effective for cost reporting periods beginning on or after October 1, 1991. Hospitals and hospital distinct part units (IPFs, IRFs, and LTCH) excluded from *the* IPPS pursuant to 42 CFR, Part 412, Subpart B, are paid for capital-related costs under their respective PPS payment systems. Also, CAHs are reimbursed on a reasonable cost basis under 42 CFR 413.70.

Lines 1 and 2--Capital costs are defined as all allowable capital-related costs for land and depreciable assets, with additional recognition of costs for capital-related items and services that are legally obligated by an enforceable contract (See *CMS* Pub. 15-1, *chapter 28,* §2800.) Betterment or improvement costs related to capital are included in capital assets. (See 42 CFR 412.302.) Capital costs incurred as a result of extraordinary circumstances are included in capital. (See 42 CFR 412.348(g).) Direct assignment of capital costs must be done in accordance with CMS Pub. 15-1, *chapter 23,* §§2307 and 2313.

Capital costs include the following:

1. Allowable depreciation on assets based on the useful life guidelines used to determine depreciation expense in the hospital's base period, which cannot be subsequently changed.

2. Allowable capital-related interest expense. Except as provided in subsections a through c below, the amount of allowable capital-related interest expense recognized as capital is limited to the amount the hospital was legally obligated to pay.

a. An increase in interest expense is recognized if the increase is due to periodic fluctuations of rates in variable interest rate loans or to periodic fluctuations of rates at the time of conversion from a variable rate loan to a fixed rate loan when no other changes in the terms of the loan are made.

b. If the terms of a debt instrument are revised, the amount of interest recognized associated with the original capital cannot exceed the amount that would have been recognized during the same period prior to the revision of the debt instrument.

c. Investment income (excluding income from funded depreciation accounts and other exclusions from investment income offset cited in CMS Pub. 15-1, *chapter 2,* §202.2) is used to reduce capital interest expense based in each cost reporting period.

3. Allowable capital-related lease and rental costs for land and depreciable assets.

a. The cost of lease renewals and the acquisition of assets continuously leased (e.g., capitalized leases) are recognized provided that the same asset remains in use, the asset has a useful life of at least 3 years, and the annual lease payment is $1,000 or more for each item or service.

b. If a hospital-owned asset is sold or given to another party and that same asset is then leased back by the hospital, the amount of allowable capital-related costs recognized as capital costs is limited to the amount allowed for that asset in the last cost reporting period during which it was owned by the hospital.

4. The appropriate portion of the capital-related costs of related organizations under 42 CFR 413.17 that would be recognized as capital costs if these costs had been incurred directly by the hospital.

Unless there is a change of ownership, the hospital must continue the same cost finding methods for capital costs. This includes its practices for the direct assignment of capital-related costs and its cost allocation bases in. If there is a change of ownership, the new owners may request that the contractor approve a change in order to be consistent with their established cost finding practices.

If a hospital desires to change its cost finding method for the direct assignment of capital costs, the request for change must be made in writing to the contractor prior to the beginning of the cost reporting period for which the change is to apply. The request must include justification as to why the change will result in more accurate and more appropriate cost finding. The contractor does not approve the change unless it determines that there is reasonable justification for the change.

Line 3--In accordance with 42 CFR 412.302(b)(4), enter all other capital-related costs, including but not limited to taxes, insurance, and license and royalty fees on depreciable assets. This line also includes any directly allocated home office other capital cost. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

PPS providers paid 100 percent Federal complete line 3, column 2, and Worksheet A-7, Parts I (if applicable), II, and III.

Lines 20 and 23--If you operate an approved nursing or allied health education program that meets the criteria of 42 CFR 413.85 and 412.113(b), both classroom and clinical portions of the costs are allowable as pass-through costs as defined in 42 CFR 413.85.

Classroom costs are those costs associated with formal, didactic instruction on a specific topic or subject in a classroom that meets at regular, scheduled intervals over a specific time period (e.g., semester or quarter) and for which a student receives a grade.

Clinical training is defined as involving the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. While it may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques, it involves no classroom instruction.

If you do not operate the program, the classroom portion of the costs is not allowable as a pass-through cost and therefore not reported on lines 20 and 23 of the Form CMS-2552-10. This cost may, however, be allowable as routine service operating cost. (See *CMS* Pub. 15-1, *chapter 4,* §404.2.) The clinical portions of these costs are allowable as pass-through costs if the following conditions as set forth in 42 CFR 413.85 are met:

1. The hospital must have claimed and have been paid for clinical costs (described above) during its latest cost reporting period that ended on or before October 1, 1989.

2. The proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program and allowable under 42 CFR 413.85 during a cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the hospital's most recent cost reporting period ending on or before October 1, 1989.

3. The hospital receives a benefit for the support it furnishes to the education program through the provision of clinical services by nursing and allied health students participating in the program.

4. The clinical training costs must be incurred by the provider or by an educational institution related to the provider by common ownership or control as defined by 42 CFR 413.17(b) and *CMS* Pub. 15-1, *chapter 10,* §1002 (cost to related organizations). Costs incurred by a third party, regardless of its relationship to either the provider or the educational institution, are not allowed.

5. The costs incurred by the hospital for the program do not exceed the costs that would have been incurred by the hospital if the program had been operated by the hospital.

6. The clinical training must occur on the premises of the hospital; i.e., in the hospital itself or in the physical area immediately adjacent to the hospital buildings or in other areas and structures located within 250 yards of the main buildings.

Line 20--Enter the cost for the nursing school.

Line 21--Enter the cost of intern and resident salaries and salary-related fringe benefits. Do not include salary and salary-related fringe benefits applicable to teaching physicians which are included in line 22.

Line 22--Enter the other costs applicable to interns and residents in an approved teaching program.

Line 23--For this line establish a separate cost center for each paramedical education program (e.g., one for medical records or hospital administration). If additional lines are needed, subscript line 23 consecutively and sequentially. If the direct costs are included in the costs of an ancillary cost center, reclassify them on Worksheet A-6 to line 23. Appropriate statistics are required on Worksheet B-1 to ensure that overhead expenses are properly allocated to this cost center. Identify all other medical education costs on line 23.99. These costs, if present and applicable, may be used on worksheets D, Parts III and IV.

Lines 24 *through* 29--Reserved for future use.

Lines 30 *through* 46--These lines are for the inpatient routine service cost centers.

Line 30--The purpose of this cost center is to accumulate the incurred routine service cost applicable to adults and pediatrics (general routine care) in a hospital. Do not include incurred costs applicable to subproviders or any other cost centers which are treated separately.

Lines 31 *through* 35--Use lines 31 through 35 to record the cost applicable to intensive care type inpatient hospital units. (See 42 CFR 413.53(b) and (d) and *CMS* Pub. 15-1, *chapter 22,* §2202.7.) Label line 35 appropriately to indicate the purpose for which it is being used.

Lines 36 *through* 39--Reserved for future use.

Line 40--Use this line to record the IPF service costs of a subprovider. Hospital units that are excluded units from *the* IPPS are treated as subproviders for cost reporting purposes.

Line 41--Use this line to record the IRF service costs of a subprovider. Hospital units that are excluded units from *the* IPPS are treated as subproviders for cost reporting purposes.

Line 42--Use this line to record the inpatient routine service costs of other subproviders as applicable.

Line 43--Use this line to record the costs associated with the nursery.

Line 44--Use this line to record the costs of SNFs certified for titles V, XVIII, or XIX if your State accepts one level of care.

Line 45--Use this line to record the cost of NFs certified for title V or title XIX but not certified as an SNF for title XVIII. Subscript this line to record the cost of ICF/*IID*. Do not report nursing facility costs on this subscripted line.

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

Lines 47 *through* 49--Reserved for future use.

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

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

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

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

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

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

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

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

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

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

Line 72--Include on this line high cost implantable devices charged to patients bearing the revenue codes established by the NUBC as indicated in the *73 FR 48462 (*August 19, 2008*)*, and not reported on line 71. Obtain the expense amounts from your records as follows depending on how you accumulate these expenses in your general ledger (GL). (1) If the expenses for chargeable implantable devices are accumulated together with non-chargeable implantable devices in the "Central Services" GL account and are reported in that cost center (line 14 on Worksheet A), do not include the high cost chargeable implantable devices expenses on Worksheet A, line 72. Rather, allocate the costs in column 14 of Worksheet B to line 72 (and other lines) using the recommended "costed requisitions" statistics. (2) If the expenses for high cost chargeable implantable devices are reported in a separate GL account, include these expenses on Worksheet A, line 72, column 2. (3) If the expenses for high cost chargeable implantable devices are reported in a specific subaccount(s) under the GL accounts for various routine and ancillary departments (i.e., operating room, adults and pediatrics, or clinic), report the sum of the balances in that subaccount(s) on Worksheet A, line 72, column 2. If you reported the total balance (i.e., including the amounts for high cost chargeable implantable devices) of the various GL accounts (i.e., operating room, adults and pediatrics, or clinic), in those respective cost centers in column 2 of Worksheet A, reclassify the cost of the high cost chargeable implantable devices from those cost centers to the "implantable devices charged to patients" cost center (line 72). (See CMS Pub. 15-1, chapter 23, §2308.2 and 42 CFR 413.53(a)(1).)

Line 95--Report all ambulance costs on this line for both owned and operated services and services under arrangement. No subscripting is allowed for this line.

Lines 96 and 97--Use these lines to report durable medical equipment *(DME)* rented or sold, respectively. Enter the direct expenses incurred in renting or *selling DME* items to patients. Also, include all direct expenses incurred by you in requisitioning and issuing DME to patients.

For a hospital-based SNF, report support surfaces by subscripting line 97, and use the proper cost center code.

Line 99--This cost center accumulates the direct costs for outpatient rehabilitation providers (CORFs and OPTs) and CMHCs. However, only CMHCs complete the J series worksheets. Use lines 99 *through* 99.09 for CMHCs, 99.10 *through* 99.19 for CORFs, 99.20 *through* 99.29 for OPTs, lines 99.30 *through* 99.39 for OOTs, and lines 99.40 *through* 99.49 for OSPs. If you have multiple components, subscript this line using the proper cost center code.

Line 100--Use this line if your hospital operates an intern and resident program not approved by Medicare.

Line 101--This cost center accumulates costs specific to HHA services. If you have more than one certified hospital-based HHA, subscript line 101 for each HHA.

Provider-based HHAs are operated and managed in a variety of ways within the context of the health care complexes of which they are components. In some instances, there are discrete management and administrative functions pertaining to the HHA, the cost of which is readily identifiable from the books and records.

In other instances, the administration and management of the provider-based HHA is integrated with the administration and management of the health care complex to such an extent that the cost of administration and management of the home health agency can be neither identified nor derived from the books and records of the health care complex. In other instances, the cost of administration and management of the HHA is integrated with the administration and management of the health care complex, but the cost of the HHA administration and management can be derived through cost finding. However, in most cases, even when the cost of HHA administration and management can be either identified or derived, the extent to which the costs are applicable to the services furnished by the provider-based HHA is not readily identifiable.

Even when the costs of administration and management of a provider-based HHA can be identified or derived, such costs do not generally include all of the general service costs (i.e., overhead costs) applicable to the HHA. Therefore, allocation of general service costs through cost finding is necessary for the determination of the full costs of the provider-based HHA.

When the provider-based HHA can identify discrete management and administrative costs from its books and records, these costs are included on line 101.

Similar situations occur for the services furnished by the provider-based HHA. For example, in some instances, physical therapy services are furnished by a discrete HHA physical therapy department. In other instances, physical therapy services are furnished to the patient of the provider-based HHA by an integrated physical therapy department of a hospital health care complex in such a manner that the direct costs of furnishing the physical therapy services to the patients of the provider-based HHA cannot be readily identified or derived. In other instances, physical therapy services are furnished to patients of the provider-based HHA by an integrated physical therapy department of a hospital health care complex in such a manner that the costs of physical therapy services furnished to patients of the provider-based HHA can be readily identified or derived.

When you maintain a separate therapy department for the HHA apart from the hospital therapy department furnishing services to other patients of the hospital health care complex or when you are able to reclassify costs from an integrated therapy department to an HHA therapy cost center, make a reclassification entry on Worksheet A-6 to the appropriate HHA therapy cost center. Make a similar reclassification to the appropriate line for other ancillaries when the HHA costs are readily identifiable.

NOTE: This cost report provides separate HHA cost centers for all therapy services. If services are provided to HHA patients from a shared hospital ancillary cost center, make the cost allocation on Worksheet H-1, Part II.

Lines 102 *through* 104--Reserved for future use.

Lines 105 *through* 117--Use these lines for special purpose cost centers. Special purpose cost centers include kidney, heart, liver, lung, pancreas, intestinal, and islet acquisition costs as well as costs of other organ acquisitions which are nonreimbursable but which CMS requires for data purposes, cost centers which must be reclassified but which require initial identification, and ASC and hospice costs which are needed for rate setting purposes.

NOTE: Prorate shared acquisition costs (e.g., coordinator salaries, donor awareness programs) among the type of organ acquisitions. Generally, this is done based on the number of organs procured. Further, if multiple organs have been procured from a community hospital or an independent organ procurement organization, prorate the cost among the type of acquisitions involved.

These cost centers include the cost of services purchased under arrangement or billed directly to the hospital in connection with the acquisition of organs. Such direct costs include but are not limited to:

- Fees for physician services (preadmission for transplant donor and recipient tissue-typing and all tissue-typing services performed on cadaveric donors);
- Cost for organs acquired from other providers or organ procurement organizations;
- Transportation costs of organs;
- Organ recipient registration fees;

4014. WORKSHEET A-6 - RECLASSIFICATIONS

This worksheet provides for the reclassification of certain costs to effect proper cost allocation under cost finding. For each reclassification adjustment, assign an alpha character in column 1 to identify each reclassification entry, e.g., A, B, C. DO NOT USE NUMERIC DESIGNATIONS. All reclassification entries must have a corresponding Worksheet A line number reference in columns 3 and 7. In column 10, indicate the column of Worksheet A-7 impacted by the reclassification, where applicable. If more than one column on Worksheet A-7 is impacted by one reclassification, report each entry as a separate line to properly report each column impacted on Worksheet A-7. If you directly assign the capital-related costs, i.e., insurance, taxes, and other, reclassify these costs to line 3. Do not reclassify other capital-related costs reported or reclassified to line 3 of Worksheet A back to the other capital lines 1-2 of Worksheet A. This is accomplished through Worksheet A-7.

Submit with the cost report copies of any workpapers used to compute the reclassifications effected on this worksheet.

Identify any reclassifications made as salary and other costs in the appropriate column. However, when transferring to Worksheet A, transfer the sum of the two columns.

NOTE: Salary amounts paid to an employee in addition to direct salaries or wages (such as paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay) must be reported on Worksheet A, column 1 of the same cost center as the employees direct salaries and wages. For example, if the indirect salaries (such as paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay) are reported in the "Employee Benefits" cost center or in column 2 of the cost where the related direct salary and wages are reported, a reclassification entry must be made to reclassify them to column 1 of the cost center(s) in which the related direct salaries and wages are reported.

If there is any reclassification to general service cost centers for compensation of provider-based physicians, make the appropriate adjustment for *reasonable compensation equivalent (*RCE*)* limitation on Worksheet A-8-2. (See §4018.)

Examples of reclassifications that may be needed are:

- Reclassification of related organization rent expenses included in the A & G cost center which are applicable to lines 1 and 2 of Worksheet A. See instructions for Worksheet A-8-1 for treatment of rental expenses for related organizations.

- Reclassification of interest expense included on Worksheet A, column 3, line 113, which is applicable to funds borrowed for A & G purposes (e.g., operating expenses) or for the purchase of buildings and fixtures or movable equipment. Allocate interest on funds borrowed for operating expenses with A & G expenses.

- Reclassification of employee benefits expenses (e.g., employee health service, hospitalization insurance, workers compensation, employee group insurance, social security taxes, unemployment taxes, annuity premiums, past service benefits, and pensions) included in the A & G cost center.

- Reclassification of utilization review cost applicable to the hospital-based SNF to A & G costs. If the scope of the utilization review covers the entire population, reclassify the total allowable utilization review cost included on Worksheet A, column 3, line 114. However, if the scope of the utilization review in the hospital-based SNF covers only Medicare patients or Medicare and title XIX patients, only the allowable utilization review costs included on

Worksheet A, column 3, line 114 (other than the compensation of physicians for their personal services on utilization review committees) are reclassified to A & G costs.

The appropriate adjustment for physicians' compensation is made on Worksheet A-8. For further explanations concerning utilization review in skilled nursing facilities, see CMS Pub. 15-1, chapter 21, §2126.2.

- Reclassification of any dietary cost included in the dietary cost center which is applicable to the cafeteria, nursery, and to any other cost centers such as gift, flower, coffee shops, and canteen.

- Reclassification of any direct expenses included in the central service and supply cost center which are directly applicable to other cost centers such as intern-resident service, intravenous therapy, and oxygen (inhalation) therapy.

- Reclassification of any direct expenses included in the laboratory cost center which are directly applicable to other cost centers such as whole blood and packed red blood cells or electrocardiology.

- Reclassification of any direct expenses included in the radiology-diagnostic cost center which are directly applicable to other cost centers such as radiology-therapeutic, radioisotope, or electrocardiology.

- When you purchase services (e.g., physical therapy) under arrangements for Medicare patients but do not purchase such services under arrangements for non-Medicare patients, your books reflect only the cost of the Medicare services. However, if you do not use the grossing up technique for purposes of allocating overhead and if you incur related direct costs applicable to both Medicare and non-Medicare patients (e.g., paramedics or aides who assist a physical therapist in performing physical therapy services), reclassify the related costs on Worksheet A-6 from the ancillary service cost center. Allocate them as part of A&G expense. However, when you purchase services that include performing administrative functions such as completion of medical records, training, etc. as described in CMS Pub. 15-1, chapter 14, §1412.5, the overall charge includes the provision of these services. Therefore, for cost reporting purposes, these related services are NOT reclassified to A&G.

- If a beneficiary receives outpatient renal dialysis for an extended period of time and you furnish a meal, the cost of this meal is not an allowable cost for Medicare. Make an adjustment on Worksheet A-8. However, the dietary counseling cost attributable to a dialysis patient is an allowable cost. Reclassify this cost from the dietary cost center, line 10, to the renal dialysis cost center, line 74.

- When interns and residents are employed to replace anesthetists, you must reclassify the related direct costs from the intern and resident cost center to the anesthesiology cost center. (See 49 FR 208 dated January 3, 1984.)

NOTE: These interns and residents do not qualify for the *IME* adjustment and must be excluded for the intern and resident FTE for that purpose. (See 42 CFR 412.113(c).)

- If you incur costs for an unpaid guarantee for emergency room physician availability, attach a separate worksheet showing the computation of the necessary reclassification. (See CMS Pub. 15-1, chapter 21, §2109.)

- Reclassification of the costs of malpractice insurance premiums, self-insurance fund contributions, and uninsured malpractice losses incurred either through deductible or coinsurance provisions, as a result of an award in excess of reasonable coverage limits, or as a government provider to the A & G cost center.

4015. WORKSHEET A-7 - RECONCILIATION OF CAPITAL COST CENTERS

This worksheet consists of three parts:

Part I - Analysis of Changes in Capital Asset Balances.
Part II - Reconciliation of amounts from worksheet A, column 2, lines 1 and 2.
Part III - Reconciliation of Capital Cost Centers.

See the instructions for Worksheet A for a definition of capital. All providers must complete Parts I, II, and III.

NOTE: Include assets which are directly allocated to the provider from the home office or related organization and the related other capital costs in Parts I and II of this worksheet.

The intent of Worksheet A-7, Part I, is to reflect assets which relate to the hospital. However, examine the cost finding elections made at the time you submit the cost report to consider the cost finding treatment of SNF, HHA, hospice, subproviders, CORF, CMHC, the physician office building, and any other nonallowable cost centers.

Where you have elected to cost find any of these areas through the cost report, related assets must be included in Worksheet A-7, Part I, as appropriate, to properly allocate the related insurance, taxes, etc.

4015.1 Part I - Analysis of Changes in Capital Asset Balances.--This part enables the Medicare program to analyze the changes that occurred in your capital asset balances during the current reporting period. Complete this worksheet only once for the entire hospital complex (certified and non-certified components). However, only include in Part I assets that relate to hospital services or are commingled and cannot be separated.

Columns 1 and 6--Enter the balance recorded in your books of accounts at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6). You must submit a reconciliation demonstrating that the amount reported on Part I, column 6, line 10, agrees with the total fixed assets on Worksheet G, plus any directly allocated assets from the home office or related organization, less any assets not allocated through the cost finding method on Worksheet B. Include fully depreciated assets still used for patient care.

Columns 2 *through* 4--Enter the cost of capital assets acquired by purchase in column 2 and the fair market value at date acquired of donated assets in column 3. Enter the sum of columns 2 and 3 in column 4.

NOTE: The amounts in Part I, column 2, must also include transfers of assets from a change of ownership.

Column 5--Enter the cost or other approved basis of all capital assets sold, retired, or disposed of in any other manner during your cost reporting period.

Column 6--Enter the sum of columns 1 and 4 minus column 5.

Column 7--Enter the initial acquisition cost of fully depreciated assets for each category. An asset that is fully depreciated and continues to be used in the facility must be recorded in this column. There will be no depreciation expense recorded after the asset is fully depreciated.

Line Descriptions

Line 7--If you acquired certified *health information technology (*HIT*)* assets and are an EHR technology meaningful user (Worksheet S-2, Part I, line 167 is yes) in accordance with ARRA 2009, section 4102, enter the corresponding amounts on this line.

Line 9--If you have included in lines 1 through 7 of Part I any of the following, enter those amounts on line 9.

- Capitalized a lease in accordance with generally accepted accounting principles (GAAP) and included it in the assets reported on Worksheet G,
- Excess of amounts paid for the acquisition of assets over their fair values or the amount recognized under §2314 of DEFRA for transactions after July 18, 1984, or
- Construction in progress at the end of the cost reporting period.

Line 10--Enter line 8 minus line 9.

4015.2 Part II - Reconciliation of Amounts From Worksheet A, Column 2, Lines 1 and 2.--The purpose of this worksheet is to segregate and specifically identify the depreciation and capital related costs which are directly assigned to Worksheet A, column 2, lines 1 and 2.

Columns 9 *through* 14--Enter in columns 9 through 14, the depreciation and other capital-related costs. (Do not report in columns 12 through 14 any amounts previously reported in Part III, columns 5 through 7). The sum of columns 9 through 14 of this part, which is reported in column 15, lines 1 and 2 must agree with the amounts reported on Worksheet A, column 2, lines 1 and 2.

4015.3 Part III - Reconciliation of Capital Cost Centers.--Use this part to allocate allowable insurance, taxes, and other capital expenditures (not including depreciation, lease, and interest expense) to the capital-related cost centers. This part also summarizes the amounts in the capital-related cost centers on Worksheet A, lines 1 and 2, column 7.

Lines 1 and 2--The allowable costs for other capital-related expenses (including but not limited to taxes, insurance, and license and royalty fees on depreciable assets) are apportioned by applying the ratio of the hospital's capital related building and fixtures and capital related movable equipment gross asset value to total asset value in each cost reporting period. These lines compute the appropriate gross asset ratios used in allocating other capital-related costs in columns 5 through 7.

Line 3--Enter the sum of lines 1 and 2. Column 4 must equal 1.000000.

Columns 1 *through* 4, Lines 1 and 2--Use these columns and lines to compute ratios of capital related building and fixtures and capital related movable equipment gross asset values to total gross asset values. Use these ratios on columns 5 through 7 to allocate other capital costs (insurance, taxes, and other) to the capital-related cost center lines (Worksheet A, lines 1 and 2).

Column 1--Enter on line 1 your gross asset value (asset value before accumulated depreciation) for buildings and fixtures (which also includes old land and land improvements). Enter on line 2 your gross asset value for movable equipment.

NOTE: Part III, column 1, line 3, must agree with the sum of Part I, column 6, line 8.

Column 2--Enter in column 2, line as appropriate, any amounts that you have included in column 1, lines 1 and 2, and which were reported on line 8 of Part I, as appropriate.

Column 3--Enter column 1 less column 2.

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 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 *PPS* implemented under 42 *CFR 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 RCEs are not applied to Medicare non-reimbursable or Medicare non-certified areas of the hospital and t*he 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, 105 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.

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

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

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

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

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

NOTE: 42 CFR 415.60(b) requires that physician compensation be allocated between physician services to patients, the provider, and nonallowable services such as research. Physicians' nonallowable services must not be included in columns 4 or 5. The instructions for column 18 insure that the compensation for nonallowable services included in column 3 is correctly eliminated on Worksheet A-8.

Column 6--*For each line of data, enter the RCE limit applicable to the physician's compensation included in that cost center. Obtain the RCE limit from the applicable chart in the Federal Register as listed below. If the physician specialty is not identified in the chart, use the RCE for the "Total" category (from the same chart).*

Cost Reporting Period Beginning On or After	*Federal Register*	*Note*
January 1, 2004	*68 FR 45459 (August 1, 2003)*	*Your location governs which of the three geographical categories are applicable: non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million.*
January 1, 2015	*79 FR 50162 (August 22, 2014)*	*Not applicable.*

Column 7--Enter for each line of data the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040 in this column. The hours entered are the actual hours for which the physician is compensated by you for furnishing services of a general benefit to your patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered. Time records or other documentation that supports this allocation must be available for verification by your contractor upon request. (See CMS Pub. 15-1, *chapter 21,* §2182.3E.)

Column 8--Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 6 and the ratio of the physician's provider component hours entered in column 7 to 2080 hours.

Column 9--Enter for each line of data five percent of the amounts entered in column 8.

Column 12--You may adjust upward, up to five percent of the computed limit (column 9), to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by you.

Enter for each line of data the actual amounts of these expenses paid by you.

Column 13--Enter for each line of data the result of multiplying column 5 by column 12, and dividing that amount by column 3.

Column 14--You may also adjust upward the computed RCE limit in column 8 to reflect the actual malpractice expense incurred by you for the services of a physician or group of physicians to your patients.

Enter for each line of data the actual amounts of these malpractice expenses paid by you.

Column 15--Enter for each line of data the result of multiplying column 5 by column 14, and dividing that amount by column 3.

Column 16--Enter for each line of data the sum of columns 8 and 15, plus the lesser of column 9 or 13.

Column 17--Compute the RCE disallowance for each cost center by subtracting the RCE limit in column 16 from your component remuneration in column 5. If the result is a negative amount, enter zero. Transfer the amounts for each cost center to Worksheet C, Part I, column 4, for all hospitals subject to PPS. (See 42 CF*R 4*12.)

Column 18--The adjustment for each cost center entered represents the PBP elimination from costs entered on Worksheet A-8, column 2, line 10, and on Worksheet A, column 6, to each cost center affected. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 16 (adjusted RCE limit) from the total remuneration recorded in column 3.

NOTE: If you incur cost for unpaid guarantee for emergency room physician availability, attach a separate worksheet showing the computation of the necessary reclassification. (See CMS Pub. 15-1, *chapter 21,* §2109.)

Line Descriptions

Line 200--Enter the total of lines 1 through 11 for columns 3 through 5, 7 through 9, and 12 through 18.

Lines 21 and 22--If the sum of hours in columns 1 and 2 for respiratory therapy or 1 through 3 for all others, line 9 is less than or equal to the product found on line 2, complete these lines. (See the exception above where you cannot gross up costs and charges, and services are provided to program patients only.)

Line 21--Enter the result of line 17 divided by the sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others.

Line 22--Enter the result of line 2 times line 21.

Line 23--If there are no entries on lines 21 and 22, enter the amount on line 20. Otherwise, enter the sum of the amounts on lines 18, 19, and 22 for respiratory therapy or lines 18 and 22 for all others.

4019.3 Part III - Standard and Optional Travel Allowance and Travel Expense Computation - Provider Site--This part provides for the computation of the standard and optional travel allowance and travel expense for services rendered on site.

Lines 24 *through* 28--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed at your site. One standard travel allowance is recognized for each day an outside supplier performs skilled therapy services at your site. For example, if a contracting organization sends three therapists to you each day, only one travel allowance is recognized per day. (See CMS Pub. 15-1, §1403.1 for a discussion of standard travel allowance and §1412.6 for a discussion of standard travel expense.)

Line 24--Include the standard travel allowance for supervisors and therapists. This standard travel allowance for supervisors does not take into account the additional allowance for administrative and supervisory responsibilities. (See CMS Pub. 15-1, §1402.4.)

Line 25--Include the standard travel allowance for assistants for physical therapy, occupational therapy, and speech pathology.

Line 26--Enter the amount from line 24 for respiratory therapy or the sum of lines 24 and 25 for physical therapy, occupational therapy, or speech pathology.

Line 27--Enter the result of line 7 times line 3 for respiratory therapy or line 7 times the sum of lines 3 and 4 for all others.

Lines 29 *through* 35--Complete these lines for computing the optional travel allowance and expense when proper records are maintained.

Line 31--Enter the amount on line 29 for respiratory therapy or the sum of lines 29 and 30 for all others.

Line 32--Enter the result of line 8 times the sum of columns 1 and 2, line 13 for respiratory therapy or columns 1, 2, and 3, line 13 for all other.

Lines 33 through 35--Enter an amount in one of these lines depending on the method utilized.

4019.4 Part IV - Standard and Optional Travel Allowance and Standard Travel Expense Computation - Services outside Provider Site--This part provides for the computation of the standard travel allowance, the standard travel expense, the optional travel allowance, and the optional travel expense. (See CMS Pub. 15-1, *chapter 14,* §§1402ff, 1403.1 and 1412.6.)

Lines 36 *through* 39--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with offsite visits. Only use these lines if you do not use the optional method of computing travel. A standard travel allowance is recognized for each visit to a patient's residence. If services are furnished to more than one patient at the same location, only one standard travel allowance is permitted, regardless of the number of patients treated.

Lines 40 *through* 43--Complete the optional travel allowance and optional travel expense computations for physical therapy, occupational therapy, and speech pathology services in conjunction with home health services only. Compute the optional travel allowance on lines 40 through 42. Compute the optional travel expense on line 43.

Lines 44 *through* 46--Choose and complete only one of the options on lines 44 through 46. However, use lines 45 and 46 only if you maintain time records of visits. (See CMS Pub. 15-1, *chapter 14,* §1402.5.)

4019.5 Part V - Overtime Computation--This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for you in excess of your standard work week. No overtime allowance is given to a therapist who receives an additional allowance for supervisory or administrative duties. (See CMS Pub. 15-1, *chapter 14,* §1412.4.)

Line 47--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 5 are either zero or, equal to or greater than 2080, the overtime computation is not applicable. Make no further entries on lines 48 through 55 (If there is a short period prorate the hours). Enter zero in each column of line 56. Enter in column 5, the sum of the hours recorded in columns 1, 3, and 4, for respiratory therapy, and columns 1 through 3, for physical therapy, speech pathology, and occupational therapy.

Line 48--Enter in the appropriate column the overtime rate (the AHSEA from line 10, column as appropriate, multiplied by 1.5).

Line 50--Enter the percentage of overtime hours by class of employee. Determine this amount by dividing each column on line 47 by the total overtime hours in column 5, line 47.

Line 51--Use this line to allocate your standard work year for one full-time employee. Enter the numbers of hours in your standard work year for one full-time employee in column 5. Multiply the standard workyear in column 5 by the percentage on line 50 and enter the result in the corresponding columns.

Line 52--Enter in columns 1 through 3, for physical therapy, speech pathology, and occupational therapy the AHSEA from Part I, line 10, columns 2 through 4, as appropriate. Enter in columns 1, 3, and 4, the AHSEA from Part I, line 10, columns 2, 4, and 5, for respiratory therapy.

Line 56--Enter in column 5, the sum of the amounts recorded in columns 1, 3, and 4, for respiratory therapy, and columns 1 through 3, for physical therapy, speech pathology, and occupational therapy.

4019.6 Part VI - Computation of Therapy Limitation and Excess Cost Adjustment--This part provides for the calculation of the adjustment to the therapy service costs in determining the reasonableness of therapy cost.

Line 58--Enter the amount reported on lines 33, 34, or 35.

Line 59--Enter the amount reported on lines 44, 45, or 46.

Lines 61 and 62--When the outside supplier provides the equipment and supplies used in furnishing direct services to your patients, the actual cost of the equipment and supplies incurred by the outside supplier (as specified in CMS Pub 15-1, *chapter 14,* §1412.1) is considered an additional allowance in computing the limitation.

Line 64--Enter the amounts paid and/or payable to the outside suppliers for the hospital, if applicable, for therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime, or any other expenses related to supplying therapy services for you. Add all subscripted lines together for purposes of calculating the amount to be entered on this line.

Line 65--Enter the excess cost over the limitation, i.e., line 64 minus line 63. If the amount is negative, enter a zero. Transfer this amount to Worksheet A-8, line 23, for respiratory therapy; line 24, for physical therapy; line 30, for occupational therapy; and line 31, for speech pathology.

4020. WORKSHEET B, PART I - COST ALLOCATION - GENERAL SERVICE COSTS AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

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

The provider can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the contractor, in writing, 90 days prior to the end of that reporting period. The contractor has 60 days to make a decision and notify the provider of that decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or should demonstrate simplification in maintaining the changed statistics. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (see CMS Pub. 15-1, *chapter 23,* §2313)

Simplified Cost Allocation Methodology

As an alternative approach to the cost finding methods identified in CMS Pub. 15-1, *chapter 23,* §2306, the provider may request a simplified cost allocation methodology. This methodology reduces the number of statistical bases a provider maintains. It may result in reducing Medicare reimbursement. A comparison is recommended if the possible loss reimbursement is surpassed by the reduced costs of maintaining voluminous statistics. The following statistical bases must be used for purposes of allocating overhead cost centers. There can be no deviation of the prescribed statistics and it must be utilized for all the following cost centers.

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

NOTE: The election of the alternative method discussed above cannot result in inappropriately shifting costs.

*Contract labor is not included and is not grossed up.
**If this is a meals on wheels program, a Worksheet A-8 adjustment is required.

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

The 90-day and 60-day rule previously discussed in this section still applies (CMS Pub. 15-1, *chapter 23,* §2313).

Continuation of the Standard Allocation Methodology Instructions

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

All direct *GME* costs (inpatient and outpatient in approved programs) are reimbursed based on a specific amount per resident as computed on Worksheet E-4. Costs applicable to interns and residents must still be allocated in columns 21 and 22. These costs are, however, eliminated from total costs in column 25, unless you qualify for an exception. See the instructions for column 25 for a more detailed explanation.

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

NOTE: General service columns 1 through 23, and subscripts thereof, must be consistent on Worksheets B, Parts I, and II; H-2, Part I; J-1, Part I; K-5, Part I; and L-1, Part I.

The statistical basis shown at the top of each column on Worksheet B-1 is the recommended basis of allocation of the cost center indicated which must be used by all providers completing this form (Form *CMS-2552*-10), even if a basis of allocation other than the recommended basis of allocation was used in the previous iteration of the cost report (Form *CMS-2552*-96). If a different basis of allocation is used, you must indicate the basis of allocation actually used at the top of the column subject to the applicable provisions of CMS Pub 15-1, *chapter 23,* §2313. Additionally, the following overhead cost center statistics can be substituted for the recommended statistics printed on Worksheet B-1 subject to the applicable provisions of CMS Pub 15-1, *chapter 23,* §2313.

Cost Center	Statistical Basis
Housekeeping	Square Footage
Cafeteria	FTEs
Maintenance of Personnel	Eliminate and move to A&G
Medical Records	Gross Patient Revenue

Most cost centers are allocated on different statistical bases. However, for those cost centers with the same basis (e.g., square feet), the total statistical base over which the costs are allocated differs because of the prior elimination of cost centers that have been closed.

The general service cost centers are ordered sequentially such that the cost centers that render the most services to and receive the least services from other cost centers are listed first. When closing the general service cost centers, first close the cost centers that render the most services to and receive the least services from other cost centers. List the cost centers in this sequence from left to right on the worksheets. However, your circumstances may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: General service cost centers are not allocated to provider-based physician (PBP) clinical lab service (line 61) because this cost center is treated as a purchased service under arrangements provided only to program beneficiaries.

If the amount of any cost center on Worksheet A, column 7, has a credit balance, show this amount as a credit balance on Worksheet B, Part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated, do not allocate the general service cost center. Rather, enter the credit balance in parentheses on line 201, as well as on the first line of the column, and on line 202. This enables column 24, line 202, to crossfoot to columns 0 and 4A, line 202, if the provider has intern & resident costs or a post-stepdown adjustment in column 25. However, column 26 will cross foot to columns 0 and 4A, if the provider has no interns & residents costs or a post-stepdown adjustment in column 25. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, Part I, column 26, do not carry forward a credit balance to any worksheet.

On Worksheet B-1, enter on the first line in the column of the cost center being allocated the total statistical base over which the expenses are allocated (e.g., in column 1, capital-related cost - building and fixtures, enter on line 1, the total square feet of the building on which depreciation was taken). For all cost centers to which the capital-related cost is allocated, enter that portion of the total statistical base applicable to each. The sum of the statistical base applied to each cost center receiving the services rendered must equal the total base entered on the first line. Use accumulated cost for allocating administrative and general expenses.

Do not include any statistics related to services furnished under arrangements except if:

- Both Medicare and non-Medicare costs of arranged for services are recorded in your records; or

- Your contractor determines that you are able to (and do) gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if you had furnished such services directly to all patients. (See CMS Pub. 15-1, *chapter 23,* §2314.)

Enter on line 202 of Worksheet B-l the total expenses of the cost center being allocated. Obtain this amount from Worksheet B, Part I, from the same column and line number used to enter the statistical base on Worksheet B-1. (In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 1.)

Divide the amount entered on line 202, by the total statistic entered in the same column on the first line. Enter the resulting unit cost multiplier on line 203. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B, Part I, in the corresponding column and line. (See §4000.1 for rounding standards.)

After applying the unit cost multiplier to all the cost centers receiving the services rendered, the total cost (line 202) of all the cost centers receiving the allocation on Worksheet B, Part I, must equal the amount entered on the first line. Perform the preceding procedures for each general service cost center. Complete the column for each cost center on both Worksheets B, Part I, and B-1 before proceeding to the column for the next cost center.

If a general service cost center has a credit balance at the point it is allocated on Worksheet B, Part I, do not allocate the general service cost centers. However, display the statistic departmentally, but do not calculate a unit cost multiplier for lines 203 and 205 on Worksheet B-1. Use line 204 of Worksheet B-1 in conjunction with the allocation of capital-related costs on Worksheet B, Part II. Complete line 204 for all columns after Worksheets B, Part I, and B-1 are completed and the amount of direct and indirect capital-related cost is determined on Worksheet B, Part II, column 2A. Use line 205 for all columns in allocating the direct and indirect capital-related cost on Worksheet B, Part II. Compute the unit cost multiplier (after the amount entered on line 204 has been determined) by dividing the capital-related costs recorded on line 204 by the total statistic entered in the same column on the first line. Round the unit cost multipliers to six decimal places. (See instructions for Worksheet B, Part II, for the complete methodology and exceptions.)

Do not use line 200 to allocate costs on Worksheet B, Part I.

Since intern and resident costs are segregated into two cost centers, properly allocate general service costs applicable to each center. A listing of general service cost centers which may be applicable and the appropriate allocation to the separate cost centers for the intern and resident costs is presented below.

Cost Center	Salary & Salary Related Fringe Benefits	Other
Capital Related Costs - Bldgs. & Fixtures		X
Capital Related Costs - Movable Equipment		X
Employee Benefits	X	X
Administrative and General	X	X
Maintenance and Repair		X
Operation of Plant		X
Housekeeping		X
Cafeteria	X	X
Maintenance of Personnel		X

After the costs of the general service cost center have been allocated on Worksheet B, Part I, enter in column 24, the sum of the costs in columns 4A through 23 for lines 30 through 201. Once overhead is allocated to these cost centers, they are closed and the costs are not further allocated to the revenue producing cost centers.

Since costs applicable to direct *GME* costs (inpatient and outpatient in approved programs) are reimbursed based on a specific amount per resident, exclude these costs from the total costs in column 26. Enter on each line in column 25, the sum of the amounts shown on each line in columns 21 and 22. If you qualify for the exception (cost reimbursed hospital such as CAHs do not offset I&R costs), enter only the amounts from Worksheet B-2.

In addition, when an adjustment to expenses is required after cost allocation, enter the amount applicable to each cost center in column 25 of Worksheet B, Part I. Corresponding adjustments to Worksheet B, Part II, may be applicable for capital-related cost adjustments. Submit a supporting worksheet showing the computation of the adjustments in addition to completing Worksheet B-2.

NOTE: The amount reported in column 25 must equal both the sum of the amounts shown in columns 21 and 22 and the amount on Worksheet B-2, unless you qualify for the exception. See the instructions for column 25 for a more detailed explanation.

Other examples of adjustments to expenses which may be required after cost allocation are (1) the allocation of available costs between the certified portion and the non-certified portion of a distinct part provider, and (2) costs attributable to unoccupied beds in a hospital with a restrictive admission policy. (See CMS Pub. 15-1, *chapter 23,* §§2342-2344.3.)

After the adjustments have been entered on Worksheet B, Part I, column 25, subtract the amounts in column 25 from the amounts in column 24, and enter the resulting amounts in column 26, for each line. The cost subtotal entered in column 24, line 202 must equal the total costs entered in column 0, line 202.

Transfer the totals in column 26, lines 30 through 46 (inpatient routine service cost centers), lines 50 through 76 (ancillary service cost centers), lines 88 through 93 (outpatient service cost centers), lines 94 through 101 (other reimbursable cost centers), and 105 through 117 (special purpose cost centers) to Worksheet C, Parts I and II, column l, lines 30 through 98. For provider based RHC/FQHCs transfer the total costs to Worksheet M-2.

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

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

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

NOTE: Do not transfer negative numbers.

Column Descriptions

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

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

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

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

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

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

Worksheet B-1, Column 5A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, Part I, column 4A, line 202, and the accumulated cost reported on Worksheet B-1, column 5, line 5. Enter any amounts reported on Worksheet B, Part I, column 4A, for (1) any service provided under arrangements to program patients and which is not grossed up and (2) negative balances. Enter a negative one (-1) in the accumulated cost column to identify the cost center which should be excluded from receiving any A&G costs. If some of the costs from that cost center are to receive A&G costs then enter in the reconciliation column the amount not to receive A&G costs to assure that only those costs to receive overhead receive the proper allocation. Including a statistical cost which does not relate to the allocation of administrative and general expenses causes an improper distribution of overhead. In addition, report on line 5 the administrative and general costs reported on Worksheet B, Part I, column 5, line 5, since these costs are not included on Worksheet B-1, column 5, as an accumulated cost statistic.

For componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 5.03 (Other A&G), the reconciliation column designation must be 5A.03.

Worksheet B-1, Column 5--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-l, column 5, line 5, is the difference between the amounts entered on Worksheet B, Part I, column 4A, and Worksheet B-1, column 5A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

Worksheet B-1, Column 23--Enter the appropriate statistics based on assigned time. If, however, the use of assigned time is not appropriate for that paramedical education program (i.e., a non-direct patient care cost center), a different statistical basis may be used. For example, if you have a paramedical education program for hospital administration, using assigned time as the statistical basis may be inappropriate. Use accumulated costs as the statistical basis for allocating hospital administrative paramedical education program costs.

4021. WORKSHEET B, PART II - ALLOCATION OF CAPITAL-RELATED COSTS

This worksheet provides for the determination of direct and indirect capital-related costs allocated to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within your organization, other general service cost centers, inpatient routine service cost centers, ancillary service cost centers, outpatient service cost centers, other reimbursable cost centers, special purpose cost centers, and nonreimbursable cost centers. Hospitals receiving 100 percent Federal rate for IPPS capital payments complete Worksheet B, Part II, in its entirety.

NOTE: Unless there is a change in ownership or the provider has elected the alternative method described in §4017, the hospital must continue the same cost finding methods (including its cost finding bases) in effect in the hospital's prior cost reporting period. If there is a change in ownership, the new owners may request that the contractor approve a change in order to be consistent with their established cost finding practices. (See CMS Pub. 15-1, *chapter 23,* §2313.)

Part II is completed by all IPPS hospitals and IPPS excluded hospitals which were part of a complex subject to IPPS. Freestanding hospitals excluded from IPPS are not required to complete Part II.

See the instructions for Worksheet A, lines 1 and 2, for a discussion of capital-related costs.

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

Column 0--Where capital-related costs have been directly assigned to specific cost centers on Worksheet A, column 7, in accordance with CMS Pub. 15-1, *chapter 23,* §2307, enter in this column those amounts directly assigned from your records. Where you include cost incurred by a related organization, the portion of these costs that are capital-related costs is considered directly assigned capital-related costs of the applicable cost center. For example, if you are part of a chain organization that includes some costs incurred by the home office of the chain organization in your administrative and general cost center, the amount so included represents capital-related costs included in this column.

Columns l and 2--Obtain the amounts entered in columns l and 2, lines 4 through 199, from the corresponding columns and lines on Worksheet B, Part I.

Column 2A--Enter the sum of columns 0 through 2 for each line.

Enter on line 204 of Worksheet B-l for each column the capital-related costs allocated. Report these costs on the first line of each column on Worksheet B, Part II. (See exceptions below.) Complete a unit cost multiplier for each column by dividing the amount on line 204 of Worksheet B-l by the statistic reported on the first line of the same column. Enter the unit cost multiplier on line 205, and round to six decimal places, e.g., .0622438 is rounded to .062244. The allocation process on Worksheet B, Part II is identical to that used on Worksheets B, Part I, and B-l.

Multiply the unit cost multipliers on line 205 by the portion of the total statistic on Worksheet B-1 applicable to each cost center. Enter the result of each computation on Worksheet B, Part II, respectively, in the corresponding column and line.

After the unit cost multipliers have been applied to all the cost centers, the total cost on Worksheet B, Part II, line 202, of all the cost centers receiving the allocation must equal the amount allocated on the first line of the column. However, this is not true in circumstances described in the second paragraph of exceptions below. Perform these procedures for each general service cost center. Complete the column for each cost center on Worksheets B-1 and B, Part II, before proceeding to the column for the next cost center.

EXCEPTIONS: When a general service cost center is not allocated on Worksheet B, Part I, because it has a negative balance at the point it is to be allocated, the capital-related cost for the same general service cost center on Worksheet B, Part II, is not allocated. Enter the total capital-related cost on line 201, the negative cost center line. This enables column 2A, line 202 to cross foot to column 26, line 202, if no intern and resident cost or post step-down adjustments are identified in column 25. Otherwise column 2A, line 202, will crossfoot to line 24.

When a general service cost center has a negative direct cost balance on Worksheet B, Part I, column 0, and the negative balance becomes positive through the cost allocation process, adjust the amount of capital-related cost determined on Worksheet B, Part II, for that general cost center to reflect the amount allocated on Worksheet B, Part I. Determine the adjusted amounts of capital-related cost allocated on Worksheet B, Part II, by dividing the capital-related cost by the total indirect cost allocated to the specific cost center on Worksheet B, Part I. (Do not include the negative direct cost.) Then multiply that ratio by the net amount allocated on Worksheet B, Part I, for that specific cost center. For cross footing purposes, enter the adjusted capital-related costs on the first line of the column and the differences between the total capital-related cost and the adjusted capital-related cost on line 201 of Worksheet B, Part II. This enables column 2A, line 202, to cross foot to column 26, line 202, if no intern and resident cost or post step-down adjustments are identified in column 25. Otherwise column 2A, line 202, will crossfoot to line 24.

After all the capital-related costs of the general service cost centers have been allocated on Worksheet B, Part II, enter in column 24, the sum of columns 2A through 23, for lines 30 through 201.

When an adjustment to expenses is required after cost allocation, show the amount applicable to each cost center in column 25 of Worksheet B, Part II. Submit a supporting worksheet showing the computation of the adjustment in addition to completing Worksheet B-2.

Adjustments to expenses which may be required after cost allocation include (1) the allocation of available costs between the certified portion and the noncertified portion of a distinct part provider and (2) costs attributable to unoccupied beds of a hospital with a restrictive admission policy. (See CMS Pub. 15-1, *chapter 23,* §§2342-2344.3.)

After the adjustments have been entered on Worksheet B, Part II, column 25, subtract the amounts in column 25 from the amounts in column 24, and enter the resulting amounts in column 26, for each line. The total costs entered in column 26, line 202, must equal the total costs entered in column 2A, line 202, if no intern and resident cost or post step-down adjustments are identified in column 25, otherwise column 2A, line 202, will equal line 24.

On Worksheet B, Part II, columns 19 through 23, lines 30 through 194, are shaded because the full amount of nonphysician anesthetists and medical education costs is obtained from Worksheet B, Part I, columns 19 through 23. Enter these amounts on line 200 for cross footing purposes. If column 20 is subscripted for additional education cost centers qualifying as educational pass through costs (see the instructions for Worksheet A, lines 20 through 23), the subscripted column(s) must be shaded similarly to column 20.

4023. WORKSHEET C - COMPUTATION OF RATIO OF COST TO CHARGES AND OUTPATIENT CAPITAL REDUCTION

4023.1 Computation of Ratio of Cost to Charges--This worksheet computes the ratio of cost to charges for inpatient services, ancillary services, outpatient services, and other reimbursable services. All charges entered on this worksheet must comply with *CMS* Pub. 15-1, *chapter 22, §§*2202.4 and 2203. This ratio is used on Worksheet D, Part V, for titles V and XIX and for title XVIII; Worksheet D-3; Worksheet D-4; Worksheet H-3, Part II; and Worksheet J-2, Part II, to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1 because of your status as IPPS, TEFRA, or other.

42 CFR 413.106(f)(3) provides that the costs of therapy services furnished under arrangements to a hospital inpatient are exempt from the guidelines for physical therapy and respiratory therapy if such costs are subject to the provisions of 42 CFR 413.40 (rate of increase ceiling) or 42 CFR 412 (inpatient prospective payment). However, therapy services furnished under arrangements to CAHs are subject to the provisions of 413.106.

42 CFR 415.70(a)(2) provides that RCE limits do not apply to the costs of physician compensation attributable to furnishing inpatient hospital services (provider component) paid for under 42 CFR Part 412ff.

To facilitate the cost finding methodology, apply the therapy limits and RCE limits to total departmental costs. This worksheet provides the mechanism for adjusting the costs after cost finding to comply with 42 CFR 413.106(f)(3) and 42 CFR 415.70(a)(2). This is done by computing a series of ratios in columns 9 through 11. In column 9, a ratio referred to as the "cost or other ratio" is computed based on the ratio of total reasonable cost to total charges. This ratio is used by you or your components not subject to *the* IPPS or TEFRA (e.g., hospital-based SNFs and CAHs). Also use this ratio for Part B services still subject to cost reimbursement. In column 10, compute a TEFRA inpatient ratio. This ratio reflects the add-back of RT/PT limitations to total cost since TEFRA inpatient costs are not subject to these limits. (TEFRA inpatient services are subject to RCE limits.) In column 11, compute an IPPS inpatient ratio. This ratio reflects the add-back of RT/PT and RCE limitations to total cost since inpatient hospital services covered by *the* IPPS are not subject to any of these limitations.

Column Descriptions

The following provider components may be subject to 42 CFR 413.40 or 42 CFR 412.1(a)ff:

- Hospital Part A inpatient services for title XVIII,
- Hospital subprovider Part A inpatient services for title XVIII,
- Hospital inpatient services for titles V and XIX, and
- Hospital subprovider services for titles V and XIX.

All components or portions of components not subject to IPPS, IPF PPS, IRF PPS, LTC PPS, or TEFRA, e.g., CAH services, are classified as "Cost or Other."

The following matrix summarizes the columns completed for Cost or Other, TEFRA Inpatient, and IPPS:

	Columns		
Type of Service Inpatient	Cost or Other	TEFRA Inpatient	IPPS, IPF-PPS, IRF-PPS
Inpatient routine service cost centers (lines 30-46)	1-3	1-3	1-5

Inpatient ancillary (lines 50-93)	1, 8, 9	1-3, 8-10	1-9, 11
Other Reimbursable (lines 94-98)	1, 8, 9	1-3, 8-10	1-9, 11
Other Reimbursable (lines 99-101)	1, 8	1-3, 8	1-8
Special Purpose (lines 105-117)	1, 8	1-3, 8	1-8

Column 1--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 26. Transfer the amount on line 92 from Worksheet D-1, Part IV, line 89, if you do not have a distinct observation bed area. If you have a distinct observation bed area, subscript line 92 into line 92.01, and transfer the appropriate amount from Worksheet B, Part I, column 26. In a complex comprised of an acute care hospital with an excluded unit(s) (excluded from *the* IPPS), only the acute care hospital may report observation bed costs. Any services provided by the RHC/FQHC outside the benefits package for those clinics are reported by the hospital in its appropriate ancillary cost center, but not in the RHC/FQHC cost center lines 88 and 89. Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 26.

Column 2--Enter the amount of therapy limits applied to the cost center on lines 65 to 68. Obtain these amounts from Worksheet A-8, lines 23, 24, 30, and 31 respectively.

NOTE: Complete this column only when the hospital or subprovider is subject to PPS or TEFRA rate of increasing ceiling (see 42 CFR, Part 412, subpart N and P and 42 CFR 413.40, respectively). If the hospital and all subproviders have correctly indicated that their payment system is in the "other" category on Worksheet S-2, do not complete columns 2 through 5, 10, and 11.

Column 3--Enter on each cost center line the sum of columns 1 and 2.

Column 4--Only complete this section if you or your subproviders are subject to IPPS, IPF PPS, IRF PPS, or LTC PPS. Enter on each line the amount of the RCE disallowance. Obtain these amounts from the sum of the amounts for the corresponding line on Worksheet A-8-2, column 17.

Column 5--Complete this section only if you or your subproviders are subject to a PPS. Enter on each cost center line the sum of the amounts entered in columns 3 and 4.

Columns 6 and 7--Enter on each cost center line the total inpatient and outpatient gross patient charges including charges for charity care patients and, where applicable, standard customary charges for items reimbursed on a fee schedule (e.g., DME, oxygen, prosthetics, and orthotics). Also include the total inpatient and outpatient gross charges for cost centers which have a credit balance on Worksheet B, Part I, *c*olumn 26 and, therefore, do not contain "cost" in *c*olumn 1 of Worksheet C, Part I.

Total charges on Worksheet C, Part I, for each department are for provider services only. Therefore, Medicare charges on Worksheets D, Parts II and IV, D-2, D-3, and D-4 must also include provider services only. When reporting charges for a complex, e.g., hospital, subprovider, SNF, charges for like services must be uniform. (See CMS Pub. 15-1, *chapter 22,* §2203.)

When certain services are furnished under arrangements and an adjustment is made on Worksheet A-8 to gross up costs, gross up the related charges entered on Worksheet C, Part I, in accordance with CMS Pub. 15-1, *chapter 23,* §2314. If no adjustment is made on Worksheet A-8, show only the charges you actually billed on Worksheet C, Part I.

NOTE: Any cost center that includes CRNA charges must exclude these charges unless the hospital qualifies for the rural exception as outlined in §4013. All cost centers for which CRNA costs are excluded on Worksheet A-8 must also exclude the charges associated with these costs.

NOTE: Any charges for ancillary services provided to clinic, RHC and FQHC patients must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, laboratory. A similar adjustment must be made to program charges.

Report on line 92, all charges for observation bed services provided in the inpatient routine care area of the hospital. The charges relate to all payer classes and include those observation bed charges for patients released as outpatients and those patients admitted as inpatients. If you have a distinct observation bed unit, report your gross charges on line 92.01 (which was subscripted on Worksheet A).

Column 8--Enter the total of columns 6 and 7.

Column 9 through 11--Cost-to-charge ratios are not calculated for lines 99 through 117. The corresponding locations on Worksheet C, Part I, are shaded.

Column 9, lines 50 through 98--Always complete this column. Divide the cost for each cost center in column 1 by the total charges for the cost center in column 8, to determine the ratio of total cost to total charges (referred to as the "Cost or Other" ratio) for that cost center. Enter the resultant departmental ratios in this column. Round ratios to 6 decimal places.

Column 10, lines 50 through 98--Complete this section only when the hospital or its subprovider is subject to the TEFRA rate of increase ceiling. (See 42 CFR 413.40.) Divide the amount reported in column 3 (which represents the total cost adjusted for the add-back of amounts excluded on Worksheet A-8 for the RT/PT limits) for each cost center by the total charges for the cost center in column 8.

This computation determines the RT/PT adjusted ratio of cost to charges (referred to as the TEFRA inpatient ratio) for each cost center. Enter the resultant departmental ratio. Round ratios to 6 decimal places.

Column 11, lines 50 through 98--Complete this section only when the hospital is subject to *the* IPPS or *the* LTC PPS or when its subprovider is subject to its respective PPS reimbursement methodology. (See 42 CFR 412.1(a) through 412.125, 42 CFR, Part 412, subparts O, N, and P, respectively). Divide the amount reported in column 5 (which represents the total cost adjusted for the add-back of amounts excluded on Worksheet A-8 for the RT/PT and the RCE limits) for each cost center by the total charges for the cost center in column 8.

This computation determines the RCE/RT/PT adjusted ratio of cost to charges (referred to as the PPS inpatient ratio) for each cost center. Enter the resultant departmental ratio. Round ratios to 6 decimal places.

Line Descriptions

Lines 30 *through* 117--These cost centers have the same line numbers as the respective cost centers on Worksheets A, B, and B-1. This design facilitates referencing throughout the cost report.

Therefore, if you have subscripted any lines on those worksheets, you must subscript the same lines on this worksheet.

NOTE: The worksheet line numbers start at line 30 because of the line referencing feature.

Line 200--For each of the columns 1 through 5 (total costs), enter the sum of lines 30 through 199 for all unshaded lines in accordance with Worksheet C, Part I.

For each of the columns 6, 7, and 8 (total charges), enter the sum of lines 30 through 60 and 62 through 199 for all unshaded lines in accordance with Worksheet C, Part I. Since the charges on line 61 are also included on line 60 (laboratory), the charges on line 61 must be excluded to avoid overstating total charges.

Line 201--Enter the amounts from line 92 for columns 1, 3, and 5. Calculate the observation bed cost on line 92 using the routine cost per diem from Worksheet D-1 because it is part of routine costs and, as such, has been included in the amounts reported on line 30 for the hospital. Therefore, in order to arrive at the total allowable costs, subtract this cost to avoid reporting these costs twice.

Line 201, columns 6, 7, and 8, are shaded.

Line 202--For columns 1, 3, and 5, subtract line 201 from line 200, and enter the result.

Transfer Referencing

Costs--The costs of the inpatient routine service cost centers are transferred:

From Worksheet C (Columns 1, 3, or 5)	To
Line 30	Wkst. D-1, Part I, *l*ine 21
Lines 31 - 35	Wkst. D-1, Part II, *l*ines 43 - 47
Line 40, 41, 42 and subscripts	Separate Wkst. D-1, Part I, *l*ine 21
Line 43 (titles V and XIX only)	Wkst. D-1, Part II, *l*ine 42
Line 44 (title XVIII only)	Separate Wkst. D-1, Part I, *l*ine 21
Line 45 and subscripts (titles V and XIX only)	Separate Wkst. D-1, Part I, *l*ine 21

Charges--Transfer the total charges for each of lines 50 through 98, column 8, to Worksheet D, Part IV, column 7, lines as appropriate.

Ratios

Cost or Other Ratios--The "Cost or Other" ratio is transferred from column 9:

For	To
Inpatient ancillary services for titles V, XVIII, Part A, and XIX *furnished by the hospital, subprovider, SNF, NF, swing-bed SNF, and swing-bed NF*	Wkst. D-3, column 1, for each cost center
Ancillary services furnished by the hospital-based HHA	Wkst. H-3, Part II, column 1, line as appropriate

For	To
Hospital-based CMHC (titles V, XVIII, and XIX) shared ancillary services	Wkst. J-2, Part II, column 3, line as appropriate

TEFRA Inpatient Ratio--Transfer the TEFRA inpatient ratio on lines 50 through 94 and 96 through 98 from column 10 for hospital or subprovider components for titles V, XVIII, Part A, and XIX inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) to Worksheet D-3, column 1, for each cost center.

PPS Inpatient Ratio--Transfer the PPS inpatient ratio on lines 50 through 94 and 96 through 98 from column 11 for hospital or subprovider components for titles V, XVIII, Part A, and XIX inpatient services subject to *the* IPPS (see 42 CFR 412.1(a) through 412.125) to Worksheet D-3, column 1, for each cost center. The transfer of the PPS inpatient ratio also applies when the facility is an IPF subject to IPF PPS, a LTCH subject to LTCH PPS, or an IRF subject to IRF PPS (see 42 CFR 412, subparts N, O, and P, respectively).

4023.2 Part II - Calculation of Outpatient Services Cost-to-Charge Ratios Net of Reductions for Medicaid Only.--This worksheet is not applicable for title XVIII. It is only applicable for select state Medicaid programs. This worksheet computes the outpatient cost-to-charge ratios reflecting the following:

- The percentage of capital reduction as identified on Worksheet S-2, Part I, line 95, the applicable column.
- The reduction in reasonable costs of hospital outpatient services (other than the capital-related costs of such services (also known as operating reduction)) is based upon the percentage entered on Worksheet S-2, Part I, line 97, the applicable column.

Column Descriptions

Column 1--Enter the amounts for each cost center from Worksheet B, Part I, column 26, as appropriate. Transfer the amount on line 92 from Worksheet D-1, Part IV, line 89, for the hospital and if you use inpatient routine beds as observation beds. If you have a distinct observation bed area, add subscripted line 92.01 and transfer the appropriate amount from Worksheet B, Part I, column 26. Do not bring forward costs in any cost center with a credit balance from Worksheet B, Part I, column 26.

Column 2--Enter the sum of the amounts for each cost center from Worksheet B, Part II, as appropriate. Do not bring forward costs in any cost center with a credit balance on Worksheet B, Part I, *or* Worksheet B, Part II. For line 92, enter the amounts from Worksheet D-1, Part IV, column 5, line 90. Combine the hospital and subprovider amounts if applicable.

Column 3--For each line, subtract column 2 from column 1, and enter the result.

Column 4--Multiply column 2 by the appropriate capital reduction percentage, and enter the result.

Column 5--Multiply column 3 by the outpatient reasonable cost reduction percentage, and enter the result.

Column 6--Subtract columns 4 and 5 from column 1, and enter the result.

Column 7--Enter the total charges from Worksheet C, Part I, column 8.

Column 8--Divide column 6 by column 7, and enter the result.

4024. WORKSHEET D - COST APPORTIONMENT

Worksheet D consists of the following five parts:

Part I	-	Apportionment of Inpatient Routine Service Capital Costs
Part II	-	Apportionment of Inpatient Ancillary Service Capital Costs
Part III	-	Apportionment of Inpatient Routine Service Other Pass Through Costs
Part IV	-	Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
Part V	-	Apportionment of Medical and Other Health Services Costs

At the top of each part, indicate by checking the appropriate boxes the health care program, provider component, and the payment system, as applicable, for which the part is prepared.

NOTE: Only hospital components subject to PPS or TEFRA complete Worksheet D, Parts I through IV. New children's and new cancer hospitals complete only Worksheet D, Parts III and IV (*l*ine 85 of Worksheet S-2, Part I, has a "Y" response). CAHs do not complete Parts I through IV. Hospital-based SNF and NF providers are added to the Worksheet D, Part III, and will also complete a separate Worksheet D, Part IV.

Line Descriptions for Parts I *t*hrough V

Lines 30 through 43 (for Parts I and III) and lines 44 and 45 (for Part III) and 50 through 98 (for Parts II, IV, and V)--These cost centers have the same line numbers as the respective cost centers on Worksheets A, B, B-1, and C. This design facilitates referencing throughout the cost report. Therefore, any lines subscripted on those worksheets, must subscripted on this worksheet.

4024.1 Part I - Apportionment of Inpatient Routine Service Capital Costs--This part computes the amount of capital-related costs applicable to hospital inpatient routine service costs. Complete only one Worksheet D, Part I, for each title. Report hospital and subprovider information on the same worksheet, lines as appropriate. Complete this part for all payment methods.

Column 1--Enter on each line the capital-related cost for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 26.

Column 2--Compute the amount of the swing-bed adjustment. If you have a swing-bed agreement or have elected the swing-bed optional method of reimbursement, determine the amount for the cost center in which the swing-beds are located by multiplying the amounts in column 1 by the ratio of the amount entered on Worksheet D-1, line 26, to the amount entered on Worksheet D-1, Part I, line 21.

Column 3--For each line, subtract the amount, if any, in column 2 from the amount in column 1, and enter the result.

Column 4--Enter on each line the total patient days, excluding swing-bed days, for that cost center. For line 30, enter the total days reported on Worksheet S-3, Part I, column 8, the sum of lines 1 and 28. For lines 31 through 43, enter the days from Worksheet S-3, Part I, column 8, lines 8 through 12, 13, and 16 *through* 18 (as applicable).

Column 5-- Divide the capital costs of each cost center in column 3 by the total patient days in column 4 for each line to determine the capital per diem cost. Enter the resultant per diem cost in column 5.

Column 6--Enter the program inpatient days for the applicable cost centers. For line 30, enter the days reported on Worksheet S-3, Part I, columns 5, 6, or 7, as appropriate, line 1. For

lines 31 through 43, enter the days from Worksheet S-3, Part I, columns 5, 6, or 7, as appropriate, lines 8 through 12, 13, and 16 *through* 18 (as applicable), respectively.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type inpatient hospital days for purposes of computing the intensive care type inpatient hospital unit per diem. However, count the program days as general routine days in computing program reimbursement. (See CMS Pub. 15-1, chapter 22, §2217.) Add any program days for general care patients of the component who temporarily occupied beds in an intensive care or other special care unit to line 30, and decrease the appropriate intensive care or other special care unit by those days.

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 applicable to inpatient routine services, as applicable.

4024.2 Part II - Apportionment of Inpatient Ancillary Service Capital Costs--This worksheet is provided to compute the amount of capital costs applicable to hospital inpatient ancillary services for titles V, XVIII, Part A, and XIX. Complete a separate copy of this worksheet for 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 B, Part II, column 26. For the hospital component or subprovider, if applicable, enter on line 92 the amount from Worksheet D-1, Part IV, column 1, line 90.

Column 2--Enter on each line the total charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 3--Divide the capital cost of each cost center in column 1 by the charges in column 2 for each line to determine the cost-to-charge ratio. Round the ratios to six decimal places, e.g., round 0321514 to .032151. Enter the resultant departmental ratio in column 3.

Column 4--Enter on each line the appropriate title V, XVIII, Part A, or XIX inpatient charges from Worksheet D-3, column 2. For title XVIII, enter on line 92, the observation bed charges applicable to title XVIII patients subsequently admitted after being treated in the observation area. Enter on line 96, the Medicare charges for medical equipment rented by an inpatient. The charges are reimbursed under the DRG. However, you are entitled to the capital-related cost pass through applicable to this medical equipment.

NOTE: Program charges for PPS providers are reported in the cost reporting period in which the discharge is reported. TEFRA providers report charges in the cost reporting period in which they occur.

Do not include in Medicare charges any charges identified as MSP/LCC.

Column 5--Multiply the capital ratio in column 3 by the program charges in column 4 to determine the program's share of capital costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

4024.3 Part III - Apportionment of Inpatient Routine Service Other Pass Through Costs--This part computes the amount of pass through costs other than capital applicable to hospital inpatient routine service costs. Determine capital-related inpatient routine service costs on Worksheet D, Part I. Complete only one Worksheet D, Part III, for each title. Report hospital, subprovider, hospital-based SNF and NF/ICF-*IID* (if applicable) information on the same worksheet, lines as appropriate. SNFs are now required to report medical education costs as a pass through cost.

Column 1--Transfer from Worksheet B, Part I, column 20, for each applicable line, (plus or minus post step down adjustments reported on Worksheet B-2, if applicable), the applicable medical education costs for nursing school when Worksheet S-2, Part I, line 60, is yes. Do not transfer the costs if the response is no.

Column 2--Transfer from Worksheet B, Part I, column 23, for each applicable line, (plus or minus post step down adjustments reported on Worksheet B-2, if applicable), the applicable medical education costs for paramedical education (allied health) when Worksheet S-2, Part I, line 60, is yes. Do not transfer the costs if the response is no.

Column 3--Transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, plus or minus post step down adjustments (reported on Worksheet B-2), the applicable medical education costs for interns and residents when Worksheet S-2, Part I, line 57, column 1, is yes, and column 2, is no. Otherwise do not transfer the costs.

NOTE: If you qualify for the exception in 42 CFR 413.77(e)(1), because this is the first cost reporting period in which you are training residents in approved programs and the residents were not on duty during the first month of this cost reporting period, then all direct *GME* costs are reimbursed as a pass through based on reasonable cost.

Column 4--Compute the amount of the swing-bed adjustment. If you have a swing-bed agreement, determine the amount for the cost center in which the swing-beds are located by multiplying the sum of the amounts in columns 1 through 3 by the ratio of the amount entered on Worksheet D-1, Part I, line 26, to the amount entered on Worksheet D-1, Part I, line 21.

Column 5--Enter the sum of columns 1 through 3 (including subscripts) minus column 4.

Column 6--Enter on each line the total patient days, excluding swing-bed days, for that cost center. Transfer these amounts from the appropriate Worksheet D, Part I, column 4. For SNFs enter total patient days from Worksheet S-3, Part I, column 8, line 19.

Column 7--Enter the per diem cost for each line by dividing the cost of each cost center in column 5 by the total patient days in column 6.

Column 8--Enter the program inpatient days for the applicable cost centers. Transfer these amounts from the appropriate Worksheet D, Part I, column 6. For SNF (line 44) enter the program days from Worksheet S-3, Part I, column 6, line 19.

Column 9--Multiply the per diem cost in column 7 by the inpatient program days in column 8 to determine the program's share of pass through costs applicable to inpatient routine services, as applicable. Transfer the sum of the amounts on lines 30 through 35 and 43 to Worksheet D-1, Part I, line 50, for the hospital. If you are a title XVIII hospital paid under *the* IPPS, also transfer this sum to Worksheet E, Part A, line 57. Transfer the amounts on lines 40 through 42 to the

appropriate Worksheet D-1, line 50, for the subprovider. Also transfer the amount on line 40 to Worksheet E-3, Part II, line 28, and the amount on line 41 to Worksheet E-3, Part III, line 29. For hospital-based SNF, NF or ICF/*IID* that follow Medicare principles, transfer the amount in column 9, line 44, to Worksheet E-3, Part VI, line 2, or for NF or ICF/*IID* to Worksheet E-3, Part VII, line 26, as applicable.

4024.4 Part IV - Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs--The TEFRA rate of increase limitation applies to inpatient operating costs. In order to determine inpatient operating costs, it is necessary to exclude capital-related and medical education costs as these costs are reimbursed separately. Hospitals and subprovider components subject to *the* IPPS and/or *the Outpatient Prospective Payment System (*OPPS*)* must also exclude direct medical education costs as these costs are reimbursed separately. Determine capital-related inpatient ancillary costs on Worksheet D, Part II. SNFs are required to report medical education costs as a pass through cost. Prepare a separate Worksheet D, Part IV for the SNF and NF or ICF/*IID* (if applicable).

This worksheet is provided to compute the amount of pass through costs other than capital applicable to hospital inpatient and outpatient ancillary services for titles V, XVIII, Part A, and XIX. Complete a separate copy of this worksheet for 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--Transfer from Worksheet B, Part I, column 19, for each applicable line (plus or minus any adjustments reported on Worksheet B-2, if applicable) the nonphysician anesthetist's costs which qualify for a reasonable cost payment in accordance with 42 CFR 412.113(c). (See also §4013, line 19, description for more information.)

Column 2--Transfer from Worksheet B, Part I, column 20, for each applicable line, (plus or minus post step down adjustments made on Worksheet B-2, if applicable), the applicable medical education costs for nursing school when Worksheet S-2, Part I, line 60, is yes. Do not transfer the costs if the response is no. For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 91.

Column 3--Transfer from Worksheet B, Part I, column 23, for each applicable line, (plus or minus post step down adjustments made on Worksheet B-2, if applicable), the applicable medical education costs for paramedical education (allied health) when Worksheet S-2, Part I, line 60, is yes. Do not transfer the costs if the response is no. For the hospital component only, enter on line 92, the observation bed amount from Worksheet D-1, Part IV, column 5, line 92.

Column 4--Transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, (plus or minus post step down adjustments made on Worksheet B-2, if applicable), the applicable medical education costs for interns and residents when Worksheet S-2, Part I, line 57, column 1, is yes and column 2 is no, otherwise do not transfer the costs. For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 93.

NOTE: If you qualify for the exception in 42 CFR 413.77(e)(1) because this is the first cost reporting period in which you are training residents in approved programs and the residents were not on duty during the first month of this cost reporting period, then all direct *GME* costs for interns and residents in approved programs are reimbursed as a pass-through based on reasonable cost.

Column 5--This column represents total inpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 1 through 4, and applicable subscripts.

Column 6--This column represents outpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 2, 3, and 4 and applicable subscripts.

Column 7--Enter on each line the charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 8--Divide the cost of each cost center in column 5 by the charges in column 7, 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 ratio in column 8.

Column 9--This column computes the outpatient ratio of cost to charges. Divide the cost of each cost center in column 6 by the charges in column 7, 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 ratio in column 9.

Column 10--Enter on each line titles V, XVIII, Part A, or XIX inpatient charges from Worksheet D-3. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 11--Multiply the ratio in column 8 by the charges in column 10 to determine the program's share of pass through costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

For hospitals and subproviders, transfer column 11, line 200, to Worksheet D-1, Part II, column 1, line 51. If you are an IPPS hospital, also transfer this amount to Worksheet E, Part A, line 58. If you are an IPF or IPF subprovider, also transfer this amount to Worksheet E-3, Part II, line 28. If you are an IRF or IRF subprovider, also transfer this amount to Worksheet E-3, Part III, line 29. For SNFs, for title XVIII transfer the amount on line 200 to Worksheet E-3, Part VI, line 3, or titles V and XIX, SNFs, NFs and ICF/*IIDs* to Worksheet E-3, Part VII, line 26, as applicable.

Column 12--Enter on each line titles XVIII, Part B, V or XIX (if applicable) outpatient charges from Worksheet D, Part V, column 2, and applicable subscripts. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 13--Multiply the ratio in column 9 by the charges in column 12 to determine the program's share of pass through costs applicable to titles XVIII, Part B, V or XIX (if applicable) outpatient ancillary services, as appropriate.

For providers subject to *the* OPPS, transfer column 13, line 200, to Worksheet E, Part B, line 9.

4024.5 Part V - Apportionment of Medical and Other Health Services Costs--This worksheet provides for the apportionment of costs applicable to hospital outpatient services reimbursable under titles V, XVIII, and XIX. Title XVIII is reimbursed in accordance with 42 CFR 413.53. For services rendered on and after August 1, 2000, outpatient services are subject to *the OPPS*.

Enter in the appropriate cost center the program charges from the PS&R or from provider records.

Providers exempt from outpatient PPS (i.e., CAHs), complete columns 3, 4, 6, and 7. All other providers subscript columns 2 and 5 as necessary. Include charges for vaccine, i.e., pneumococcal, flu, hepatitis, and osteoporosis as indicated on line 73 below.

Exclude charges for which costs were excluded on Worksheet A-8. For example, CRNA costs reimbursed on a fee schedule are excluded from total cost on Worksheet A-8. For titles V and XIX, enter the appropriate outpatient service charges.

NOTE: Do not enter CORF, OPT, OSP, OOT, or CMHC charges on Worksheet D, Part V. Report only charges for CMHCs on Worksheet J-2.

For title XVIII, complete a separate Worksheet D, Part V, for each provider component as applicable. Enter the applicable component number in addition to the hospital provider number. Make no entries in columns 5 through 7 of this worksheet for any cost centers with a negative balance on Worksheet B, Part I, column 26. However, complete columns 1 through 4 for such cost centers.

In accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108, the Temporary Payroll Tax Cut Continuation Act of 2011, section 308, and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, hold harmless payments are extended for rural hospitals with 100 or fewer beds through December 31, 2012; SCHs and EACHs regardless of bed size through February 29, 2012; and SCHs and EACHs with 100 or fewer beds through December 31, 2012. As such, rural hospitals and SCHs or EACHs that qualify and whose cost reporting period overlaps the effective date, (Worksheet S-2, Part I, line 120, column 1 or 2, is yes), must subscript column 2 and enter the applicable charges that correspond to the respective portion of the cost reporting period.

In accordance with ACA 2010, section 3138, cancer hospitals must utilize a predetermined payment-to-cost ratio (PCR) to calculate the corresponding transitional outpatient payment effective for services rendered beginning January 1, 2012. The PCR may be revised each calendar year. Where the cost reporting period overlaps a PCR revision date, subscript column 2 and the corresponding column 5 to represent the portion of the cost reporting period that corresponds to each unique PCR. See section 4030.2 for further instruction/information.

Column 1--Enter on each line in column 1 the ratio from the corresponding line on Worksheet C, column 9.

Columns 2 through 4--General Instructions--Do not include in Medicare charges any charges identified as MSP/LCC.

Column 2--PPS Reimbursed Services--Enter the charges for services rendered which are subject to *PPS*. These charges should not include services paid under the fee schedule such as physical therapy, speech pathology or occupational therapy. Create separate subscripted column (e.g. 2.01, 2.02) when a cost reporting period overlaps the effective dates for the various transitional corridor payments and/or when a provider experiences a geographic reclassification from urban to rural. However, no subscripting is required when a provider geographically reclassifies from rural to urban. The subscripting of this column will directly correspond to the subscripts of Worksheet E, Part B, lines 2 through 8.

Do not include in any column services excluded from *the* OPPS because they are paid under another fee schedule, e.g., rehabilitation services and clinical diagnostic lab.

Column 3--Cost Reimbursed Services Subject to Deductibles and Coinsurance--Enter the charges for services rendered which are subject to cost reimbursement. This includes services rendered by CAHs.

Include the charges for drugs and supplies related to ESRD dialysis (excluding EPO and Aranesp, and any drugs or supplies paid under the composite rate), and corneal tissue on line 73.

Column 4--Cost Reimbursed Services Not Subject to Deductibles and Coinsurance--Vaccine Cost Apportionment--This column provides for the apportionment of costs which are not subject to deductible and coinsurance i.e., Pneumococcal, Influenza, Hepatitis B, and Osteoporosis. Enter such charges for services which are not subject to deductible and coinsurance.

Column 5--Multiply the charges in column 2 and subscripts, if necessary, by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Column 6--Multiply the charges in column 3 by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Column 7--Multiply the charges in column 4 by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Line Descriptions

Line 60--Generally, for title XVIII, Medicare outpatient covered clinical laboratory services are paid on a fee basis, and should not be included on this line. Outpatient CAH clinical laboratory services will be paid on a reasonable cost basis not subject to deductibles and coinsurance. In addition, hospital outpatient laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area will also be paid on a reasonable cost basis not subject to deductibles and coinsurance, for cost reporting periods beginning on or after July 1, 2010, but before July 1, 2012 (Patient Protection and Affordable Care Act of 2010, section 3122, amended by the MMEA, §109). For title V and XIX purposes, follow applicable State program instructions.

For CAHs, outpatient clinical laboratory diagnostic tests are paid at 101 percent of reasonable costs, and the beneficiary is not required to be physically present in the CAH at the time the specimen is collected. As such, enter the corresponding charges on this line. See MIPPA 2008, section 148 and CR 6395, transmittal 1729, dated May 8, 2009.

Line 61--Enter the program charges for provider clinical laboratory tests for which the provider reimburses the pathologist. See §4013 for a more complete description on the use of this cost center. For title XVIII, do not include charges for outpatient clinical diagnostic laboratory services. For titles V and XIX purposes, follow applicable State program instructions.

NOTE: Since the charges on line 61 are also included on line 60, laboratory, reduce the total charges to prevent double counting. Make this adjustment on line 201.

Line 71--Enter in columns 2 and 3, the charges for medical supplies charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics.

Line 72--Enter in columns 2 and 3, the charges for implantable devices charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics.

Line 73--Enter the program charges for drugs charged to patients. Enter in column 2, charges for vaccines and drugs reimbursed at 100 percent under *the* OPPS. Include in column 3, charges for drugs paid at 80 percent of cost subject to deductibles and coinsurance, such as osteoporosis drugs and drugs paid under *the* OPPS such as hepatitis vaccines. Include in column 4, vaccine charges for vaccines reimbursed at 100 percent of cost such as pneumococcal and influenza vaccines not subject to deductibles and coinsurance.

Line 74--The only renal dialysis services entered on this line are for inpatients that are not reimbursed under the composite rate regulations. (See 42 CFR 413.170.) Therefore, include only inpatient Part B charges on this line in column 3. Enter the related costs in column 6.

4025. WORKSHEET D-1 - COMPUTATION OF INPATIENT OPERATING COST

This worksheet provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment). All providers must complete this worksheet.

Complete a separate copy of this worksheet for the hospital (including CAH), each subprovider, hospital-based SNF, and hospital-based other nursing facility. Also, complete a separate copy of this worksheet for each health care program under which inpatient operating costs are computed. When this worksheet is completed for a component, show both the hospital and component numbers.

At the top of each page, indicate by checking the appropriate line the health care program, provider component, and the payment system for which the page is prepared.

Worksheet D-1 consists of the following four parts:

Part I - All Provider Components
Part II - Hospital and Subproviders Only
Part III - Skilled Nursing Facility, Other Nursing Facility, and ICF/*IID* Only
Part IV - Computation of Observation Bed Pass Through Cost

NOTE: If you have made a swing-bed election for your certified SNF, treat the SNF costs and patient days as though they were hospital swing-*bed SNF-type* costs and patient days on Parts I and II of this worksheet. Do not complete Part III for the SNF. (See CMS Pub. 15-1, *chapter 22,* §2230.9B.)

Definitions

The following definitions apply to days used on this worksheet.

Inpatient Day--The number of days of care charged to a beneficiary for inpatient hospital services is always documented in units of full days. A day begins at midnight and ends 24 hours later. Use the midnight to midnight method in reporting the days of care for beneficiaries even if the hospital uses a different definition for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. However, do not count the day of discharge or death, or a day on which a patient begins a leave of absence, as a day. If both admission and discharge or death occur on the same day, consider the day a day of admission and count it as one inpatient day.

Include a maternity patient in the labor/delivery room ancillary area at midnight in the census of the inpatient routine (general or intensive) care area only if the patient has occupied an inpatient routine bed at some time since admission. Count no days of inpatient routine care for a maternity inpatient who is discharged (or dies) without ever occupying an inpatient routine bed. However, once a maternity patient has occupied an inpatient routine bed, at each subsequent census include the patient in the census of the inpatient routine care area to which she is assigned, even if the patient is located in an ancillary area (labor/delivery room or another ancillary area) at midnight. In some cases, a maternity patient may occupy an inpatient bed only on the day of discharge if the day of discharge differs from the day of admission. For purposes of apportioning the cost of inpatient routine care, count this single day of routine care as the day of admission (to routine care) and discharge. This day is considered as one day of inpatient routine care. (See CMS Pub. 15-1, *chapter 22,* §2205.2.)

When an inpatient is occupying any other ancillary area (e.g., surgery or radiology) at the census taking hour prior to occupying an inpatient bed, do not record the patient's occupancy in the ancillary area as an inpatient day in the ancillary area. However, include the patient in the inpatient census of the routine care area.

When the patient occupies a bed in more than one patient care area in one day, count the inpatient day only in the patient care area in which the patient was located at the census taking hour.

Newborn Inpatient Day--Newborn inpatient days are the days that an infant occupies a newborn bed in the nursery. Include an infant remaining in the hospital after the mother is discharged who does not occupy a newborn bed in the nursery, an infant delivered outside the hospital and later admitted to the hospital but not occupying a newborn bed in the nursery, or an infant admitted or transferred out of the nursery for an illness in inpatient days. Also, include an infant born in and remaining in the hospital and occupying a newborn bed in the nursery after the mother is discharged in newborn inpatient days.

Private Room Inpatient Day--Private room inpatient days are the days that an inpatient occupies a private room. If you have only private rooms, report your days statistic as general inpatient days. Inpatient private room days are used for computing any private room differential adjustment on Worksheet D-1, Part I if you have a mixture of different type rooms to accommodate patients. Do not count swing-*bed SNF* or swing-*bed NF-type* services rendered in a private room as private room days.

Inpatient Swing-Bed Days--Inpatient swing-bed days are the days applicable to swing-*bed SNF* or swing-*bed NF-type* services. See 413.53(a)(2)

Intensive Care Type Inpatient Days--Intensive care type inpatient days are those days applicable to services rendered in intensive care type inpatient hospital units. These units must meet the requirements specified in CMS Pub. 15-1, *chapter 22,* §2202.7.II.A.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type inpatient hospital days for purposes of computing the intensive care type inpatient hospital unit per diem. However, count the program days as general routine days in computing program reimbursement. (See CMS Pub. 15-1, *chapter 22,* §2217.)

Observation Beds--Observation beds, for purposes of this worksheet, are those beds in general routine areas of the hospital which are not organized as a distinct, separately staffed observation area and which are used to house patients for observation. These beds need not be used full time for observation patients. These beds are not to be confused with a subintensive care unit (i.e., definitive observation unit, a stepdown from intensive care reported as an inpatient cost center following surgical intensive care (line 34)). If you have a distinct observation bed unit (an outpatient cost center), report the costs of this unit on the subscripted line 92.01 on Worksheet A.

4025.1 Part I - All Provider Components--This part provides for the computation of the total general inpatient routine service cost net of swing-bed cost and private room cost differential for each separate provider component. When this worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

Lines 1 through 16--Inpatient days reported, unless specifically stated, exclude days applicable to newborn and intensive care type patient stays. Report separately the required statistics for the hospital, each subprovider, hospital-based SNF, hospital-based other nursing facility and ICF/*IID*. Obtain the information from your records and/or Worksheet S-3, Part I, columns and lines as indicated.

Line 1--Enter the total general routine inpatient days, including private room days, swing-bed days, observation bed days, and hospice days, as applicable. Do not include routine care days rendered in an intensive care type inpatient hospital unit. Enter the total days from Worksheet S-3, Part I, column 8, for the component and lines as indicated: hospitals from lines 7 and 28; subproviders from lines 16 through 18, as applicable, and 28, if applicable; SNFs from line 19; and NFs from line 20. If you answered yes to line 92 of Worksheet S-2, the NF days come from line 19 for the SNF level of care, and line 20 for the NF level of care, and you will need to prepare a separate Worksheet D-1 for each level of care for title XIX.

Line 2--Enter the total general routine inpatient days. Include private room days and exclude swing-bed and newborn days. Hospitals enter the sum of the days entered on Worksheet S-3, Part I, column 8, lines 1 and 28. Subproviders, SNFs, and NFs enter the days from line 1 of this worksheet.

Line 3--Enter the total private room days excluding swing-bed private room days and observation bed days. If you have only private room days, do not complete this line.

Line 4--Enter the result of line 2, minus line 3, minus total observation bed days from Worksheet S-3, Part I, column 8, line 28. The result will be semi-private room days exclusive of swing-bed semi-private room days and observation bed days. If you have only private room days, such days will be included in this line.

NOTE: For purposes of this computation, the program does not distinguish between semi-private and ward accommodations. (See CMS Pub. 15-1, chapter 22, §2207.3.)

Line 5--Enter the total swing-*bed SNF-type* inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all swing-*bed SNF-type* inpatient days.

Line 6--Enter the total swing-*bed SNF-type* inpatient days, including private room days, after December 31 of your cost reporting period. If you are on a calendar year end, enter zero. The sum of lines 5 and 6 equals Worksheet S-3 Part I, line 5, column 8.

Line 7--Enter the total swing-*bed NF-type* inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all swing-*bed NF-type* inpatient days. This line includes title V, title XIX, and all other payers.

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

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

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

Type of Provider	From
Hospital	Wkst. S-3, Part I, cols. 5, 6, or 7, line 1
Subprovider	Wkst. S-3, Part I, cols. 5, 6, or 7, line 16, 17, or 18, as applicable
SNF	Wkst. S-3, Part I, cols. 5, 6, or 7, line 19
NF	Wkst. S-3, Part I, cols. 5, 6, or 7, for SNF only level of care; line 19. If line 92 of Wkst S-2, Part I is a "Y", two D-1s must be completed for title XIX using line 19 for SNF level of care and line 20 for the NF level of care; or line 20 only for NF level of care.

Include private room days and exclude swing-bed and newborn days for each provider component. Add any program days for general care patients of the component who temporarily occupied beds in an intensive care or other special care unit. (See CMS Pub. 15-1, chapter 22, §2217.)

NOTE: If Worksheet S-2, line 92 columns 1 or 2, as applicable is "Y" for yes, then Worksheet D-1 for title XIX (for the SNF and NF component) must be completed. The results are to be combined and transferred to title XIX SNF, Worksheet E-3, Part VII, line 1.

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

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

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

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

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

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

Line 15--Enter, for titles V or XIX only, the total nursery inpatient days from Worksheet S-3, Part I, column 8, line 13.

Line 16--Enter, for titles V or XIX only, the total nursery inpatient days applicable to the program from Worksheet S-3, Part I, columns 5 and 7, respectively, line 13.

Lines 17 *through* 27--These lines provide for the carve-out of reasonable cost of extended care services furnished by a swing-bed hospital. Under the carve out method, the total costs attributable to SNF-type and NF-type routine services furnished to all classes of patients are subtracted from total general inpatient routine service costs before computing the average cost per diem for general routine hospital care. The rates on lines 17 through 20 are supplied by your contractor.

Line 17--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 5 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-1, chapter 22, §2230ff.) *CAHs* do not complete this line.

Line 18--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 6 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-1, chapter 22, §2230ff.) *CAHs* do not complete this line.

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

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

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

For titles V, XVIII, and XIX, enter the amounts from Worksheet C, Part I, line 30 for adults and pediatrics or lines 40, 41, or 42, as applicable for the subprovider, as appropriate:

COST or OTHER	Inpatient - Column 1 (includes CAHs)
TEFRA	Inpatient - Column 3 (includes cancer and children's hospitals)
PPS	Inpatient - Column 5 (includes acute, IPFs, IRFs, & LTCHs)

SNF/NF Inpatient Routine--For title XVIII, transfer this amount from Worksheet C, Part I, column 5, line 44 (SNF). For titles V and XIX, transfer this amount from Worksheet B, Part I, column 26, line 45 (NF) or 45.01 *(* ICF/*IID)*.

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

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

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

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

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

For *CAHs*, subtract the sum of lines 24 and 25 from the amount reported on line 21. Divide that result by the patient days equal to lines 2, 5, and 6 above to arrive at a per diem (*r*etain this amount for the calculation required on lines 38, 64, and 65). Multiply the per diem by the total days reported on lines 5 and 6. Add that result to the amounts reported on lines 24 and 25.

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

Lines 28 *through* 36--All providers must complete lines 28 through 36. PPS providers complete these lines for data purposes only. However, if line 4 equals line 2 above or if line 3 above is zero, you are not to complete these lines.

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

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

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

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

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

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

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

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

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

Line 37--Subtract the private room cost differential adjustment (line 36) from the general inpatient routine service cost net of swing-*bed SNF-type* and *NF-type* costs (line 27) to determine the adjusted general inpatient routine service cost net of swing-*bed SNF-type* service costs, *NF-type* service costs, and the private room accommodation cost differential adjustment. If line 4 equals line 2, enter the amount from line 27 above.

4025.2 Part II - Hospital and Subproviders Only--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX and the calculation of program excludable cost for all hospitals and subproviders. For hospitals reimbursed under TEFRA, it provides for the application of a ceiling on the rate of cost increase for the hospital and subproviders. When the worksheet is completed for a component, show both the hospital and component numbers.

CAHs are also required to complete this worksheet.

Line Descriptions

Line 38--For non-IPPS providers, (includes CAHs), divide the adjusted general inpatient routine service cost (line 37) by the total general inpatient routine service days including private room (excluding swing-bed and newborn) days (line 2) to determine the general inpatient routine service average cost per diem (rounded to two decimal places).

For PPS providers (includes IRFs, IPFs, and LTCHs under 100 percent PPS), divide the sum of lines 36 and 37 by the inpatient days reported on line 2.

For CAHs the per diem, unless there is an adjustment for private room differential, should be equal to the per diem calculated in the formula on line 26. If this is a CAH and there is a private room differential, process as a non-PPS provider.

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

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

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

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

Column 1--Enter the total inpatient cost applicable to the nursery from Worksheet C, Part I, line 43.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient, or IPF, IRF, and LTCH PPS	Column 5

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

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

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

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

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

Column 1--Enter on the appropriate line the total inpatient routine cost applicable to each of the indicated intensive care type inpatient hospital units from Worksheet C, Part I, lines 31 through 35, as appropriate.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient, or IPF, IRF and LTCH PPS	Column 5

Column 2--Enter on the appropriate line the total inpatient days applicable to each of the indicated intensive care type inpatient units. Transfer these inpatient days from Worksheet S-3, Part I, column 8, lines 8 through 12, as appropriate.

Column 3--For each line, divide the total inpatient cost in column 1 by the total inpatient days in column 2 (rounded to two decimal places).

Column 4--Enter on the appropriate line the program days applicable to each of the indicated intensive care type inpatient hospital units. Transfer these inpatient days from Worksheet S-3, Part I, columns 5, 6, or 7, as appropriate, lines 8 through 12.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type unit days for the purpose of computing the intensive care type unit per diem. The days are included in column 2. However, count the program days as general routine days in computing program reimbursement. Enter the program days on line 9 and not in column 4, lines 43 through 47, as applicable. (See CMS Pub. 15-1, *chapter 22,* §2217.)

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

Line 48--Enter the total program inpatient ancillary service cost from the appropriate Worksheet D-3, column 3, line 200.

Line 49--Enter the sum of the amounts on lines 41 through 48. When this worksheet is completed for components, neither subject to prospective payment, nor subject to the target rate of increase ceiling (i.e., "Other" box is checked), transfer this amount to Worksheet E-3, Part V, line 1, or Part VII, line 1, as appropriate. Do not complete lines 50 *through* 63.

For all inclusive rate providers (Method E), apply the percentage to the sum of the aforementioned lines (lines 41 through 48) based on the provider type designated on Worksheet S-2, column 4, line 3 (see CMS Pub. 15-1, *chapter 22, §*2208).

Lines 50 *through* 53--These lines compute total program inpatient operating cost less program capital-related, nonphysician anesthetists, and approved medical education costs. Complete these lines for all provider components.

Line 50--Enter on the appropriate worksheet the total pass through costs including capital-related costs applicable to program inpatient routine services. Transfer capital-related inpatient routine cost from Worksheet D, Part I, column 7, sum of lines 30 through 35 and line 43 for the hospital, and line 40, 41, or 42, as applicable, for the subprovider. Add that amount to the other pass through costs from Worksheet D, Part III, column 9, sum of lines 30 through 35 and line 43, for the hospital, and line 40, 41, or 42, as applicable, for the subprovider.

Line 51--Enter the total pass through costs including capital-related costs applicable to program inpatient ancillary services. Transfer capital-related inpatient ancillary costs from Worksheet D, Part II, column 5, line 200. Add that amount to the other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 52--Enter the sum of lines 50 and 51.

Line 53--Enter total program inpatient operating cost (line 49) less program capital-related, nonphysician anesthetists (if appropriate), and approved medical education costs (line 52).

Lines 54 through 63--Except for those hospitals specified below, all hospitals (and distinct part hospital units) excluded from prospective payment *and "subclause (II)" LTCHs* are reimbursed under cost reimbursement principles and are subject to the ceiling on the rate of hospital cost increases (TEFRA). (See 42 CFR 413.40.) CAHs do not complete these lines as *CAH* reimbursement is based on reasonable cost. The following hospitals are reimbursed under special provisions and, therefore, are not generally subject to TEFRA or prospective payment:

- Hospitals reimbursed under approved State cost control systems (see 42 CFR 403.300 through 403.322);
- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

For your components subject to the *PPS* or not otherwise subject to the rate of increase ceiling as specified above, make no entries on lines 54 through 63.

NOTE: A new non-PPS hospital or subprovider (*l*ines 85 and/or 86 of Worksheet S-2 with a "Y" response) is cost reimbursed for all cost reporting periods through the end of its first 12-month cost reporting period. The 12-month cost reporting period also becomes the TEFRA base period unless an exemption under 42 CFR 413.40(f) is granted. If such an exemption is granted, cost reimbursement continues through the end of the exemption period. The last 12-month period of the exemption is the TEFRA base period.

NOTE: ***For lines 54 through 63:*** *In the FFY 2015 IPPS final rule, (79 FR 50356 (August 22, 2014)), CMS established a payment adjustment under LTCH PPS for hospitals "classified under subclause (II) of subsection (d)(1)(B)(iv)" of the Act (referred to as "subclause (II)" LTCHs), effective for cost reporting periods beginning on or after October 1, 2014, (that is, FFY 2015 and subsequent fiscal years). The payment adjustment is determined based on reasonable cost, as described at 42 CFR 412.526(c).*

Line 54--Enter the number of program discharges including deaths (excluding newborn and DOAs) for the component from Worksheet S-3, Part I, columns 12 through 14 (as appropriate), lines 14 and 16 through 18 (as appropriate). A patient discharge, including death, is a formal release of a patient.

Line 55--Enter the target amount per discharge as obtained from your contractor. The target amount establishes a limitation on allowable rates of increase for hospital inpatient operating cost. The rate of increase ceiling limits the amount by which your inpatient operating cost may increase from one cost reporting period to the next. (See 42 CFR 413.40.)

Line 56--Multiply the number of discharges on line 54 by the target amount per discharge on line 55, to determine the rate of increase ceiling.

Line 57--Subtract line 53 from line 56, to determine the difference between adjusted inpatient operating cost and the target amount.

Line 58 through 62--*New providers and "subclause (II)" LTCHs do not complete lines 58 through 62.* This line provides incentive payments when your cost per discharge for the cost reporting period subject to the ceiling is less than the applicable target amount per discharge. In addition, bonus payments are provided for hospitals who have received PPS exempt payments for three or more previous cost reporting periods and whose operating costs are less than the target amount, expected costs (lesser of actual costs or the target amount for the previous year), or trended costs (lesser of actual operating costs or the target amount in 1996; or for hospitals where its third full cost reporting period was after 1996 the inpatient operating cost per discharge), updated and compounded by the market basket. It also provides for an adjustment when the cost per discharge exceeds the applicable target amount per discharge. If line 57 is zero, enter zero on lines 58 through 62.

Line 58--If line 57 is a positive amount (actual inpatient operating cost is less than the target amount), enter on line 58 the lesser of 15 percent of line 57 or 2 percent of line 56. If line 57 is negative, do not complete line 58 (leave blank); however, complete line 62 for calculation of any adjustments to the operating costs.

Line 59--Enter the inpatient operating cost per discharge updated and compounded by the market basket for each year through the current reporting year.

Line 60--Enter from the prior year cost report, the lesser of the hospital's inpatient operating cost per discharge (line 53 ÷ line 54) or line 55, updated by the market basket.

Line 61--If (line 53 ÷ line 54) is less than the lower of lines 55, 59, or 60, enter the lesser of 50 percent of the amount by which operating costs (line 53) are less than expected costs (line 54 times line 60), or 1 percent of the target amount (line 56); otherwise enter zero. (*See* 42 CFR 413.40(d)(4)(i).)

Line 62--If line 57 is a negative amount (actual inpatient operating cost is greater than the target amount) and line 53 is greater than 110 percent of line 56, enter on this line the lesser of (1) or (2): (1) 50 percent of the result of (line 53 minus 110 percent of line 56) or (2) 10 percent of line 56; otherwise enter zero. (*See* 42 CFR 413.40(d)(3).)

Line 63--Allowable Cost Plus incentive Payment--If line 57 is a positive amount, enter the sum of lines 52, 53, 58, and 61 (if applicable). If line 57 is a negative amount, enter the sum of lines 52, 56, and 62. If line 57 is zero, enter the sum of lines 52 and 56. New providers *and "subclause (II)" LTCHs* enter the lesser of lines 53 or 56, plus line 52.

Line 64--Enter the amount of Medicare swing-*bed SNF-type* inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing-*bed SNF-type* inpatient days on line 10, by the rate used on line 17. For CAHs multiply line 10, times the per diem calculated on line 38.

Line 65--Enter the amount of Medicare swing-*bed SNF-type* inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing-*bed SNF-type* inpatient days on line 11, by the rate used on line 18. For CAHs multiply line 11, times the per diem calculated on line 38.

Line 66--Enter the sum of lines 64 and 65. For CAHs only transfer this amount to Worksheet E-2, column 1, line 1.

Line 67--Enter the amount of titles V or XIX swing-*bed NF-type* inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing-*bed NF-type* inpatient days on line 12, by the rate used on line 19.

Line 68--Enter the amount of titles V or XIX swing-*bed NF-type* inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing-*bed NF-type* inpatient days on line 13, by the rate used on line 20.

Line 69--Enter the sum of lines 67 and 68. Transfer this amount to the appropriate Worksheet E-2, column 1, line 2. If your state recognizes only one level of care obtain the amount from line 66.

4025.3 Part III - *SNF, NF*, and *ICF/IID* Only--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX. Hospital-based SNFs complete lines 70 through 74 and 83 through 86 for data purposes only as SNFs are reimbursed under SNF PPS for title XVIII. Complete lines 70 *through* 89 for titles V and XIX. When this worksheet is completed for a component, show both the hospital and component numbers. Any reference to the nursing facility will also apply to the *ICF*/*IID* unit.

Line Descriptions

Line 70--Enter the hospital-based SNF or other nursing facility routine service cost from Part I, line 37.

Line 71--Calculate the adjusted general inpatient routine service cost per diem by dividing the amount on line 70, by inpatient days, including private room days, shown on Part I, line 2.

Line 72--Calculate the routine service cost by multiplying the program inpatient days, including the private room days in Part I, line 9, by the per diem amount on line 71.

Line 73--Calculate the medically necessary private room cost applicable to the program by multiplying the days shown in Part I, line 14, by the per diem in Part I, line 35.

Line 74--Add lines 72 and 73 to determine the total reasonable program general inpatient routine service cost.

Lines 75 *through* 82--Apportionment of Inpatient Operating Costs for Other Nursing Facilities (NF)--These lines are used for titles V and/or XIX only. For title XVIII Medicare, skip lines 75 through 82, and continue with line 83.

Line 75--Enter the capital-related cost allocated to the general inpatient routine service cost center. For titles V and XIX, transfer this amount from Worksheet B, Part II, column 26, line 45 (NF).

Line 76--Calculate the per diem capital-related cost by dividing the amount on line 75 by the days in Part I, line 2.

Line 77--Calculate the program capital-related cost by multiplying line 76 by the days in Part I, line 9.

Line 78--Calculate the inpatient routine service cost by subtracting line 77 from line 74.

Line 79--Enter the aggregate charges to beneficiaries for excess costs obtained from your records.

Line 80--Enter the total program routine service cost for comparison to the cost limitation. Obtain this amount by subtracting line 79 from line 78.

Line 81--Enter the inpatient routine service cost per diem limitation. This amount is provided by your state contractor.

Line 82--Enter the inpatient routine service cost limitation. Obtain this amount by multiplying the number of inpatient days shown on Part I, line 9 by the cost per diem limitation on line 81.

Line 83--For titles V and XIX, enter the amount of reimbursable inpatient routine service cost determined by adding line 77 to the lesser of line 80 or line 82. If you are a provider not subject to the inpatient routine service cost limit, enter the sum of lines 77 and 80. For title XVIII, enter the amount from line 74.

Line 84-- Enter the program ancillary service amount from Worksheet D-3, column 3, line 200.

Line 85--Enter (only when Worksheet D-1 is used for a hospital-based SNF and NF) the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees to an SNF and/or NF. Include the amount eliminated from total

costs on Worksheet A-8, line 25. If the utilization review costs are for more than one program, the sum of all the Worksheet D-1 amounts reported on this line must equal the amount adjusted on Worksheet A-8, line 25.

Line 86--Calculate the total program inpatient operating cost by adding the amounts on lines 83 through 85. Transfer this amount to the appropriate Worksheet E-3, Part VII, line 1 except for SNFs subject to SNF PPS. For NF and ICF/*IID*, transfer this amount to Worksheet E-3, Part VII, line 1, for titles V and XIX.

4025.4 Part IV - Computation of Observation Bed Pass Through Cost--This part provides for the computation of the total observation bed costs and the portion of costs subject to reimbursement as a pass through cost for observation beds that are only in the general acute care routine area of the hospital. For title XIX, insert the amount calculated for title XVIII for the hospital, if applicable. To avoid duplication of reporting observation bed costs, do not transfer the title XIX amount to Worksheet C.

Line 87--Transfer the total observation bed days from Worksheet S-3, Part I, column 8, line 28. NOTE: Observation days are only recognized and reported in the inpatient routine area of the hospital.

Line 88--Calculate the result of general inpatient routine cost on line 27 divided by line 2.

Line 89--Multiply the number of days on line 87 by the cost per diem on line 88, and enter the result. Transfer this amount to Worksheet C, Parts I and II, column 1, line 92.

Lines 90 through 93--These lines compute the observation bed costs used to apportion the routine pass through costs and capital-related costs associated with observation beds for PPS, TEFRA, and new children's and new cancer providers. Lines 90 through 93 correspond to specific medical education programs reported on Worksheet D, Part III, columns 1, 2, and 3, respectively.

Column 1--For line 90, transfer the amount from Worksheet D, Part I, column 1, line 30, for the hospital. For line 91 through 93, enter the cost from Worksheet D, Part III, columns 1, 2 and 3, line 30.

Column 2--Enter on each line the general inpatient routine cost from line 27. Enter the same amount on each line.

Column 3--Divide column 1 by column 2, for each line, and enter the result. If there are no costs in column 1, enter 0 in column 3.

Column 4--Enter the total observation cost from line 89. Enter the same amount on each line.

Column 5--Multiply the ratio in column 3 by the amount in column 4. Use this cost to apportion routine pass through costs associated with observation beds on Worksheet D, Parts II and IV.

Transfer the amount in column 5:

From	To	To
Wkst. D-1, Part IV	Wkst. D, Part II	Wkst D, Part IV
Col. 5, line 90	Col. 1, line 92	
Col. 5, line 91		Col. 2, line 92
Col. 5, line 92		Col. 3, line 92
Col. 5, line 93		Col. 4, line 92

Columns 8, 9, and 10--Multiply the average cost per day in column 4 by the health care program days in columns 5, 6, and 7, respectively. Enter the resulting amounts in columns 8, 9, and 10, as appropriate, for each cost center.

Outpatient

Column 3--Enter the total charges applicable to each outpatient service area. Obtain the total charges from Worksheet C, column 8, lines 88 through 93.

Column 4--Compute the total outpatient cost-to-charge ratio by dividing costs in column 2 by charges in column 3, for each cost center.

Columns 5, 6, and 7--Enter in these columns program charges for outpatient services. Do not include in Medicare charges any charges identified as MSP/LCC.

Titles V and XIX:

		Sum of	
Description	Enter in col. 5 for title V or col. 7 for title XIX	Worksheet D-3, col. 2	Worksheet D, Part V, sum of cols. 2 - 4 (& applicable subscripts)
RHC	line 21	line 88	line 88
FQHC	line 22	line 89	line 89
Clinic	line 23	line 90	line 90
Emergency	line 24	line 91	line 91
Observation Beds	line 25	line 92	line 92
Other Outpatient	line 26	line 93	line 93

Title XVIII:

		From			
Description Charges	Enter in col. 6 for Title XVIII	Worksheet D-3, col. 2	Worksheet D, Part V cols. 2 - 4 (& applicable subscripts)		Less Part A Only
RHC	line 21	line 88	plus	line 88 minus	
FQHC	line 22	line 89	plus	line 89 minus	From
Clinic	line 23	line 90	plus	line 90 minus	Provider
Emergency	line 24	line 91	plus	line 91 minus	Records
Observation Beds	line 25	line 92	plus	line 92 minus	
Other Outpatient	line 26	line 93	plus	line 93 minus	

NOTE: Submit a reconciliation worksheet with the cost report showing the computations used for the charges for column 6.

If you have subproviders, the amounts entered in these columns are the sum of the hospital and subprovider Worksheets D-3 and D, Part V.

Columns 8, 9, and 10, lines 21 *through* 26--Compute program outpatient costs for titles V and XIX and title XVIII, Part B cost by multiplying the cost-to-charge ratio in column 4 by the program outpatient charges in columns 5, 6, and 7. Enter the resulting amounts in columns 8, 9, and 10, as appropriate, for each cost center.

Transfer program expenses.

From Title V (Column 8)/Title XIX (Column 10)

Hospital: Sum of lines 9 and 27	TO	Worksheet E-3, Part VII, line 19
Subprovider: lines 10-12, as applicable	TO	Worksheet E-3, Part VII, line 19
Other Nursing Facility: line 14	TO	Worksheet E-3, Part VII, line 19

From Title XVIII (Column 9) (only if Part II is not utilized)

Hospital: Sum of lines 9 and 27	TO	Worksheet E, Part B, line 22
Subprovider: line 10-12, as applicable	TO	Worksheet E, Part B, line 22
Skilled Nursing Facility: line 13	TO	Worksheet E, Part B, line 22

4026.2 Part II - In An Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only)--This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicare beneficiaries who have Part B coverage and are not entitled to benefits under Part A. (See CMS Pub. 15-1, chapter 4, and *chapter 21,* §2120.) Do not complete this section unless you qualify for the new teaching hospital exception for *GME* payments in 42 CFR 413.77(e)(1).

Column 1--Enter the amounts allocated in the cost finding process to the indicated cost centers. Obtain these amounts from Worksheet B, Part I, sum of the amounts in columns 21 and 22, as adjusted for any post-stepdown adjustments applicable to interns and residents in approved teaching programs.

Column 2--Enter the adjustment for interns and residents costs applicable to swing-bed services but allocated to hospital routine cost. Compute these amounts as follows:

Swing Inpatient Bed Amount	=	Interns and Residents Costs Allocated to Adults & Pediatrics	times	Total *Swing-* Bed Days	divided by	Total Days
For line 30 (SNF)		Wkst. D-2, col. 1, line 29		Wkst. D-1, sum of lines 5 and 6		Wkst. D-1, line 1
For line 31 (NF)		Wkst. D-2, col. 1, line 29		Wkst. D-1, sum of lines 7 and 8		Wkst. D-1, line 1

The amount subtracted from line 29 must equal the sum of the amounts computed for lines 30 and 31.

If you have swing-beds in your IPF subprovider, complete line 38 to adjust for swing-bed costs. Compute the swing-bed amounts as explained above except that the interns and residents costs allocated to adults and pediatrics (line 38) comes from Worksheet D-2, column 1, line 38. The amount subtracted from line 38 must equal the sum of subscripts of line 38, as applicable. If you have swing-beds in your IRF subprovider, complete line 39 to adjust for swing-bed costs. Compute the swing-bed amounts as explained above except that the interns and residents costs allocated to adults and pediatrics (line 39) comes from Worksheet D-2, column 1, line 39. The amount subtracted from line 39 must equal the sum of subscripts of line 39, as applicable.

Column 3--Enter on lines 29, and 38 through 40, as applicable, the amounts in column 1 minus the amount in column 2. Enter on line 30 the amount from column 2. Enter on lines 32 through 36, and 41, the amounts from column 1.

Column 4--Enter the total inpatient days applicable to the various patient care areas of the complex. (See instructions for Part I, column 3. For line 30, this is from Worksheet D-1, sum of lines 5 and 6.)

Column 5--Divide the allocated expense in column 3 by the inpatient days in column 4 to arrive at the average per diem cost for each cost center.

Column 6--Enter on lines 29, 30, 32 through 36, and 38 through 41, as applicable, the total number of days in which inpatients were covered under Medicare Part B but did not have Part A benefits available.

Column 7--Multiply the average per diem cost in column 5 by the number of inpatient days in column 6 to arrive at the expense applicable to title XVIII for each cost center. Transfer the amount on line 30, or lines 38 through 40 if you are a subprovider with a swing-bed, to Worksheet E-2, column 2, line 6.

For columns 1, 3, and 7, enter on line 37, the sum of the amounts on line 29 plus the sum of the amounts on lines 32 through 36.

Transfer the expenses on lines 37 through 41 to the appropriate lines on Part III, column 4, whenever you complete both Parts I and II.

However, when only Part II is completed, transfer the amount entered in column 7, lines 37 through 41 to Worksheet E, Part B, line 22, as appropriate.

4026.3 Part III - Summary for Title XVIII (To be completed only if both Parts I and II are used)--Do not complete this section unless you qualify for the exception for *GME* payments in 42 CFR 413.77(e)(1). This part is applicable to Medicare only and is provided to summarize the amounts apportioned to the program in Parts I and II. This part is completed only if both Parts I and II are used.

Transfer title XVIII expenses.

Description	From Column 6		
Hospital	Line 45	TO	Worksheet E, Part B, line 22
Subprovider	Line 46-48	TO	Worksheet E, Part B, line 22
SNF	Line 49	TO	Worksheet E, Part B, line 22

4027. WORKSHEET D-3 - INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

This worksheet provides for the apportionment of cost applicable to hospital inpatient services reimbursable under titles V, XVIII and XIX as indicated in 42 CFR 413.53. All hospitals filing a full cost report, including CAHs (Worksheet S-2, line 105 is "Y") must complete this worksheet. Complete a separate copy of this worksheet for each sub-provider, distinct part SNF and NF, swing-bed SNF and NF, or any other component. Identify the health care program, provider component, and the payment system by checking the appropriate boxes at the top of the worksheet.

The cost centers on this worksheet have the same line numbers as the respective cost centers on Worksheets A, B, B-1, and C. This design facilitates referencing throughout the cost report.

Column 1--Enter the ratio of cost to charges developed for each cost center from Worksheet C, lines 50 through 94, and 96 through 98. The ratios in columns 10 and 11 of Worksheet C are used only for hospital or subprovider components for titles V, XVIII, and XIX inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) or PPS (see 42 CFR 412, Subpart N, O, or P), respectively. Use the ratios in column 9 in all other cases.

Column 2--Enter from the PS&R or your records the inpatient program charges applicable to the provider component services only (not professional component) in the appropriate cost centers as detailed below. Also include charges for cost centers with a negative balance on Worksheet B, Part I, column 26. Do not include program charges for swing-bed services and Medicare charges identified as MSP/LCC.

Lines 30 through 35--Enter the program charges from the PS&R or your records (hospital only).

Lines 40 through 42--Enter in column 2 the inpatient program charges for the subproviders' component only. For subprovider components do not complete lines 30 through 35 and 43. For a hospital complex, do not complete lines 40 through 42.

Line 43--Enter the charges for your nursery department for which you were reimbursed. Complete this for Medicaid services only.

Line 61--Enter the program charges for your clinical laboratory tests for which you reimburse the pathologist. See the instructions for Worksheet A (see §4013) for a more complete discussion on the use of this cost center.

> **NOTE:** Since the charges on line 61 are also included on line 60, laboratory, you must reduce total charges to prevent double counting. Make this adjustment on line 201.

Line 73--Enter only the program charges for drugs charged to patients that are not paid a predetermined amount.

Lines 88 *through* 90 and 93--Do not enter on these lines program charges related to any inpatient ancillary services (e.g., radiology- diagnostic, laboratory) provided in a clinic, RHC, or FQHC and billed as inpatient services. Instead, reclassify such program charges to the related ancillary cost centers.

Lines 92 and 92.01--Enter on these lines, as applicable, the program charges for observation bed services if the patient was subsequently admitted as an inpatient. However, these program charges can only be reported on the main hospital's (e.g., acute care hospital, freestanding psychiatric hospital, freestanding rehabilitation hospital) Worksheet D-3. (That is, program charges for observation bed services provided to patients subsequently admitted as inpatients to an acute hospital's excluded psychiatric or rehabilitation unit must be reported on Worksheet D-3 of the acute hospital.)

Lines 96 and 97--Do not enter program charges for oxygen rented or sold as the fee schedule applies for these services.

Line 200--Enter the total of the amounts in columns 2 and 3, lines 50 through 94, and 96 through 98.

Line 201--Enter in column 2, program charges for your clinical laboratory tests when the physician bills you for program patients only. Obtain this amount from line 61.

Line 202--Enter in column 2, the amount on line 200 less the amount on line 201.

Transfer the amount in column 2, line 202, as follows:

For title XVIII, Part A (other reimbursement), transfer the amount to Worksheet E-3, Part V, line 8. Do not transfer this amount if you are reimbursed under PPS or TEFRA. No transfers of swing-bed charges are made to Worksheet E-2 since no LCC comparison is made. For titles V and XIX (if not a PPS provider), transfer the amount plus the amount from Worksheet D, Part V, sum of columns 3 and 4, line 202, to Worksheet E-3, Part VII, column 1, line 9.

Column 3--Multiply the indicated program charges in column 2, by the ratio in column 1, to determine the program inpatient expenses.

Transfer column 3, line 200, as follows:

Type of Provider	TO
Hospital	Wkst. D-1, Part II, col. 1, line 48
Subprovider	Wkst. D-1, Part II, col. 1, line 48
SNF	Wkst. D-1, Part III, col. 1, line 84
NF	Wkst. D-1, Part III, col. 1, line 84
Swing-*Bed SNF*	Wkst. E-2, col. 1, line 3
Swing-*Bed NF*	Wkst. E-2, col. 1, line 3

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-*charge* 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 *the* 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 *PPS*. Worksheet E-4 computes total direct *GME* costs.

Worksheet E consists of the following two parts:

Part A - Inpatient Hospital Services Under *the I*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 *the* 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 *redesignation* as a result of the OMB standards for delineating statistical areas adopted by CMS in *FY 2015*, 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, *IME* and *d*isproportionate *s*hare *h*ospital (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 *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.

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 *GME* 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.

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, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 21) to the .405 power) - 1} times {the sum of lines 1, 1.01, 1.02, 1.03, 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, enter the sum of lines 1, 1.01, 1.02, 1.03, 1.04, and 3, multiplied by the factor on line 27. *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--Enter 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 *redesignation* 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 *or column 2,* and *yes* 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, *leave* column 1 blank and *complete* only column 2. For cost reporting periods that begin on October 1, complete only column 2*; however, when the cost reporting period begins on October 1 and overlaps October 1 of the subsequent year, complete column 1 for the first period (October 1 through September 30) and complete column 2 for the remainder of the cost reporting period*.

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 *F*actor 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 *F*actor 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"), *F*actor 3 must be calculated. In determining *F*actor 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 *F*actor 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 *column* 1 and *column* 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, compute the amount by multiplying line 35 times line 35.01, for *column* 1 and *column* 2. 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, *l*ine 35.02 times the number of days in the cost reporting period prior to October 1 divided by the total days in the FF*Y*. Enter in column 2, *l*ine 35.02 times the number of days in the cost reporting period on or after October 1 divided by the total days in the FF*Y*.

For example, a calendar year cost reporting period January 1, 2013 through December 31, 2013, enter zero in column 1, for the period *of J*anuary 1, 2013 through September 30, 201*3, t*his period is prior to FFY 14; enter in column 2, for the period *of O*ctober 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 *of J*anuary 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 O*ctober 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--*SCHs* are paid the highest of the federal payment rate, the hospital-specific rate (HSR) determined based on a *FFY* 1982 base period (see 42 CFR 412.73), the hospital-specific rate determined based on a *FFY* 1987 base period (see 42 CFR 412.75), for cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate determined based on a *FFY* 1996 base period (see 42 CFR 412.77), or for cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate determined based on a *FFY* 2006 base period (see 42 CFR 412.78). *MDHs* are paid the highest of the federal payment rate, or the federal rate plus 75 percent of the amount of the excess over the federal rate of the highest rate for the 1982, 1987, or 2002 (see 42 CFR 412.79), base period hospital specific rate. For SCHs and *MDHs*, enter the applicable hospital-specific payments.

For *SCHs* 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 *SCHs* only (effective for cost reporting periods beginning on or after

January 1, 2009), use the highest of the determined hospital specific rate based on *FFY* 1982, 1987, 1996, or 2006.

For MDH discharges occurring on or after October 1, 2006, and before *October 1, 2017*, an MDH can use a FFY 2002 hospital specific rate. The MDH program ends on *September 30, 2017*.

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 *October 1, 2017*, 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 *n*ursing and *a*llied *h*ealth managed *c*are 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. 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 *FFYs* 2011 through 201*7* (e.g., standard *FFYs*: 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 *FFY (October 1* through *September 30*), use line 70.97 only. For cost reporting periods that overlap October 1 for years 2010 *through 2017*, enter on lines 70.96 *(l*ow-volume adjustment (enter the corresponding federal year for the period prior to *October 1*)) and line 70.97 (*l*ow-volume adjustment (enter the corresponding federal year for the period ending on or after *October 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 *the sum of* lines 69, *70 through 70.88,* 70.90, 70.91, 70.93, 70.94, *and* 70.96 *through* 70.98; *minus the sum of* lines 68, 70.89, 70.92, 70.95, *and 70.99*.

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, *P*art 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 2017 (discharges before October 1, 2017), 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 2017 (discharges before *October 1, 2017*) 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 2017 (discharges before *October 1, 2017*). 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 *the* 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 201*7* (discharges before *October 1, 2017*) 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 *1*. If the cost reporting period is not concurrent with a federal year of October *1* through September *30,* do not include discharges occurring on or after October *1* in this column.

If the provider goes in and out of eligibility for discharges occurring prior to October *1,* add all discharges for the eligibility periods prior to October *1* 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 *1*.

Column 4--Enter amounts related to discharges occurring during the provider's low-volume eligibility period and on or after October *1*. If the cost reporting period is concurrent with a federal year of October *1* through September *30,* report all discharges occurring on or after October *1* in this column. If the provider goes in and out of eligibility for discharges occurring on or after October *1*, add all discharges for the eligibility periods on or after October *1* 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 *1*.

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 federal 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, 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 *FFYs* 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 *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 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, 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 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, enter 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 36)--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 *MDHs*, 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 *October 1, 2017*, 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*, column 1, and, if applicable, column 1.01*.

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*, column 1, and, if applicable, column 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. *If the amounts on lines 20 and/or 20.01, columns 3 and/or 4, or applicable subscripts of either column, pertain to rural status, enter zero.* 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 201*7* (discharges before *October 1, 2017*), 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 1)--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 1)--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 (cols. 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	36						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

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 *FFYs* 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 *36*)--Enter the uncompensated care payments. For cost reporting periods that overlap October 1, 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 *MDHs*, 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 *October 1, 2017*, 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*, column 1, and, if applicable, column 1.01*.

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*, column 1, and, if applicable, column 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. *If the amounts on lines 20 and/or 20.01, columns 2 and/or 3, or applicable subscripts of either column, pertain to rural status, enter zero.* 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 *1)*--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 *1)*--Enter the amount from Worksheet E, Part A, line 70.97, in column 3.

Line 30 (Corresponds to Worksheet E, Part A, *line 70.93*)--Enter the HVBP payment adjustment amount. The PS&R information for Worksheet E, Part A, line *70.93* 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 E, *Part A, line 70.93*.

Line 30.01 (Corresponds to Worksheet E, Part A, line 70.90)--Enter in columns 2 and 3, the HVBP payment adjustment amounts from Worksheet E, Part A, line 102, columns 1 and 2, respectively. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 70.90.

Line 31 (Corresponds to Worksheet E, Part A, *line 70.94*)--Enter the HRR adjustment amount. The PS&R information for Worksheet E, Part A, line 70.9*4*, 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 E, Part A, *line 70.94*.

Line 31.01 (Corresponds to Worksheet E, Part A, line 70.91)--Enter in columns 2 and 3, the HRR adjustment amounts from Worksheet E, Part A, line 104, columns 1 and 2, respectively. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 70.91.

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, *30.01, 31 and 31.01,* 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, *30.01, 31, and 31.01,* 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	36					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)	*70.93*					30
30.01	*HVBP payment adjustment for HSP bonus payment (see instructions)*	*70.90*					*30.01*
31	HRR adjustment (see instructions)	*70.94*					31
31.01	*HRR adjustment for HSP bonus payment (see instructions)*	*70.91*					*31.01*
32	HAC Reduction Program adjustment (see instructions) *(amount in col. 4 to Wkst. E, Pt. A)*	70.99					32

For CAHs enter on this line 101 percent of line 11.

Line 22--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

Provider/Component	Title XVIII Hospital	Title XVIII Subprovider	Title XVIII SNF
Hospital	Part I, col. 9, line 9 plus line 27; or Part II, col. 7, line 37; or Part III, col. 6, line 45	Part I, col. 9, lines 10, 11 or 12; or Part II, col. 7, lines 38, 39 or 40 or Part III, col. 6, line 46, 47 or 48	Part I, col. 9, line 13; or Part II, col. 7, line 41; or Part III, col. 6, line 49

Line 23--Teaching hospitals or 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 21. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 21.

Line 24--Enter the sum of lines 3, 4, 8, and 9, all columns.

Computation of reimbursement Settlement

Line 25--Enter the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for coinsurance, enter on this line the full coinsurance amount not the discounted amount.

Line 26--Enter the deductible and coinsurance relating to the amounts reported on line 24.

NOTE: If these services are exempt from LCC as a result of charges being equal to or less than 60 percent of cost (refer to Worksheet S-2, Part I, lines 155 through 161 columns 1 through 5, as applicable), enter the Part B deductibles billed to program beneficiaries only. Do not enter any Part B coinsurance. For CAHs, enter the deductibles on line 25 and the coinsurance on line 26.

Line 27--Subtract lines 25 and 26 from lines 21 and 24 respectively. Add to that result the sum of lines 22 and 23.

NOTE: If these services are exempt from LCC, (line 21 minus line 25 minus Worksheet D, Part V, line 202, column 7) times 80 percent, then add back Worksheet D, Part V, line 202, column 7, plus lines 22 and 23. Add to that result line 24 minus line 26.

CAHs enter the lesser of (line 21 minus the sum of lines 25 and 26) or 80 percent times the result of (line 21 minus line 25 minus 101% of lab cost (Worksheet D, Part V, column 6, lines 60, 61, and subscripts) minus 101% of costs not subject to deductible and coinsurance (Worksheet D, Part V, column 7, line 202). Add back the aforementioned 101% of lab cost and 101% of cost not subject to deductibles and coinsurance. Add to that result the sum of lines 22 and 23.

Line 28--Enter in column 1 the amount from Worksheet E-4, line 50. Complete this line for the hospital component only.

Line 29--Enter in column 1 the amount from Worksheet E-4, line 36. Complete this line for the hospital component only.

Line 30--Enter in column 1 the sum of columns 1 and 1.01, lines 27 through 29.

Line 31--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, the services are treated as if they were non-program services for cost reporting purposes only. (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 charges in total charges but not in program charges. In this situation, enter no primary payer payment on line 31. 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 charges in program charges, and include the charges in charges for cost apportionment purposes. Enter the primary payer payment on line 31 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 31.

Line 32--Enter line 30 minus line 31.

Line 33--Enter the amount of allowable bad debts for deductibles and coinsurance for ESRD services reimbursed under the composite rate system from Worksheet I-5, line 11.

Allowable bad debts (Exclude bad debts for professional services)

Line 34--Enter from your records allowable bad debts for deductibles and coinsurance net of recoveries for other services, excluding professional services. Do not include ESRD bad debts. These are reported on line 33. Bad debts associated with ambulance services rendered (since these costs are reimbursed on a fee basis) are not allowable. If recoveries exceed the current year's bad debts, lines 34 and 35 will be negative.

Line 35--Multiply the amount (including negative amounts) on line 34 times 70 percent (hospitals and subproviders only). The reduction does not apply to *CAHs*.

For cost reporting periods that begin on or after October 1, 2012, multiply the amount (including negative amounts) on line 34 times 65 percent (hospitals and subproviders only).

For CAHs with cost reporting periods beginning on or after October 1, 2012, multiply the amount on line 34 (including negative amounts) times 88 percent. For cost reporting periods beginning on or after October 1, 2013, multiply the amount on line 34 times 76 percent. For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 34 times 65 percent.

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.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to you (excluding payments made under the composite rate for ESRD services), including amounts paid under PPS, pass through payments, and payments from the supplemental PS&R associated with the Model 4 BPCI. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must also include amounts withheld from your interim payments due to an offset against overpayments applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 7--Enter in columns 2 and 4 the sum of lines 4 through 6. Enter amounts due the program as a negative number. These amounts must agree with amount due provider reported on Worksheet E, Part A, line 71, less the amount on line 71.01; Worksheet E, Part B, line 40, less the amount on line 40.01; Worksheet E-2, line 19, less the amount on line 19.01; Worksheet E-3, Part I, line 18, less the amount on line 18.01; Worksheet E-3, Part II, line 31, less the amount on line 31.01; Worksheet E-3, Part III, line 32, less the amount on line 32.01; Worksheet E-3, Part IV, line 22, less the amount on line 22.01; Worksheet E-3, Part V, line 30, less the amount on line 30.01; and Worksheet E-3, Part VI, line 15, less the amount on line 15.01.

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

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

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

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

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

Data Collection Required for the Health Information Technology Calculation--

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

NOTE: For standard cost reporting periods, the provider will complete lines 30 and 31 in the "as filed" cost report, and the amount computed on line 32 will be transferred to Worksheet S, Part III, column 4. For non-standard cost reporting periods, the "as filed" cost report will display 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 non-standard 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. *The HIT payment calculation uses a Medicare share calculation defined as follows:*

> *EHR Medicare share: (Part A days + Part C days) ÷ [(total inpatient days) × ((total hospital charges - charity care charges) ÷ total hospital charges)].*

The EHR Medicare share is expressed as {(H1/(line 4 × H2)} in the CAH HIT calculation (see following paragraphs), and as {(H2/(line 4 × H3)} for the IPPS hospital HIT calculation (see following paragraphs). The EHR Medicare share calculation is rounded to 4 decimal places, with no rounding of the imbedded calculations.

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 = *l*ine 2 plus line 3. H2 = *t*otal 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 = *l*ine 2 plus line 3. H3 = *t*otal 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 = *t*he 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 *the* 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. *For CAH* title XVIII services, *transfer* 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 *GME* 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.

4033. WORKSHEET E-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT

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

Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA
Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS
Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS
Part IV - Calculation of Medicare Reimbursement Settlement Under LTCH PPS
Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement (CAHs)
Part VI - Calculation of Reimbursement Settlement - All Other Health Services for Part A Services for Title XVIII PPS SNFs
Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services

4033.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA--Use Worksheet E-3, Part I to calculate Medicare reimbursement settlement under TEFRA for cancer *hospitals,* children's hospitals*, and "subclause (II)" LTCHs*.

Line Descriptions

Line 1--Enter the amount from Worksheet D-1, Part II, line 63.

Line 2--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-4, Part III, column 1, line 69. If you are not an approved CTC do not complete line 2.

Line 3--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 4--Enter the sum of lines 1, 2 and 3.

Line 5--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 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

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

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

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

Line 9--Enter the Part A coinsurance.

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

Line 11--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year’s bad debts, lines 11 and 12 will be negative.

Line 12--Multiply the amount (including negative amounts) from line 11 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 13--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 11.

Line 14--Enter the sum of lines 10 and 12.

Line 15--Enter the amount from Worksheet E-4, line 49 for the hospital component only.

Line 16--DO NOT USE 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, *chapter 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, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the *fourth* 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, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the *fourth* 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, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the *fourth* 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, *if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the sixth program year following the new program growth period of the first new program, then prorate the FTE count accordingly. (See* 42 CFR 413.79(e)(1)*.)*

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, beginning with the program year following the new program growth period of the first new program's existence, enter the lower of the FTE count on line 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 *fourth* 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. *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 sixth program year following the new program growth period of the first new program.*

Beginning with the program year that does not coincide with but follows 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.

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 *n*ursing and *a*llied *h*ealth *m*anaged *c*are 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 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, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the *fourth* 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 *fourth* 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, if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the *fourth* 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, *if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the sixth program year following the new program growth period of the first new program, then prorate the FTE count accordingly.*

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

For providers that qualify to receive a cap adjustment (see 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, beginning with the program year following the new program growth period of the first new program's existence, enter the lower of the FTE count on line 7 or the FTE count on line 6. Add to this count the FTEs on line 8 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the *fourth* 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. *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 sixth program year following the new program growth period of the first new program.*

Beginning with the program year that does not coincide with but follows 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.

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 *n*ursing and *a*llied *h*ealth *m*anaged *c*are 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.

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.) *Providers that qualify as "subclause (II)" LTCHs do not complete this worksheet, but rather complete Worksheet E-3, Part I.*

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 *n*ursing and *a*llied *h*ealth *m*anaged *c*are 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.

4033.5 Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement--Use Worksheet E-3, Part V, to calculate reimbursement settlement for Medicare Part A services furnished under cost reimbursement for (1) *CAHs*; and (2) new children's or new cancer hospital*s* exempt from the rate of increase limits in accordance with 42 CFR 413.40(f).

Line Descriptions

Line 1--Enter the inpatient operating costs for the hospital (CAH, new children's hospital, or new cancer hospital) from Worksheet D-1, Part II, line 49.

Line 2--Enter the amount of *n*ursing and *a*llied *h*ealth *m*anaged *c*are payments, if applicable. Only complete this line if your facility is a CAH.

Line 3--If you are approved as a CTC, enter the cost of organ acquisition from Worksheet D-4, Part III, column 1, line 69, when this worksheet is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 3 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

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

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

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

Line *6--For* a new children's or new cancer hospital that is cost reimbursed, enter the result of line 4 minus line 5.

For CAHs: For cost reporting periods beginning before October 1, 2014, (multiply the amount on line 4 by 101 percent) minus the amount on line 5.

For cost reporting periods beginning in FFY 2015 and subsequent years, if the CAH is a meaningful user, (multiply the amount on line 4 by 101 percent) minus the amount on line 5.

If the CAH is not a meaningful user of EHR for cost reporting periods beginning in FFY 2015 and subsequent years, (Worksheet S-2, line 167 is "N") and it does not qualify for a hardship exception (Worksheet S-2, line 168.01 is "N"), calculate line 6 as follows:

For cost reporting periods beginning in FFY 2015 (October 1, 2014 through September 30, 2015), (multiply the amount on line 4 by 100.66 percent) minus the amount on line 5.
For cost reporting periods beginning in FFY 2016 (October 1, 2015 through September 30, 2016), (multiply the amount on line 4 by 100.33 percent) minus the amount on line 5.
For cost reporting periods beginning in FFY 2017 and each subsequent fiscal year (cost reporting periods beginning on or after October 1, 2016), (multiply the amount on line 4 by 100 percent) minus the amount on line 5.

Computation of Lesser of Reasonable Cost or Customary Charges-- This part provides for the computation of the lesser of reasonable cost of services furnished to beneficiaries or customary charges made by you for the same services, as defined in 42 CFR 413.13(a). A new children's or new cancer hospital exempt from the rate of increase limits must complete lines 7 through 16.

CAHs do not complete lines 7 through 16 as they are exempt from the application of the LCC principle.

Line Descriptions

Lines 7 through 16--These lines provide for the accumulation of charges which relate to the reasonable cost on line 6.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, chapter 21, §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-1, chapter 25, §§2570-2577.

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

Line 8--Enter the total charges for inpatient ancillary services from Worksheet D-3, column 2, sum of lines 50 through 98.

Line 9--If you are an approved CTC, enter the organ acquisition charges from Worksheet D-4, Part III, column 3, line 69, when Worksheet E-3, Part V, is completed for the hospital or the hospital component of a health care complex.

Line 10--Enter the sum of lines 7 through 9.

Lines 11 through 14--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or when you fail to make reasonable efforts to collect such charges from those patients. If line 13 is greater than zero, multiply line 10 by line 13, and enter the result on line 14. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 11 through 13. Enter on line 14 the amount from line 10. In no instance may the customary charges on line 14 exceed the actual charges on line 10. (See 42 CFR 413.13(e).)

Line 15--Enter the excess of the customary charges on line 14 over the reasonable cost on line 6.

Line 16--Enter the excess of reasonable cost on line 6 over the customary charges on line 14. Transfer line 16 to line 21.

Line 17--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. CAHs do not complete this line.

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 lines 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/*IIDs*.

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/*IID* - 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.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, chapter 21, §2104.3), and, (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-1, chapter 25, §§2570-2577.

Line 8--Enter in column 1 the program inpatient routine service charges from your records for the applicable component for title V or XIX. This includes charges for both routine and special care units.

The amounts entered on line 8 include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 9--Enter the sum of the appropriate program ancillary charges from Worksheet D, Part V, columns 3 and/or 4, plus subscripts as applicable, line 202 in column 2. Enter charges from Worksheet D-3, column 2, line 202, in column 1.

Line 10--Enter in column 1, for title V or XIX, the organ acquisition charges from line 3.

Line 11--Enter in column 1, for title V or XIX, the amount of the incentive resulting from the target amount computation on Worksheet D-1, Part II, line 58, if applicable.

Line 12--Enter the sum of the amounts recorded on lines 8 through 11.

Lines 13 *through* 16--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or fail to make reasonable efforts to collect such charges from those patients. If line 15 is greater than zero, multiply line 12 by line 15, and enter the result on line 16. If you do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 13 through 15. Enter on line 16, the amount from line 12. In no instance may the customary charges on line 16 exceed the actual charges on line 12.

Line 17--Enter the excess of the customary charges over the reasonable cost. If the amount on line 16 is greater than the amount on line 4, enter the excess.

Line 18--Enter the excess of total reasonable cost over the total customary charges. If the amount on line 4 exceeds the amount on line 16, enter the excess.

Line 19--Enter for title V or XIX, columns 1 and 2, the cost of services rendered by interns and residents as follows from Worksheet D-2:

	Col. 1 Title V	Col. 2 Title V	Col. 1 Title XIX	Col. 2 Title XIX
Hospital	Part I, col. 8, line 9	Part I, col. 8, line 27	Part I, col. 10, line 9	Part I, col. 10, line 27
Subprovider	Part I, col. 8, lines 10-12 as applicable		Part I, col. 10, lines 10-12 as applicable	
Nursing Facility, ICF/*IID*	Part I, col. 8, line 14		Part I, col. 10, line 14	

Line 20--Teaching hospitals or 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 amounts from Worksheet D-5, Part II, column 3, as follows:

Title	From Worksheet D-5, Part II, column 3	To Worksheet E-3, Part VII, line 20:
V	Line 18	Column 1
V	Line 19	Column 2
XIX	Line 22	Column 1
XIX	Line 23	Column 2

For cost reporting periods ending on or after June 30, 2014, transfer the amounts from Worksheet D-5, Part IV, as follows:

Title	From Worksheet D-5, Part IV	To Worksheet E-3, Part VII, line 20:
V	Line 18	Column 1
V	Line 19	Column 2
XIX	Line 22	Column 1
XIX	Line 23	Column 2

Line 21--Enter the lesser of line 4 or line 16. If this is a CAH, or otherwise exempt from lower of cost or charges, transfer the amount from line 4.

Prospective Payment Amount

NOTE: Lines 22 through 26 must only be completed for PPS providers.

Line 22--Enter the total IPPS payments for titles V and/or XIX, as applicable, in column 1. Enter the total OPPS payments for title V or XIX, as applicable, in column 2. Obtain this from your books and records.

Line 23--Enter the amount of outlier payments made for *the* IPPS discharges during the period, in column 1. Enter the outlier payment for *the* OPPS in column 2.

Line 24--Enter in column 1 the payment for inpatient program capital costs from Worksheet L, Part I, line 12; or Part II, line 5, as applicable.

Line 25--Enter in column 1 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 26--Enter in column 1, the routine and ancillary service other pass through costs from Worksheet D, Part III, column 9, line 200, and from Worksheet D, Part IV, column 11, line 200, respectively. Enter in column 2, the amount from Worksheet D, Part IV, column 13, line 200.

Line 27--For each column, enter the sum of lines 22 through 26.

Line 28--For title V or XIX only, enter the customary charges for *the* IPPS in column 1, and *the* OPPS in column 2.

Line 29--For each column, enter the sum of lines 21 and 27.

Computation of Reimbursement Settlement

Line 30--For each column, enter the amount, if any, from line 18.

Line 31--For each column, enter the sum of lines 19 and 20 plus line 29 minus lines 5 and 6.

Line 32--For each column, enter any deductible amounts imposed.

Line 33--For each column, enter any coinsurance amounts imposed.

Line 34--For each column, enter from your records reimbursable bad debts for deductibles and coinsurance net of bad debt recoveries.

Line 35--Enter in column 1, the reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include the amount on this line in the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, Part III, line 85.

Line 36--For each column, enter the sum of lines 31, 34, and 35, minus the sum of lines 32 and 33.

Line 37--For each column, enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Line 38--For each column, enter the result of line 36 plus or minus line 37.

Line 39--Enter the amount from Worksheet E-4, line 31, in column 1.

Line 40--For each column, enter the sum of lines 38 and 39.

Line 41--For each column, enter the interim payments obtained from your records.

Line 42--For each column, enter the result of line 40 minus line 41. Transfer the sum of columns 1 and 2 to Worksheet S, Part III, column 1 (title V) or column 5 (title XIX), line as appropriate.

Line 43--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.

4034. WORKSHEET E-4 - DIRECT GRADUATE MEDICAL EDUCATION (GME) AND ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Use this worksheet to calculate each program's payment (i.e., titles XVIII, V, and XIX) for *direct GME costs* as determined under 42 CFR 413.75 through 413.83. This worksheet applies to the direct *GME* cost applicable to interns and residents in approved teaching programs in hospitals and hospital-based providers. Complete this worksheet if the response to line 56 of Worksheet S-2, Part I, is yes. The direct medical education costs of the nursing school and paramedical education programs continue to be paid on a reasonable cost basis as determined under 42 CFR 413.85. However, the nursing school and paramedical education costs, formerly paid through the ESRD composite rate as an exception, are paid on this worksheet on the basis of reasonable cost under 42 CFR 413.85. Effective for cost reporting periods beginning on or after October 1, 1997, the unweighted direct *GME* FTE is limited to the hospital's FTE count for the most recent cost reporting period ending on or before December 31, 1996. This limit applies to allopathic and osteopathic residents but excludes dentistry and podiatry. The GME payment is also based on the inclusion of Medicare HMO patients treated in the hospital. This worksheet will also calculate payment for direct GME as determined under 42 CFR 413.79(c)(3) and (4) and IME as determined under 42 CFR 412.105(f)(1)(iv)(B) and (C) for hospitals that received an adjustment (reduction or increase) to their FTE resident caps for direct GME and/or IME under section 422 of Public Law 108-173.

NOTE: Do not complete this worksheet for a cost reporting period prior to the base period used for calculating the per resident amount (PRA) in situations where the hospital did not train residents in approved residency training programs or did not participate in the Medicare program during the base period but either condition changed in a cost reporting period beginning on or after July 1, 1985. 42 CFR 413.77(e)(1) specified that in this situation, any GME costs for the cost reporting period prior to the base period are reimbursed on a reasonable cost basis.

Also, do not complete this worksheet for residents training in the general acute care part of a CAH since the associated costs are reimbursed on a reasonable cost basis.

Complete this worksheet if this is the first month in which residents were on duty during the first month of the cost reporting period or if residents were on duty during the entire prior cost reporting period. (See 42 CFR 413.77(e)(1).)

This worksheet consists of five sections:

1. Computation of Total Direct GME Amount
2. Computation of Program Patient Load
3. Direct Medical Education Costs for ESRD Composite Rate - Title XVIII only
4. Apportionment of Medicare Reasonable Cost (title XVIII only)
5. Allocation of Medicare Direct GME Costs Between Part A and Part B

Computation of Total Direct GME Amount--This section computes the total approved amount.

Line Descriptions

Line 1--Enter the unweighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. If this cost report is less than a full 12 months, contact your contractor. (42 CFR 413.79(c)(2)) Also include here the 30 percent increase to the count for qualified rural hospitals (42 CFR 413.79(c)(2)(i)), and the increase due to primary care residents that were on approved leaves of absence (42 CFR 413.79(i)). Temporarily reduce the cap of a hospital that closed a program(s), if the regulations at 42 CFR 413.79(h)(3)(ii) are applicable. (Effective 10/1/2001.)

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 *PPS*. 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.

4040.3 Worksheet G-2, Parts I & II - Statement of Patient Revenues and Operating Expenses--This worksheet requires the reporting of total patient revenues for the entire facility and operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statements, submit a reconciliation report with the cost report submission. If you have more than one hospital-based HHA and/or more than one outpatient rehabilitation provider, subscript the appropriate lines on Worksheet G-2, Part I, to report the revenue for each multiple based facility separately.

Part I - Patient Revenues--Enter total patient revenues associated with the appropriate cost centers on lines 1-9, 11-15, and 18-25.

Line 1--Hospital--Enter revenues generated by the hospital component of the complex. Obtain these amounts from your accounting books and/or records.

Line 2--Subprovider - IPF--Enter revenues generated by the IPF (also referred to as the IPF excluded unit) of the complex. Obtain this amount from your accounting books and/or records.

Line 3--Subprovider - IRF--Enter revenues generated by the IRF (also referred to as the IRF excluded unit) of the complex. Obtain this amount from your accounting books and/or records.

Line 4--Subprovider - Other--Enter revenues generated by components identified as subproviders of the complex that were not identified on lines 2 or 3. Subscript this line as necessary. Obtain these amounts from your accounting books and/or records.

Line 5--Swing-*Bed SNF*--Enter the swing-*bed SNF* revenue from your accounting books and/or records.

Line 6--Swing-*Bed NF*--Enter the swing-*bed* NF revenue from your accounting books and/or records.

Line 7--Skilled Nursing Facility--Enter the skilled nursing facility revenue from your accounting books and/or records.

Line 8--Nursing Facility--Enter the nursing facility revenue from your accounting books and/or records.

Line 9--Other Long Term Care-- Enter the revenue generated from other long term care subproviders from your accounting books and/or records. Subscript this line as necessary.

Line 10--Total General Inpatient Routine Care--Sum of lines 1 through 9.

Line 11--Intensive Care Unit--Enter the intensive care unit revenue from your accounting books and/or records.

Line 12--Coronary Care Unit--Enter the coronary care unit revenue from your accounting books and/or records.

Line 13--Burn Intensive Care Unit--Enter the burn intensive care unit revenue from your accounting books and/or records.

Line 14--Surgical Intensive Care Unit--Enter the surgical intensive care unit revenue from your accounting books and/or records.

Line 15--Other Special Care-- Enter all other intensive care unit revenue not identified on lines 11 through 14 from your accounting books and/or records. Subscript this line as necessary.

Line 16--Total Intensive Care Type Inpatient Hospital--Sum of lines 11 through 15.

Line 17--Total Inpatient Routine Care Services--Sum of lines 10 and 16.

Line 18--Ancillary Services--Enter in the appropriate column revenue from inpatient ancillary services and outpatient ancillary services from your accounting books and/or records.

Line 19--Outpatient Services--Enter in the appropriate column revenue from outpatient ancillary services from your accounting books and/or records.

Line 20--Rural Health Clinic--Enter rural health clinic revenue from your accounting books and/or records. Subscript this line to identify each rural health clinic separately.

Line 21--Federally Qualified Health Center--Enter federally qualified health center revenue from your accounting books and/or records. Subscript this line to identify each federally qualified health center separately.

Line 22--Home Health Agency--Enter home health agency revenue from your accounting books and/or records. If there is more than one home health agency, include the revenues for all home health agencies on this line.

Line 23--Ambulance Services--Enter from your accounting books and/or records the revenue relative to the ambulance service cost reported on Worksheet A, line 95.

Line 24--Outpatient Rehabilitation Providers--Enter in column 2 only, the revenue generated from CMHC, CORF, outpatient therapy providers (OPTs, OOTs and OSPs), and any other outpatient rehabilitation providers. Subscript this line to identify each outpatient rehabilitation provider separately. Obtain this information from your accounting books and/or records.

Line 25--Ambulatory Surgical Center(s)--Enter from your accounting books and/or records the revenue relative to the Ambulatory Surgical Center costs report on Worksheet A, lines 75, and 115.

Line 26--Hospice--Enter from your accounting books and/or records in the appropriate column, the revenue generated from hospice services rendered. If there is more than one hospice, include the revenues for all hospices on this line.

Line 27--Enter in the appropriate column all other revenues not identified on lines 18 through 26.

Line 28--Total Patient Revenues--Enter the sum of lines 17 through 27.

Column 3--For lines 1 *through* 28, enter the sum of columns 1 and 2, as applicable, in column 3.

Part II - Operating Expenses--Enter the expenses incurred that arise during the ordinary course of operating the hospital complex.

Line 29--Operating Expenses--This amount is transferred from Worksheet A, line 200, column 3.

Lines 30-35--Add (Specify)--Identify on these lines additional operating expenses not included in line 27.

Line 36--Total Additions--Enter on line 36, column 2, the sum of lines 30 *through* 35, column 1.

Lines 37 - 41--Deduct (specify)-- Identify on these lines deductions from operating expenses not accounted for included in line 29.

Line 42--Total Deductions--Enter on line 42, column 2, the sum of lines 37 to 41, column 1.

Line 43--Total Operating Expenses--Enter on line 43, column 2, the result of line 29, column 2, plus line 36, column 2, less line 42, column 2.

4040.4 Worksheet G-3 - Statement of Revenues and Expenses--
This worksheet requires the reporting of total revenues for the entire facility and total operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statements, submit a reconciliation report with the cost report submission.

Line 1--Total Patient Revenue--Transfer from Worksheet G-2, Part I, line 28, column 3.

Line 2--Less: Allowance and Discounts on Patient's Accounts--Enter on this line total patient revenues not received. This includes:

Provision for Bad Debts,
Contractual Adjustments,
Charity Discounts,
Teaching Allowances,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Line 3--Net Patient Revenues--Subtract line 2 from line 1.

Line 4--Less: Total Operating Expenses--Transfer from Worksheet G-2, Part II, line 43.

Line 5--Net Income from Service to Patients--Subtract line 4 from line 3.

Lines 6 *through* 23--Enter on the appropriate line 6 through 23 all other revenue not reported on line 1. Obtain these amounts from your accounting books and/or records.

Line 24--Other (Specify)--Enter from hospital books. Enter all other revenue not reported on lines 6 through 23. Obtain this from your accounting books and/or records. Subscript this line as necessary.

Line 25--Total Other Income--Enter the sum of lines 6 through 24.

Line 26--Total--Enter the sum of lines 5 and 25.

Line 27--Other Expenses (Specify)--Enter all other expenses not reported on lines 6 through 24. Subscript this line as necessary.

Line 28--Total Other Expenses--Enter the sum of line 27 and subscripts.

Line 29--Net Income (or Loss) for the Period--Enter the result of line 26 minus line 28.

4041. WORKSHEET H - ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

This worksheet provides for the recording of direct HHA costs such as salaries, fringe benefits, transportation, and contracted services as well as other costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. The direct costs reported in columns 1, 2 and 4 are obtained from your accounting books and records. All of the cost centers listed do not apply to all agencies**.**

The HHA must maintain the records necessary to determine the split in salary (and employee-related benefits) between two or more cost centers and must adequately substantiate the method used to split the salary and employee-related benefits. These records must be available for audit by your contractor. Your contractor can accept or reject the method used to determine the split in salary. Any deviation or change in methodology to determine splits in salary and employee benefits must be requested in writing and approved by your contractor before any change is effectuated. Where approval of a method has been requested in writing and this approval has been received (prior to the beginning of the cost reporting period), the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until your contractor determines that the method is no longer valid due to changes in your operations.

Column 1--Enter all salaries and wages (a salary is the gross amount paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses) for the HHA in this column for the actual work performed within the specific area or cost center. For example, if the administrator spends 100 percent of his/her time in the HHA and performs skilled nursing care which accounts for 25 percent of that person's time, then 75 percent of the administrator's salary is entered on line 5 (administrative and general-HHA), and 25 percent of the administrator's salary is entered on line 6 (skilled nursing care). Enter the sum of column 1, lines 1 through 23, on line 24.

Column 2--Enter all payroll-related employee benefits for the HHA in the appropriate cost center in this column. See CMS Pub. 15-1, *chapter 21,* §§2144-2145 for a definition of fringe benefits. Entries are made using the same basis as that used for reporting salaries and wages in column 1. Therefore, using the same example as given for column 1, 75 percent of the administrator's payroll-related fringe benefits is entered on line 5 (administrative and general - HHA) and 25 percent of the administrator's payroll-related fringe benefits is entered on line 6 (skilled nursing care). Enter the sum of column 2, lines 1 through 23, on line 24.

Report payroll-related employee benefits in the cost center where the applicable employee's compensation is reported. This assignment is performed on an actual basis or upon the following basis:

- FICA based on actual expense by cost center;
- Pension and retirement and health insurance (non-union) based on gross salaries of participating individuals by cost centers;
- Union health and welfare based on gross salaries of participating union members by cost center; and
- All other payroll-related benefits based on gross salaries by cost center.

If the vaccine is administered in the course of an otherwise covered home health visit, the visit is covered as usual, but the cost and charges for the vaccine and its administration must be excluded from the cost and charges of the visit. The HHA is entitled to separate payment for the vaccine and its administration under the Part B vaccine benefit.

The cost of administering pneumococcal, influenza, and hepatitis B vaccines is reimbursed under *the OPPS*, but the actual cost of the pneumococcal, influenza, and hepatitis B vaccines are cost reimbursed. Additionally, the cost of administering the osteoporosis drugs are included in the skilled nursing visit while the actual cost of the osteoporosis drug is reimbursed at reasonable cost.

Enter on this line the vaccine and drug cost (exclusive of the cost to administer these vaccines) incurred for pneumococcal, influenza, and hepatitis B vaccines as well as osteoporosis drugs.

Some of the expenses includable in this cost center are the costs of syringes, cotton balls, bandages, etc., but the cost of travel is not permissible as a cost of administering vaccines, nor is the travel cost includable in the A&G cost center. The travel cost is non-reimbursable. Attach a schedule detailing the methodology employed to develop the administration of these vaccines. These vaccines are reimbursable under Part B only.

Line 14--Enter the direct expenses incurred in renting or *selling DME* items to the patient for the purpose of carrying out the plan of treatment. Also, include all the direct expenses incurred by you in requisitioning and issuing the DME to patients.

Lines 15 *through* 23--Lines 15 *through* 23 identify nonreimbursable services commonly provided by a home health agency. These include home dialysis aide services (line 15), respiratory therapy (line 16), private duty nursing (line 17), clinic (line 18), health promotion activities (line 19), day care program (line 20), home delivered meals program (line 21), and homemaker service (line 22). The cost of all other nonreimbursable services are aggregated on line 23. If you are reporting costs for telemedicine, these costs are to be reported on line 23.50. Use this line throughout all applicable worksheets.

4042. WORKSHEET H-1 - COST ALLOCATION - HHA GENERAL SERVICE COST

Worksheet H-1, Part I, provides for the allocation of the expenses of each HHA general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the home health agency, i.e., other general service cost centers, reimbursable cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet H, column 10. To facilitate transferring amounts from Worksheet H to Worksheet H-1, Part I, the same cost centers with corresponding line numbers (lines 1 through 24) are listed on both worksheets.

Worksheet H-1, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the home health agency general service cost centers on Worksheet H-1, Part I. If there is a difference between the total accumulated costs reported on the Part II statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part II for reporting any adjustments. See §4020 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number.

To facilitate the allocation process, the general format of Parts I and II are identical. The column and line numbers for each general service cost center are identical on both parts. In addition, the line numbers for each general, reimbursable, and nonreimbursable cost centers are identical on the two parts of the worksheet. The cost centers and line numbers are also consistent with Worksheet H.

The statistical bases shown at the top of each column on Worksheet H-1, Part II, are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

When closing the general service cost center, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: The HHA can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the contractor, in writing, 90 days prior to the end of that reporting period. The contractor has 60 days to make a decision and notify the provider of that decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or demonstrate simplification in maintaining the changed statistics. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See CMS Pub. 15-1, *chapter 23,* §2313.)

EXCEPTION: A small freestanding HHA, as defined in 42 CFR 413.24(d), does not have to request written permission to use the procedures outlined for small HHAs below.

From Worksheet H-1, Part I, Column 6	To Worksheet H-2, Part I, Column 0
8	4
9	5
10	6
11	7
12	8
13	9
14	10
15	11
16	12
17	13
18	14
19	15
20	16
21	17
22	18
23	19

4043. WORKSHEET H-2 - ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Use this worksheet only if you operate a certified hospital-based HHA as part of your complex. If you have more than one hospital-based HHA, complete a separate worksheet for each facility.

4043.1 Part I - Allocation of General Service Costs to HHA Cost Centers.--Worksheet H-2, Part I, provides for the allocation of the expenses of each general service cost center of the hospital to those cost centers which receive the services. Worksheet H-2, Part II provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet H-2, Part I.

Obtain the total direct expenses (column 0, line 20) from Worksheet A, column 7, line 101. Obtain the cost center allocations (column 0, lines 1 through 19) from Worksheet H-1, Part I, lines as indicated, the sum of which agrees with the amount entered on column 0, line 20. The amounts on line 20, columns 0 through 23 and column 25 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 23 and column 25, line 101. Complete the amounts entered on lines 1 through 19, columns 1 through 23 and column 25 in accordance with the instructions in §4043.2.

NOTE: Worksheet B, Part I, established the method used to reimburse direct *GME* cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 25, excluded the costs of interns and residents, column 25 on this worksheet must also exclude these costs.

In column 24, Part I, enter the total of columns 4A through 23.

In column 27, Part I, enter on line 21, the unit cost multiplier (column 26, line 1, divided by the sum of column 26, line 20 minus column 26, line 1). Round the unit cost multiplier to 6 decimal places. Multiply each amount in column 26, lines 2 through 19 by the unit cost multiplier on line 21, and enter the result on the corresponding line of column 27. On line 20, enter the total of the amounts on lines 2 through 19. The total on line 20 must equal the amount in column 26, line 1.

In column 28, Part I, enter on lines 2 through 19 the sum of columns 26 and 27. The total on line 20 must equal the total in column 27, line 20.

4043.2 Part II - Allocation of General Service Costs to HHA Cost Centers -Statistical Basis--To facilitate the allocation process, the general format of Worksheet H-2, Parts I and II, is identical. Worksheet H-2, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the hospital's general service cost centers on Worksheet H-2, Part I.

The statistical basis shown at the top of each column on Worksheet H-2, Part II, is the recommended basis of allocation of the cost center indicated.

Lines 1 through 19--On Worksheet H-2, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 20--Enter the total of lines 1 through 19, for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 101.

Line 21--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, line 101, from the same column used to enter the statistical base on Worksheet H-2, Part II (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 101).

Line 22--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 21 by the total statistic entered in the same column on line 20. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistic applicable to each cost center receiving the services. Enter the result of each computation on Worksheet H-2, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 20, Part I) must equal the total cost on line 21, Part II.

Perform the preceding procedures for each general service cost center.

4044. WORKSHEET H-3 - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs to titles V, XVIII, and XIX. Titles V and XIX use the columns identified as Part A for each program.

4044.1 Part I - Computation of the Aggregate Program Cost.--This part provides for the computation of the total cost and reasonable program cost by discipline based on program patient care visits as required by 42 CFR 413.20, 42 CFR 413.24, and 42 CFR 484.200. *For* HHA services rendered on or after October 1, 2000, §1895 of the Social Security Act requires a home health agency to be paid based on a *PPS* subject to periodic updates.

Cost Per Visit Computation

Column Descriptions

Column 1--Enter the cost for each discipline from Worksheet H-2, Part I, column 28, lines as indicated. Enter the total on line 7.

Column 2--Where the hospital complex maintains separate Physical Therapy, Occupational Therapy and/or Speech Pathology departments, and these departments provide services to patients of the hospital's HHA, transfer the amounts from Worksheet H-3 Part II, column 3, lines 1 through 3, to lines 2 through 4, as appropriate. Enter the total on line 7.

Column 3--Enter the sum of columns 1 and 2.

Column 4--Enter the total agency visits from your records for each type of discipline on lines 1 through 6. Total visits reported in column 4 reflect visits rendered for the entire fiscal year and equal the visits reported on S-3, Part I, regardless of when the episode was completed.

Column 5--Compute the average cost per visit for each type of discipline. Divide the number of visits (column 4) into the cost (column 3) for each discipline.

Columns 6 and 9--To determine title XVIII, Part A; V; and XIX; cost of service, multiply the number of Medicare covered visits in completed episodes made to beneficiaries (column 6) (from your records) by the average cost per visit amount in column 5, for each discipline. Enter the product in column 9.

NOTE: Statistics in column 7, lines 1 through 7, reflect statistics for services that are part of a home health plan, and thus not subject to deductibles and coinsurance. OBRA 1990 provides for the limited coverage of injectable drugs for osteoporosis. While covered as a home health benefit under Part B, these services are subject to deductibles and coinsurance. Report charges for osteoporosis injections in column 8, line 16, in addition to statistics for services that are not part of a home health plan.

Columns 7 and 10--To determine the Medicare Part B cost of service, not subject to deductibles and coinsurance, multiply the number of Medicare covered visits made in completed episodes to Part B beneficiaries (column 7) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 10. Note if the PS&R reports Part B services separately as "subject to and not subject to" deductibles and coinsurance, add the two reports together for each discipline.

Columns 6, 7, 9, 10 and 12--Enter visits and costs as applicable in columns 6, 7, 9, 10, and 12.

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.

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 *the* 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. WORKSHEET H-4 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

This worksheet provides for the reimbursement calculation of titles V*;* XVIII, Parts A and B*;* and XIX. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

Worksheet H-4 consists of the following two parts:

Part I - Computation of the Lesser of Reasonable Cost or Customary Charges
Part II - Computation of HHA Reimbursement Settlement

4045.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--Services not paid based on a fee schedule or *the* OPPS are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the providers 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).

NOTE: Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider only completes lines 1, 2, and 9, of Part I. Transfer the resulting cost to line 10 of Part II.

Line Descriptions

Line 1--This line provides for the computation of reasonable cost reimbursed program services. Enter the cost of services from Worksheet H-3, Part I, as follows:

To Worksheet H-4, Line 1	From Worksheet H-3,
Col. 1, Part A	Part I, col. 9, line 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, line 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, line 16

The above table reflects the transfer of the cost of pneumococcal and influenza vaccines from Worksheet H-3, Part I, column 10, line 16, to column 2 of this worksheet, and the cost of hepatitis B vaccines and injectable osteoporosis drugs from worksheet H-3, Part I, column 11, line 9, to column 3 of this worksheet.

Lines 2 through 6--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1. Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-1, *chapter 21,* §2104.3) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-1, *chapter 25,* §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Enter only the charges for applicable Medicare covered pneumococcal, influenza and hepatitis B vaccines and injectable osteoporosis drugs which are all cost reimbursed.

Line 2--Enter from your records in the applicable column the program charges for Part A, Part B not subject to deductibles and coinsurance, and Part B subject to deductibles and coinsurance.

Enter in column 2, the charges for Medicare covered pneumococcal and influenza vaccines (from *W*orksheet H-3, line 16, column 7). In column 3, enter the charges for Medicare covered hepatitis B vaccines and osteoporosis drugs (from *W*orksheet H-3, line 16, column 8).

Lines 3 through 6--These lines provide for the reduction of program charges when the provider does not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fails to make reasonable efforts to collect such charges from those patients. If line 5 is greater than zero, multiply line 2 by line 5, and enter the result on line 6. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 3, 4, and 5, but enter on line 6 the amount from line 2. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 6 exceed the actual charges on line 2.

Line 7--Enter in each column the excess of total customary charges (line 6) over the total reasonable cost (line 1). In situations when, in any column, the total charges on line 6 are less than the total cost on line 1 of the applicable column, enter zero on line 7.

Line 8--Enter in each column the excess of total reasonable cost (line 1) over total customary charges (line 6). In situations when, in any column, the total cost on line 1 is less than the customary charges on line 6 of the applicable column, enter zero on line 8.

Line 9--Enter the amounts paid or payable by *workers'* compensation and other primary payers where program liability is secondary to that of the primary payer. There are several situations under which program payment is secondary to a primary payer. Some of the most frequent situations in which the Medicare program is a secondary payer include:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are considered to be nonprogram services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. The provider notes this on no-pay bills submitted in these situations.) The patient visits and charges are included in total patient visits and charges, but are not included in program patient visits and charges. In this situation, no primary payer payment is entered on line 9.

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 payer payment does not satisfy the beneficiary's liability, include the covered days and charges in both program visits and charges and total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 9, to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 9 the primary payer payments that are credited toward the beneficiary's deductible and coinsurance. The primary payer rules are more fully explained in 42 CFR 411.

4053. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS

Use this worksheet only if you operate as part of your complex a certified hospital-based community mental health center (CMHC) furnishing services to Medicare titles XVIII, title XIX, and V. Additionally, while comprehensive outpatient rehabilitation facilities (CORFs), outpatient rehabilitation facilities (ORFs) which generally furnish outpatient physical therapy (OPT), outpatient occupational therapy (OOT), or outpatient speech pathology (OSP) services, do not complete the J series worksheets they must complete the applicable Worksheet A cost center for the purpose of overhead allocation. Only those cost centers that represent services for which the facility is certified are used. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

4053.1 Part I - Allocation of General Service Costs to Community Mental Health Center Cost Centers.--Worksheet J-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 22) from Worksheet A, column 7, lines as appropriate:

Component	From Worksheet A, Column 7
CMHC	line 99 and subscripts

Obtain the cost center allocations (column 0, lines 1 through 21) from your records, the sum of which must equal the amount entered on column 0, line 22. The amounts on line 22, columns 0 through 23, and column 25, must equal the corresponding amounts on Worksheet B, Part I, columns 0 through 23, and column 25, lines as appropriate:

Component	Worksheet B, Part I, Columns 0 through 23 and 25
CMHC	line 99 and subscripts

Complete the amounts entered on lines 1 through 21, columns 1 through 23, and column 25, in accordance with the instructions contained in §4053.2.

NOTE: Worksheet B, Part I, established the method used to reimburse direct *GME* cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 25, excluded the costs of interns and residents, column 25, on this worksheet must also exclude these costs.

In column 24, Part I, enter the total of columns 4A through 23.

In column 27, Part I, enter the unit cost multiplier (column 26, line 1, divided by the sum of column 26, line 22, minus column 26, line 1) on line 23. Round the unit cost multiplier to six decimal places. Multiply each amount in column 26, lines 2 through 21, by the unit cost multiplier on line 23, and enter the result on the corresponding line of column 27. On line 22, enter the total of the amounts on lines 2 through 21. The total on line 22 equals the amount in column 26, line 1.

In column 28, Part I, enter on lines 2 through 21, the sum of columns 26 and 27. The total on line 22 equals the total in column 26, line 22.

4053.2 Part II - Allocation of General Service Costs to Community Mental Health Center Cost Centers - Statistical Basis.--Worksheet J-1, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the hospital's general service cost centers on Worksheet J-1, Part I. If there is a difference between the total accumulated costs reported on the Part II statistics and the total accumulated costs calculated on Part I, use the reconciliation

column on Part II for reporting any adjustments. See §4020 for the appropriate usage of the reconciliation columns. For subscripted (componentized) A&G cost centers, the accumulated cost center line must match the reconciliation column number.

To facilitate the allocation process, the general format of Worksheet J-1, Parts I and II, is identical. The statistical basis shown at the top of each column on Worksheet J-1, Part II, is the recommended basis of allocation of the cost center indicated and must be consistent with the statistical basis utilized on Worksheet B, Part I.

Lines 1 through 21--On Worksheet J-1, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 22--Enter the total of lines 1 through 21 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, lines as appropriate:

Component	Worksheet B-1, Corresponding Column
CMHC	line 99

Line 23--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, lines as appropriate (see §4020), from the same column used to enter the statistical base on Worksheet J-1, Part II (e.g., for a CMHC provider, in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 99).

Line 24--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 23 by the total statistic entered in the same column on line 22. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistic applicable to each cost center receiving the services. Enter the result of each computation on Worksheet J-1, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 22, Part I) must equal the total cost on line 23, Part II.

Perform the preceding procedures for each general service cost center.

4054. WORKSHEET J-2 - COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS

Use this worksheet only if you operate a hospital-based CMHC. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

4054.1 Part I - Apportionment of CMHC Cost Centers.--

Column 1--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, column 28. To facilitate the apportionment process, the line numbers are the same on both worksheets. Do not transfer lines 19 and 20 from Worksheet J-1.

Column 2--Enter the charges for each cost center. Obtain the charges from your records.

Column 3--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

Columns 4, 6, and 8-- For each cost center, enter the charges from your records for title V in column 4 and title XIX in column 8. Enter 0 (zero) for each line in column 6 for title XVIII charges as CMHCs are reimbursed under *the* OPPS. Not all facilities are eligible to participate in all programs.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, by the ratio in column 3.

Line 20--Enter the totals of lines 1 through 19 in columns 1, 2, and 4 through 9.

4054.2 Part II - Apportionment of Cost of CMHC Services Furnished by Shared Hospital Departments.--Use this part only when the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the hospital's CMHC.

Column 3--For each of the cost centers listed, enter the ratio of cost to charges that is shown on Worksheet C, Part I, column 9 from the appropriate line for each cost center.

Columns 4, 6, and 8--For each cost center, enter the charges from your records for title V in column 4 and title XIX in column 8. Enter 0 (zero) for each line in column 6 for title XVIII charges as CMHCs are reimbursed under *the* OPPS.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, respectively, by the ratio in column 3.

Line 28--Enter the totals for columns 4 through 9.

Line 29--Enter the total costs from Part I, columns 5, 7, and 9, line 20 plus columns 5, 7, and 9, line 28 respectively and transfer to Worksheet J-3, line 1.

4055. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT – COMMUNITY MENTAL HEALTH CENTER PROVIDER SERVICES

Submit a separate Worksheet J-3 for each title (V, XVIII, or XIX) under which reimbursement is claimed. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

Line 1--Enter the cost of the component's services from Worksheet J-2, Part II, line 29 from columns 5, 7, or 9, as applicable (column 5 for title V, column 7 for title XVIII (enter 0 (zero)), and column 9 for title XIX).

Line 2--Enter the gross PPS payments received for services rendered during the cost reporting period excluding outliers. Obtain this amount from the PS&R and/or your records.

Line 3--Enter the total outliers payments received. Obtain this amount from the PS&R and/or your records.

Line 4--Enter the amounts paid and payable by *workers'* compensation and other primary payers where program liability is secondary to that of the primary payer (from your records).

Line 5--Title XVIII CMHCs enter the result obtained by subtracting line 4 from the sum of lines 2 and 3. Titles V and XIX providers not reimbursed under PPS enter the total reasonable costs by subtracting line 4 from line 1.

Line 6--Enter the charges for the applicable program services from Worksheet J-2, sum of Parts I and II, *c*olumns 4, 6, and 8, as appropriate, lines 20 and 28.

Lines 7 through 10--These lines provide for the reduction of program charges where the provider does not actually impose charges on most of the patients liable for payment for services on a charge basis or fails to make reasonable efforts to collect such charges from those patients. If line 9 is greater than zero, enter on line 10, the product of multiplying the ratio on line 9 by line 6.

Providers that do impose charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 7, 8, and 9, but enter on line 10, the amount from line 6. (See 42 CFR 413.13(e).) In no instance may the customary charges on line 10 exceed the actual charges on line 6.

Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-1, §2104.3), and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-1, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Lines 11 and 12--Lines 11 and 12 provide for the computation of the lesser of reasonable cost or customary charges as defined in 42 CFR 413.13(a).

Enter on line 11, the excess of total customary charges (line 10) over the total reasonable cost (line 5). In situations where the total charges on line 10 are less than the total cost on line 5, enter zero (0) on line 11.

Enter on line 12, the excess of total reasonable cost (line 5) over total customary charges (line 10). In situations when in any column the total cost on line 5 is less than the customary charges on line 10, enter zero (0) on line 12.

NOTE: CMHCs not subject to reasonable cost reimbursement do not complete lines 11 and 12.

Line 13--Enter the total reasonable costs from line 5.

Line 14--Enter the Part B deductibles billed to program patients (from your records) excluding coinsurance amounts.

Line 16--If there is an excess of reasonable cost over customary charges, enter the amount from line 12.

Line 18--CMHCs enter 0 (zero) as these services are reimbursed under *the* OPPS. For titles V and XIX, enter 100 percent less the applicable coinsurance.

4057. WORKSHEET K - ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. The K series Worksheets must be completed by all hospital-based hospices. This worksheet provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner, which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets K, K-4, Parts I *and* II, the line numbers are consistent, and the total line is set at 39). Not all of the cost centers listed apply to all providers using these forms.

Column 1--Obtain salaries to be reported from Worksheet K-1, column 9, line 3 *through* 38.

Column 2--Obtain employee benefits to be reported from Worksheet K-2, column 9, lines 3 *through* 38.

Column 3--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center enter them on line 27.

Column 4--Obtain the contracted services to be reported from Worksheet K-3, col. 9, lines 3 *through* 38.

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

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

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

Column 8--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8, line 39 must equal the total of column 6, line 39.

Column 9--In accordance with 42 CFR 413.9(c)(3), enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §4016.)

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

Transfer the amount in column 10, line 1 through 38 to the corresponding lines on Worksheet K-4, Part I, column 0, lines 1 through 38.

LINE DESCRIPTIONS

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

Do not include in these cost centers the following costs: costs incurred for the repair or maintenance of equipment or facilities; amounts included in the rentals or lease or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Line 3--Plant Operation and Maintenance--This cost center contains the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of plant, and protecting the employees, visitors, and agency property.

Plant Operation and Maintenance include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment. This cost center also includes the cost of maintenance and repair of building, parking facilities and equipment, painting, elevator maintenance, performance of minor renovation of buildings, and equipment. The maintenance of grounds such as landscape and paved areas, streets on the property, sidewalk, fenced areas, fencing, external recreation areas and parking facilities are part of this cost center. The care or cleaning of the interior physical plant, including the care of floors, walls, ceilings, partitions, windows (inside and outside), fixtures and furnishings, and emptying of trash containers, as well as the costs of similar services purchased from an outside organization which maintains the safety and well-being of personnel, visitors and the provider's facilities, are all included in this cost center.

Line 4--Transportation-Staff--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5--Volunteer Service Coordination--Enter all of the cost associated with the coordination of service volunteers. This includes recruitment and training costs.

Line 6--Administrative and General--Use this cost center to record expenses of several costs which benefit the entire facility. If the option to componentize (also known as fragmentation or subscripting) administrative and general costs into more than one cost center is elected, eliminate line 6. Componentized A&G lines must begin with subscripted line 6.01 and continue in sequential order (i.e., 6.01 A&G shared costs, 6.02 A&G reimbursable costs, etcetera) Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs.

Line 7--Inpatient - General Care--This cost center includes costs applicable to patients who receive this level of care because their condition is such that they can no longer be maintained at home. Generally, they require pain control or management of acute and severe clinical problems which cannot be managed in other settings. The costs incurred on this line are those direct costs of furnishing routine and ancillary services associated with inpatient general care for which other provisions are not made on this worksheet.

Costs incurred by a hospice in furnishing direct patient care services to patients receiving general inpatient care either directly from the hospice or under a contractual arrangement in an inpatient facility is to be included in the visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24 hours nursing care within the facility, patient meals, laundry and linen services, and housekeeping. Plant operation and maintenance cost would be recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient general care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet K-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting services section.

Line 26--Durable Medical Equipment/Oxygen--*DME,* as defined in 42 CFR 410.38, as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness, are covered. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

Line 27--Patient Transportation--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 28--Imaging Services--Enter the cost of imaging services including MRI.

Line 29--Labs and Diagnostics--Enter the cost of laboratory and diagnostic tests.

Line 30--Medical Supplies--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients.

These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Line 31--Outpatient Service--Use this line for any outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department.

Lines 32 *through* 33--Radiation Therapy and Chemotherapy--Radiation, chemotherapy and other modalities may be used for palliative purposes if you determine that these services are needed for palliation. This determination is based on the patient's condition and your care giving philosophy.

Line 34--Other--Enter any additional costs involved in providing visiting services which has not been provided for in the previous lines.

Lines 35 *through* 38--Hospice Non Reimbursable Service--Enter in the appropriate lines the applicable costs. Bereavement program costs consists of counseling services provided to the individual's family after the individual's death. In accordance with §1814 (i)(1)(A) of the Social *S*ecurity Act, bereavement counseling is a required hospice service, *but is* not reimbursable.

Line 39--Total--Line 39 column 10, should agree with Worksheet A, line 116, column 7.

4058. WORKSHEET K-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

Enter all salaries and wages for the hospice on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs visiting services which account for 25 percent of that person's time, then enter 75 percent of the administrator's salary on line 6 (A&G), and 25 percent of the administrator's salary enter on line 10 (nursing care).

The records necessary to determine the split in salary between two or more cost centers must be maintained by the hospice and must adequately substantiate the method used to split the salary. These records must be available for audit by the contractor and the contractor can accept or reject the method used to determine the split in salary. When approval of a method has been requested in writing and this approval has been received prior to the beginning of a cost reporting period, the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the contractor determines that the method is no longer valid due to changes in your operations.

Definitions

Salary--This is gross salary paid to the employee before taxes and other items are withheld, includes deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-1, chapter 21.)

Administrator (Column 1)--

Possible Titles: President, Chief Executive Officer

Duties: This position is the highest occupational level in the agency. This individual is the chief management official in the agency. The administrator develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating. The administrator is responsible for the application and implementation of established policies. The administrator may act as a liaison among the governing body, the medical staff, and any departments.

The administrator provides for personnel policies and practices that adequately support sound patient care and maintains accurate and complete personnel records. The administrator implements the control and effective utilization of the physical and financial resources of the provider.

Director (Column 2)--

Possible Titles: Medical Director, Director of Nursing, or Executive Director

Duties: The medical director is responsible for helping to establish and assure that the quality of medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques.

The nursing director is responsible for establishing the objectives for the department of nursing. This individual administers the department of nursing and directs and delegates management of professional and ancillary nursing personnel.

Medical Social Worker (Column 3)--This individual is a person who has at least a bachelor's degree from a school accredited or approved by the council of social work education. These services must be under the direction of a physician and must be provided by a qualified social worker.

Supervisors (Column 4)--Employees in this classification are primarily involved in the direction, supervision, and coordination of the hospice activities.

When a supervisor performs two or more functions, e.g., supervision of nurses and home health aides, the salaries and wages must be split in proportion with the percent of the supervisor's time spent in each cost center, provided the hospice maintains the proper records (continuous time records) to support the split. If continuous time records are not maintained by the hospice, enter the entire salary of the supervisor on line 6 (A&G), and allocate to all cost centers through stepdown. However, if the supervisor's salary is all lumped in one cost center, e.g., nursing care, and the supervisor's title coincides with this cost center, e.g., nursing supervisor, no adjustment is required.

Total Therapists (Column 6)--Include in column 6, on the line indicated, the cost attributable to the following services:

Physical therapy	-	line 12
Occupational therapy	-	line 13
Speech pathology	-	line 14

Allocate all expenses to the cost centers on the basis of square footage of the space occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

Column 2--Allocate all expenses (e.g., interest, and personal property tax) for movable equipment to the appropriate cost centers on the basis of dollar value.

Column 4--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet K, column 3, is included in this cost center. Allocate this expense to the cost centers to which it applies on the basis of miles applicable to each cost center.

This basis of allocation is not mandatory and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs, which are not directly assigned. However, a hospice must request the use of the alternative method in accordance with CMS Pub. 15-1, *chapter 23,* §2313. The hospice must maintain adequate records to substantiate the use of this allocation.

Column 6--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments.

Therefore, obtain the amounts to be entered on Worksheet K-4, Part II, column 6, from Worksheet K-4, Part I, columns 0 through 5.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet K-4, Part I, column 0) for purposes of determining the basis of allocation (Worksheet K-4, Part II, column 5) of the A&G costs. This procedure may be followed when the hospice contracts for services to be performed for the hospice and the contract identifies the A&G costs applicable to the purchased services

The contracted A&G costs must be added back to the applicable cost center after allocation of the hospice A&G cost before the reimbursable costs are transferred to Worksheet K-5. A separate worksheet must be included to display the breakout of the contracted A&G costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Contractor approval does not have to be secured in order to use the above described method of cost finding for A&G.

Worksheet K-4, Part II, Column 6A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet K-4, Part I, column 5A, line 39, and the accumulated cost reported on Worksheet K-4, Part II, column 6, line 6. Enter any amounts reported on Worksheet K-4, Part I, column 5A, for (1) any service provided under arrangements to program patients only that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead.

In addition, report on line 6 the administrative and general costs reported on Worksheet K-4, Part I, column 6, line 6, since these costs are not included on Worksheet K-4, Part II, column 6, as an accumulated cost statistic.

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

Worksheet K-4, Part II, Column 6--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, enter the amount from Worksheet K-4, Part I, column 5A.

4062. WORKSHEET K-5 - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

This worksheet distributes the hospital's overhead to the specific cost centers of the hospice.

4062.1 Part I - Allocation of General Service Costs to Hospice Cost Centers.--Worksheet K-5, Part I, provides for the allocation of the expenses of each general service cost center of the hospital to those cost centers which receive the services.

Obtain the direct total expenses (column 0, lines 2 through 33) from Worksheet K-4 Part I, lines 7 through 38. The amounts on columns 0 through 23 and column 25, line 34, must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 23, and column 25, line 116.

Complete the amounts entered on lines 1 through 33, columns 1 through 23, and column 25, in accordance with the instructions in §4062.2.

NOTE: Worksheet B, Part I established the method used to reimburse direct *GME* cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 25, excluded the costs of interns and residents, column 25 on this worksheet must also exclude these costs.

In column 24, enter the total of columns 4A through 23.

In column 27, for lines 2 through 33, multiply the amount in column 26 by the unit cost multiplier on line 35, and enter the result in this column. The total of the amounts on lines 2 through 33 must equal the amount in column 26, line 1.

In column 28, enter on lines 2 through 33 the sum of columns 26 and 27. The total on line 34 equals the total in column 26, line 34.

4062.2 Part II - Allocation of General Service Costs to Hospice Cost Centers - Statistical Basis.--Worksheet K-5, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the hospital's general service cost centers on Worksheet K-5, Part I. To facilitate the allocation process, the general format of Worksheet K-5, Parts I and II, is identical.

The statistical basis shown at the top of each column on Worksheet K-5, Part II, is the recommended basis of allocation of the cost center indicated and must be consistent with the statistical basis utilized on Worksheet B, Part I.

Lines 1 *through* 33--On Worksheet K-5, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 34--Enter the total of lines 1 through 33, for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 116.

Line 35--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, columns as indicated, line 116.

Line 36--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 35 by the total statistic entered in the same column on line 34. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistic applicable to each cost center receiving the services. Enter the result of each computation on Worksheet K-5, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (Part I, line 34) must equal the total cost on line 34, Part II.

Perform the preceding procedures for each general service cost center.

4062.3 Part III - Computation of the Total Hospice Shared Costs.--This worksheet provides for the shared therapy, drugs, or medical supplies from the hospital to the hospice.

Column Description

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 hospice, enter on the appropriate lines the charges, from the provider's records, applicable to the hospital-based hospice.

Column 3--Multiply the amount in column 2 by the ratios in column 1, and enter the result in column 3.

Line 11--Sum of column 3, lines 1 through 10.

4063. WORKSHEET K-6 - *CALCULATION OF HOSPICE PER DIEM COST*

Worksheet K-6 calculates the average cost per day for a hospice patient. It is only an average and should not be misconstrued as the absolute.

Line 1--Transfer the total cost from Worksheet K-5, Part I, column 28, line 34 less column 28, line 33, plus Worksheet K-5, Part III, column 3, line 11. This line reflects the true cost including shared cost and excluding any non-hospice related activity.

Line 2--Enter the total unduplicated days from Worksheet S-9, column 6, line 5.

Line 3--Calculate the aggregate cost per day by dividing the total cost from line 1 by the total number of days from line 2.

Line 4--Enter the unduplicated Medicare days from Worksheet S-9, column 1, line 5.

Line 5--Calculate the aggregate Medicare cost by multiplying the average cost from column 4, line 3, by the number of unduplicated Medicare days on column 1, line 4, to arrive at the average Medicare cost.

Line 6--Enter the unduplicated Medicaid days from Worksheet S-9, column 2, line 5.

Line 7--Calculate the aggregate Medicaid cost by multiplying the average cost from line 3 by the number of unduplicated Medicaid days on line 6, to arrive at the average Medicaid cost.

Line 8--Enter the unduplicated SNF days from Worksheet S-9, column 3, line 5.

Line 9--Calculate the aggregate SNF cost by multiplying the average cost from line 3 by the number of unduplicated SNF days on line 8, to arrive at the average SNF cost.

Line 10--Enter the unduplicated NF days from Worksheet S-9, column 4, line 5.

Line 11--Calculate the aggregate NF cost by multiplying the average cost from line 3 by the number of unduplicated NF days on line 10, to arrive at the average NF cost.

Line 12--Enter the unduplicated Other days from Worksheet S-9, column 5, line 5.

Line 13--Enter the *a*ggregate cost for other days by multiplying the average cost from line 3 by the number of unduplicated Other days on line 12, to arrive at the average other cost.

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 *PPS* pursuant to 42 CFR 412, Subpart M. (See 56 FR 43449 (August 30, 1991).) Only provider components paid under *the* 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 *the* 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. *If your facility experienced a geographic redesignation from urban to rural, or rural to urban (Worksheet S-2, lines 26 and 27, column 1, are "1" and "2" or "2" and "1", respectively, and the hospital contains at least 100 beds (as counted in accordance with 42 CFR 412.105(b)), subscript column 1 (add column 1.01) for lines 1 and 1.01. Enter in co1umn 1, the capital DRG payments for the portion of the reporting period the hospital is classified as urban, and enter in co1umn 1.01, the capital DRG payments for the portion of the reporting period the hospital is classified as rural.*

Line Descriptions

Line 1--Enter the amount of the federal rate portion of the capital DRG payments for other than outlier during the period. *If your facility experienced a geographic redesignation, enter in column 1 the federal rate portion of the capital DRG payments for other than outliers for discharges occurring during the urban classification portion of the cost reporting period. Enter in column 1.01, the federal rate portion of the capital DRG payments for other than outliers for discharges occurring during the rural classification portion of the cost reporting 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. *If your facility experienced a geographic redesignation, enter in column 1, the federal rate portion of the capital DRG payments for other than outliers associated with Model 4 BPCI for discharges occurring during the urban classification portion of the cost reporting period. Enter in column 1.01, the federal rate portion of the capital DRG payments for other than outliers associated with Model 4 BPCI for discharges occurring during the rural classification portion of the cost reporting period.*

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

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

Capital Disproportionate Share Adjustment

Lines 7 *through* 11

Enter the amount of the federal rate portion of the additional capital payment amounts relating to the *DSH* 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 this 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: $(e^{.2025 \text{ x line } 9})$-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--*Enter the result of* line 10 *multiplied* by the sum of lines 1 *and 1.01, column 1*.

Line 12--Enter the sum of lines 1 *and 1.01, columns 1 and 1.01, plus lines* 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.

This page is reserved for future use.

4064.3 Part III - Computation of Exception Payments.--This part computes minimum payment levels by class of provider eligible for additional exception payment for extraordinary circumstances pursuant to 42 CFR 412.312(e). Complete this part only if the provider component completed Part I of this worksheet. Complete this part only if the provider qualifies for the exception payment for extraordinary circumstances pursuant to 42 CFR 412.348(f) (the facility indicates "Y" to question 46 on Worksheet S-2, Part I).

Line 1--Enter the amount of program inpatient routine service and ancillary service capital costs. This amount is the sum of the program inpatient routine service capital costs from the appropriate Worksheet D, Part I, column 7, sum of lines 30 through 35 and 43, for the hospital, lines 40 through 42, as applicable for the subprovider, and program inpatient ancillary service capital costs from Worksheet D, Part II, column 5, line 200.

Line 2--Enter program inpatient capital costs for extraordinary circumstances as provided by 42 CFR 412.348(f), if applicable, from Worksheet L-1, sum of Part II, column 7, sum of lines 30 through 35 and 43, for the hospital; lines 40 through 42, as applicable for the subproviders; and Part III, column 5, line 200.

Line 3--Enter line 1 less line 2.

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

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

For providers that qualify for an exception payment for extraordinary circumstances pursuant to 42 CFR 412.348(f) in conjunction with 412.312(e) the appropriate minimum payment level is 70 percent.

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

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

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

Line 6--Hospitals that did not qualify as *SCHs* during the cost reporting period enter a reduction factor of 85 percent. SCHs enter 100 percent. If you were a *SCH* during a portion of the cost reporting period, compute the capital cost reduction percentage by dividing the number of days in your cost reporting period for which you were not a *SCH* (reduction factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 15 percent and subtract the amount from 100. Enter the resulting extraordinary circumstance percentage adjustment in decimal format, e.g., 85 percent is displayed as .85 or 0.85.

Line 7--Enter the product of line 2 multiplied by line 6.

Line 8--Enter the sum of lines 5 and 7.

Line 9--Enter the amount from Part I, line 12, if applicable.

Line 10--Enter line 8 less line 9.

Lines 11 *through* 14--A hospital is entitled to an additional payment if its capital payments for the cost reporting period is less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive. This additional payment amount is reduced for any amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels. The offsetting amounts will be determined based on the amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels in the lesser of the preceding 10-year period or the period of time under which the hospital is subject to the *PPS* for capital related costs.

A positive amount on line 10 represents the amount of capital payments under the minimum payment level in the current year. This amount must be offset for the amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels in prior years, as reported on line 11. If the net amount on line 12 remains a positive amount, this amount represents the current year's additional payment for capital payments under the minimum payment level. Report this amount on line 13. If the net amount on line 12 is a negative amount, this amount represents the reduced amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. In this case, no additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the following cost reporting period.

A negative amount on line 10 represents the amount of capital payments over the minimum payment level in the current year. Add any carry forward of prior years' amounts of the hospital's cumulative payments in excess of cumulative minimum payment levels, as reported on line 11, to the current year excess on line 12. The net amount on line 12 represents the total amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. No additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the subsequent cost reporting period.

Line 11--The offsetting amounts will be determined based on the amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels in the lesser of the preceding 10-year period or the period of time under which the hospital is subject to the *PPS* for capital related costs. Enter the appropriate offset amount as computed pursuant to 42 CFR 412.312(e)(3).

Line 12--Enter the sum of lines 10 and 11.

Line 13--If the amount on line 12 is positive, enter the amount on this line.

Line 14--If the amount on line 12 is negative, enter the amount on this line.

Complete lines 15 through 17 only when line 12 is a positive amount.

Line 15--Enter the current years allowable operating and capital payments calculated from Worksheet E, Part A, line 47, plus the capital payments reported on line 9 above, minus 75 percent of the current year's operating disproportionate share payment amount reported on Worksheet E, Part A, line 34.

Line 16--Current *year* operating and capital costs from Worksheet D-1, line 49 minus the sum of *Worksheet* D, Part III, lines 30 through 35, column 9 (PPS subproviders use lines 40 through 42, as applicable, column 9), and *Worksheet* D, Part IV, column 11, line 200.

Line 17--Enter on this line the current year's exception offset amount. This is computed as line 15 minus line 16. If this amount is negative, enter zero on this line. If the amount on line 13 is greater than line 17, transfer the amount on line 13, less any reported amount on line 17, to Worksheet E, Part A, line 51.

4065. WORKSHEET L-1 - ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

This worksheet provides for the determination of direct and indirect capital-related costs associated with capital expenditures for extraordinary circumstances, allocated to inpatient operating costs. Only complete this worksheet for providers that qualify for an additional payment for extraordinary circumstances under 42 CFR 412.348(f) (the facility indicates "Y" to question 46 on worksheet S-2, Part I).

4065.1 Part I - Allocation of Allowable Capital Costs for Extraordinary Circumstances.--Use this part in conjunction with Worksheet B-l. The format and allocation process employed is similar to that used on Worksheets B, Part I and B-1. Any cost center subscripted lines and/or columns added to Worksheet B, Part I, are also added to this worksheet in the same sequence.

Column 0--Assign capital expenditures relating to extraordinary costs to specific cost centers on this worksheet, column 0. Enter on the appropriate lines those capital-related expenditure amounts relating to extraordinary costs which were directly assigned on Worksheet B, Part II. Enter on lines 3 and 4, as applicable, the remaining capital expenditure amounts relating to extraordinary costs which have not been directly assigned.

Columns 1 through 23--Transfer amounts on the top lines of columns 1 and 2 from column 0, line as applicable. For example, transfer line 1, column 0 to line 1, column 1. For all other columns, the top line represents the cross total amount.

For each column, enter on line 203 of this worksheet, Part I, the total statistics of the cost center being allocated. Obtain the individual statistics from Worksheet B-1 from the same column and line number used to allocate cost on this worksheet. (For example, obtain the amount of capital-related costs - buildings and fixtures from Worksheet B-1, column 1, line 1.)

Divide the amount entered on line 203 by the total capital expenses entered in the same column on the first line. Enter the resulting unit cost multiplier on line 204. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. The applicable cost center statistics are reported on Worksheet B-1. Enter the result of each computation on this worksheet in the corresponding column and line. (See §4000.1 for rounding standards.)

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 197) of all the cost centers receiving the allocation on this worksheet must equal the amount entered on the first line. Perform the preceding procedures for each general service cost center. Complete the column for one cost center before proceeding to the column for the next cost center.

After the capital-related costs of all the general service cost centers have been allocated, enter in column 24 the sum of columns 2A through 23 for lines 30 through 196. (See §4020 for exception regarding negative cost centers.)

When an adjustment is required to capital costs for extraordinary circumstances after cost allocation, show the amount applicable to each cost center in column 25. Submit a supporting schedule showing the computation of the adjustment.

Transfer From Worksheet: L-1, Part I, Column 26	To Worksheet L-1, Part II
Line 30 - Adults and Pediatrics	Column l, line 30 for the hospital
Lines 31 through 35 - Intensive Care Type Inpatient Hospital Units	Column 1, lines 31 through 35
Lines 40 through 42, as applicable - Subprovider	Column l, lines 40 through 42, as applicable
Line 43 - Nursery	Column 1, line 43 for titles V and XIX
	To Worksheet L-1, Part III
Lines 50 through 76 - Ancillary Services	Column l, lines 50 through 76
Lines 88 through 91 and 93 - Outpatient Service Cost	Column l, lines 88 through 91 and 93
Subscripts of line 92 - Distinct Part Observation Bed Units	Column 1, subscripts of line 92
Lines 88, 89, 94, 97, and 98	Column l, lines 88, 89, 94, 97, and 98

4065.2 Part II - Computation of Program Inpatient Routine Service Capital Costs for Extraordinary Circumstances.--This part computes the amount of capital costs for extraordinary circumstances applicable to hospital inpatient routine service costs. Complete only one Worksheet L-1, Part II, for each title. Report hospital and subprovider information on the same worksheet, lines as appropriate.

Column 1--Enter on each line the capital costs for extraordinary circumstances as appropriate. Obtain this amount from Worksheet L-1, Part I, column 26.

Column 2--Compute the amount of the swing-bed adjustment. If you have a swing-bed agreement or have elected the swing-bed optional method of reimbursement, determine the amount for the cost center in which the swing-beds are located by multiplying the amount in column 1 by the ratio of the amount entered on Worksheet D-1, line 26, to the amount entered on Worksheet D-1, line 21.

Column 3--Enter column 1 minus column 2.

Column 4--Enter on each line the total patient days, excluding swing-bed days, by cost center from the corresponding lines of Worksheet D, Part I, column 4.

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 *RHC/FQHC* 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. *Effective for cost reporting periods beginning on or after October 1, 2014, FQHCs filing as part of the hospital healthcare complex do not complete the Worksheet M series but complete the new FQHC PPS "N" series worksheets in Form CMS-2552-10 when they become available.*

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 *GME* 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 *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).