

Medicare

Provider Reimbursement Manual -

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

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

Transmittal 10

Date: JUNE 2003

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NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates, Chapter 36, Hospital and Hospital Healthcare Complex Cost Report, Form CMS 2552-96 to reflect further clarification to existing instructions and to implement uncompensated care for cost reporting periods ending on or after April, 30, 2003, Long-Term Care Hospital (LTC) Prospective Payment System effective for cost reporting periods beginning on or after October 1, 2002, and the conversion of Hospital Swing Bed Facilities to the Skilled Nursing Facility (SNF) Prospective Payment System effective for cost reporting periods beginning on or after July 1, 2002. The effective date for instructional changes will vary due to various implementation dates.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after April 30, 2003.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

CHAPTER 36
HOSPITAL AND HOSPITAL
HEALTH CARE COMPLEX COST REPORT
FORM CMS-2552-96

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3600. 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 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-2552-96 with a valid OMB control number. Besides determining program payment, the data submitted on the cost report support management of the Federal programs, e.g., data extraction in developing cost limits. The information reported on Form CMS-2552-96 must conform to the requirements and principles set forth in 42 CFR, Part 412, 42 CFR, Part 413, and in the Provider Reimbursement Manual, Part I. The filing of the cost report is mandatory and failure to do so results in all payments to be deemed overpayment and 100 percent withhold until the cost report is received. (See PRM 15 II §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 ending on or after September 30, 1996.

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:

- o Reimbursement is claimed for hospital swing beds;
- o Reimbursement is claimed for a hospital-based comprehensive outpatient rehabilitation facility (CORF);
- o Reimbursement is claimed for a hospital-based community mental health center (CMHC);
- o The hospital has physical therapy services furnished by outside suppliers; or
- o The hospital is a certified transplant center (CTC).

NOTE: Public reporting burden for this collection of information is estimated to average 106 hours per response, and record keeping burden is estimated to average 551 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 Center 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 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 §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 can not exceed more than one hospital-based facility), add additional lines for each entity by subscripting the line designation. For example, subprovider, line 2, Worksheet S, Part II is subscripted 2.00 for subprovider I and 2.01 for subprovider II.

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

Similarly, add lines 31.00 and 31.01 to Worksheets A, B, Parts I through III, B-1, C, Part I, 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.

3600.1 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.

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

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

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

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

A&G	-	Administrative and General
AHSEA	-	Adjusted Hourly Salary Equivalency Amount
ASC	-	Ambulatory Surgical Center
BBA	-	Balanced Budget Act
BBRA	-	Balanced Budget Reform Act
BIPA	-	Benefits Improvement and Protection Act
CAH	-	Critical Access Hospitals (10/97)
CAPD	-	Continuous Ambulatory Peritoneal Dialysis
CAP-REL	-	Capital-Related
CCPD	-	Continuous Cycling Peritoneal Dialysis
CCU	-	Coronary Care Unit
CFR	-	Code of Federal Regulations
CMHC	-	Community Mental Health Center
CMS	-	Center for Medicare and Medicaid Services
COL	-	Column
CORF	-	Comprehensive Outpatient Rehabilitation Facility
CRNA	-	Certified Registered Nurse Anesthetist
CTC	-	Certified Transplant Center
DRG	-	Diagnostic Related Group
DSH	-	Disproportionate Share
EACH	-	Essential Access Community Hospital
ESRD	-	End Stage Renal Disease
FQHC	-	Federally Qualified Health Center
FR	-	Federal Register
FTE	-	Full Time Equivalent
GME	-	Graduate Medical Education
HHA	-	Home Health Agency
HMO	-	Health Maintenance Organization
I & Rs	-	Interns and Residents
ICF/MR	-	Intermediate Care Facility for the Mentally Retarded (9/96)
ICU	-	Intensive Care Unit
IME	-	Indirect Medical Education
INPT	-	Inpatient
IRF	-	Inpatient Rehabilitation Facility
LIP	-	Low Income Patient
LOS	-	Length of Stay
LCC	-	Lesser of Reasonable Cost or Customary Charges

LTCH	-	Long Term Care Hospital
MCP	-	Monthly Capitation Payment
MDH	-	Medicare Dependent Hospital (10/97)
MED-ED	-	Medical Education
MSA	-	Metropolitan Statistical Area (10/97)
MSP	-	Medicare Secondary Payer
NF	-	Nursing Facility
NHCMQ	-	Nursing Home Case Mix and Quality Demonstration
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
OPT	-	Outpatient Physical Therapy
OSP	-	Outpatient Speech Pathology
ORF	-	Outpatient Rehabilitation Facility
PBP	-	Provider-Based Physician
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PRO	-	Professional Review Organization
PS&R	-	Provider Statistical and Reimbursement System
PT	-	Physical Therapy
RCE	-	Reasonable Compensation Equivalent
RHC	-	Rural Health Clinic
RPCH	-	Rural Primary Care Hospitals
RT	-	Respiratory Therapy
RUG	-	Resource Utilization Group
SCH	-	Sole Community Hospitals
SCHIP	-	State Children Health Insurance Program
SNF	-	Skilled Nursing Facility
SSI	-	Supplemental Security Income
TEFRA	-	Tax Equity and Fiscal Responsibility Act of 1982
TOPPS	-	Transitional Corridor Payment for Outpatient Prospective Payment System
WKST	-	Worksheet

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

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

Where applicable, at the end of select paragraphs and/or sentences the effective date(s) is indicated in parentheses () for cost reporting periods ending on or after that date, i.e., (12/31/01). Dates followed by a “b” are effective for cost reporting periods beginning on or after the specified date, i.e., (1/1/01b). Dates followed by an “s” are effective for services rendered on or after the specified date, i.e., (4/1/01s). Instructions not followed by an effective date are effective retroactive back to 9/30/96 (transmittal 1).

3601. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-2552-96

Part I - Departmental Cost Adjustments and Cost Allocations

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
1	S-2	Read §3604. Complete entire worksheet.
2	S-3, (Parts I-III)	Read §3605-3605.3. Complete worksheets.
3	S-10	Read §3609.4
4	A	Read §3610. Complete columns 1-3, lines 1-101.
5	A-6	Read §3611. Complete, if applicable.
6	A	Read §3610. Complete columns 4 and 5, lines 1-101.
7	A-7	Read §3612. Complete entire worksheet.
8	A-8-1	Read §3614. Complete Part A. If the answer to Part A is yes, complete Parts B and C.
9	A-8-2	Read §3615. Complete, if applicable.
10	A-8-3	(Parts I-VII) Read §§3616-3616.7. Complete, if applicable.
11	A-8	Read §3613. Complete entire worksheet.
12	A	Read §3610. Complete columns 6 and 7, lines 1-101.
13	B, Part I and B-1	Read §3617. Complete all columns through column 27.
14	B, Parts II and III	Read §3618. Complete worksheets.
15	B-2	Read §3619. Complete, if applicable.
16	L-1, Part I	Read §§3661 and 3661.1. Complete, if applicable.

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
<u>Part II - Departmental Cost Distribution and Cost Apportionment</u>		
1	C, Parts I, II, III, IV, and V	Read §3620-3620.5. Complete all applicable columns of worksheet, lines 25-61 and 63-101.
2	D, Part I	Read §§3621 and 3621.1. Complete entire worksheet.
3	D, Part III	Read §§3621 and 3621.3. Complete entire worksheet.
4	L-1, Part II	Read §3661.2. Complete, if applicable.
5	D-1 (Parts I and IV)	
6	D, Part II	Read §§3621 and 3621.2. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each hospital and subprovider subject to PPS or TEFRA provisions.
7	D, Part IV	Read §§3621 and 3621.4. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each hospital and subprovider subject to PPS or TEFRA provisions.
8	L-1, Part III	Read §3661.3. Complete, if applicable.
9	D, Part V	Read §§3621 and 3621.5. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each applicable provider component.
10	D, Part VI	Read 3621.6. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each applicable provider component.

<u>Form CMS</u>	<u>Worksheet</u>	<u>Part</u>	<u>Health Care Program (Title)</u>	<u>Component</u>
2552-96	S-6		XVIII	Hospital-Based CORF
2552-96	S-7		XVIII	Hospital-Based SNF
2552-96	S-8		XVIII	Hospital-Based RHC/FQHC
2552-96	S-9		XVIII	Hospital-Based Hospice
2552-92	S-10		XVIII	Hospital
2552-96	A			
2552-96	A-6			
2552-96	A-7			
2552-96	A-8			
2552-96	A-8-1			
2552-96	A-8-2			
2552-96	A-8-3	I - VII		
2552-96	A-8-4	I - VII		
2552-96	B	I		
2552-96	B	II		
2552-96	B	III		
2552-96	B-1			
2552-96	B-2			
2552-96	C	I - V		Hospital
2552-96	D	I	V	Hospital
2552-96	D	II	V	Hospital
2552-96	D	III	V	Hospital
2552-96	D	IV	V	Hospital
2552-96	D	V	V	Hospital
2552-96	D	VI	V	Hospital
2552-96	D	II	V	Subprovider
2552-96	D	V	V	Subprovider
2552-96	D	I	XVIII	Hospital
2552-96	D	II	XVIII	Hospital
2552-96	D	III	XVIII	Hospital
2552-96	D	IV	XVIII	Hospital
2552-96	D	V	XVIII	Hospital
2552-96	D	VI	XVIII	Hospital
2552-96	D	II	XVIII	Subprovider
2552-96	D	III	XVIII	Subprovider
2552-96	D	V	XVIII	Subprovider
2552-96	D	VI	XVIII	Subprovider
2552-96	D	III	XVIII	Swing Bed SNF
2552-96	D	III	XVIII	SNF
2552-96	D	I	XIX	Hospital
2552-96	D	II	XIX	Hospital
2552-96	D	III	XIX	Hospital
2552-96	D	IV	XIX	Hospital
2552-96	D	V	XIX	Hospital
2552-96	D	VI	XIX	Hospital
2552-96	D	II	XIX	Subprovider
2552-96	D	V	XIX	Subprovider
2552-96	D	VI	XIX	Subprovider
2552-96	D-1	I, II, & IV	V	Hospital
2552-96	D-1	I, II, & IV	V	Subprovider
2552-96	D-1	I & III	V	SNF
2552-96	D-1	I & III	V	NF, ICF/MR

<u>Form CMS</u>	<u>Worksheet</u>	<u>Part</u>	<u>Health Care Program (Title)</u>	<u>Component</u>
2552-96	D-1	I, II, & IV	XVIII	Hospital
2552-96	D-1	I, II, & IV	XVIII	Subprovider
2552-96	D-1	I & III	XVIII	SNF
2552-96	D-1	I, II, & IV	XIX	Hospital
2552-96	D-1	I, II, & IV	XIX	Subprovider
2552-96	D-1	I & III	XIX	SNF
2552-96	D-1	I & III	XIX	NF, ICF/MR
2552-96	D-2	I	V, XVIII, & XIX	
2552-96	D-2	II	XVIII	
2552-96	D-2	III	XVIII	
2552-96	D-4		V	Hospital
2552-96	D-4		V	Subprovider
2552-96	D-4		V	Swing Bed SNF
2552-96	D-4		V	Swing Bed NF
2552-96	D-4		V	SNF
2552-96	D-4		V	NF, ICF/MR
2552-96	D-4		XVIII	Hospital
2552-96	D-4		XVIII	Subprovider
2552-96	D-4		XVIII	Swing Bed SNF
2552-96	D-4		XIX	Hospital
2552-96	D-4		XIX	Subprovider
2552-96	D-4		XIX	Swing Bed SNF
2552-96	D-4		XIX	Swing Bed NF
2552-96	D-4		XIX	SNF
2552-96	D-4		XIX	NF, ICF/MR
2552-96	D-6	I - IV	XVIII	
2552-96	D-9	I	V, XVIII, & XIX	
2552-96	D-9	II	V, XVIII, & XIX	Hospital
2552-96	D-9	II	V, XVIII, & XIX	Subprovider
2552-96	E	A	XVIII	Hospital
2552-96	E	B	XVIII	Hospital
2552-96	E	C	V, XVIII, & XIX	Hospital
2552-96	E	D	V, XVIII, & XIX	Hospital
2552-96	E	E	V, XVIII, & XIX	Hospital
2552-96	E-1		XVIII	Hospital
2552-96	E-1		XVIII	Subprovider
2552-96	E-1		XVIII	Swing Bed SNF
2552-96	E-1		XVIII	SNF
2552-96	E-2		V	Swing Bed SNF
2552-96	E-2		V	Swing Bed NF
2552-96	E-2		XVIII	Swing Bed SNF
2552-96	E-2		XIX	Swing Bed SNF
2552-96	E-2		XIX	Swing Bed NF
2552-96	E-3	I or II	XVIII	Hospital
2552-96	E-3	I or II	XVIII	Subprovider
2552-96	E-3	II	XVIII	SNF
2552-96	E-3	III	V	Hospital
2552-96	E-3	III	V	Subprovider
2552-96	E-3	III	V	SNF
2552-96	E-3	III	V	NF, ICF/MR
2552-96	E-3	III	XIX	Hospital
2552-96	E-3	III	XIX	Subprovider

<u>Form CMS</u>	<u>Worksheet</u>	<u>Part</u>	<u>Health Care Program (Title)</u>	<u>Component</u>
2552-96	E-3	III	XIX	SNF
2552-96	E-3	III	XIX	NF, ICF/MR
2552-96	E-3	IV	V, XVIII, & XIX	Hospital
2552-96	E-3	V	V, XVIII, & XIX	Hospital
2552-96	G			
2552-96	G-1			
2552-96	G-2			
2552-96	G-3			
2552-96	I-2 - I-4			Renal Dialysis
2552-96	I-2 - I-4			Home Program
				Dialysis
2552-96	J-1 - J-2			CORF, CMHC, and OPT
2552-96	J-3		V	CORF, CMHC, and OPT
2552-96	J-3		XVIII	CORF, CMHC, and OPT
2552-96	J-3		XIX	CORF, CMHC, and OPT
2552-96	J-4		XVIII	CORF, CMHC, and OPT
2552-96	K			Hospital-based Hospice
2552-96	K-1			Hospital-based Hospice
2552-96	K-2			Hospital-based Hospice
2552-96	K-3			Hospital-based Hospice
2552-96	K-4	I & II		Hospital-based Hospice
2552-96	K-5	I, II & III		Hospital-based Hospice
2552-96	K-6		XVIII, XIX	Hospital-based Hospice
2552-96	L		V, XVIII, & XIX	Hospital
2552-96	L		V, XVIII, & XIX	Subprovider
2552-96	L-1	I		Hospital
2552-96	L-1	II	V, XVIII, & XIX	Hospital
2552-96	L-1	III	V, XVIII, & XIX	Hospital
2552-96	L-1	III	V, XVIII, & XIX	Subprovider
2552-96	M-1		V, XVIII, & XIX	Hospital-based RHC/FQHC
2552-96	M-2		V, XVIII, & XIX	Hospital-based RHC/FQHC
2552-96	M-3		V, XVIII, & XIX	Hospital-based RHC/FQHC
2552-96	M-4		V, XVIII, & XIX	Hospital-based RHC/FQHC
2552-96	M-5		V, XVIII, & XIX	Hospital-based RHC/FQHC

3603. WORKSHEET S - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

The intermediary should indicate in the appropriate box whether this is the initial cost report (first cost report filed for the period), final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened.

3603.1 Part I - Certification by Officer or Administrator of Provider(s).--This certification is read, prepared, and signed after the cost report has been completed in its entirety.

Check the appropriate box to indicate whether you are filing electronically or manually. 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 intermediary and is archived accordingly. This file is your original submission and is not to be modified.

3603.2 Part II - 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:

<u>Hospital/ Hospital Component</u>	<u>Title V</u>	<u>FROM</u>		
		<u>Title XVIII Part A</u>	<u>Title XVIII Part B</u>	<u>Title XIX</u>
Hospital	Wkst. E-3, Part III, line 58	Wkst. E, Part A, line 29 or Wkst. E-3, Part I, line 20 or Wkst. E-3, Part line 33	Wkst. E, Part B, line 35	Wkst. E-3, Part III, line 58
Subprovider	Wkst E-3, Part III, line 58	Wkst E, Part A, line 29 or line Wkst E-3 Part I line 20 or Wkst E-3 Part II line 33	Wkst E Part B, line 35	Wkst E-3, E-3, Part III line 58
Swing Bed - SNF	Wkst. E-2,col.1, line 21	Wkst. E-2, col. 1,line 21	Wkst. E-2, col. 2,line 21	Wkst E-2, col. 1,line 21
Swing Bed - NF	Wkst. E-2, col.1, line 21	N/A	N/A	Wkst. E-2, col. 1, line 21

Line 8--This is any other hospital-based facility not listed above. The beds in this unit are not certified for titles V, XVIII, or XIX.

Line 9--This is a distinct part HHA that has been issued an HHA identification number and which meets the requirements of §§1861(o) and 1891 of the Act. If you have more than one hospital-based HHA, subscript this line, and report the required information for each HHA.

Line 10--Do not use this line.

Line 11--This is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and which meets the conditions for coverage in 42 CFR 416, Subpart B. The ASC operated by a hospital must be a separately identifiable entity which is physically, administratively, and financially independent and distinct from other operations of the hospital. (See 42 CFR 416.30(f).) Under this restriction, hospital outpatient departments providing ambulatory surgery (among other services) are not eligible. (See 42 CFR 416.120(a).)

Line 12--This is a distinct part hospice and separately certified component of a hospital which meets the requirements of §1861(dd) of the Act. No payment designation is required in columns 4,5, and 6. (10/00)

Line 13--Do not use this line.

Line 14--This line is used by rural health clinics (RHC) and/or Federally qualified health clinics (FQHC) which have been issued a provider number and meet the requirements of §1861(aa) of the Act. If you have more than one RHC, report on lines 14 through 14.09. For FQHCs, report on lines 14.10 through 14.19. Report the required information in the appropriate column for each. (See Exhibit 2, Table 4, Part IV, page 36-755.)

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

Line 16--If this facility operates a renal dialysis center, enter in column 2 the satellite number. Subscript this line for more than one satellite facility.

Line 17--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of your operations which generally cover a consecutive 12 month period of your operations. (See CMS Pub. 15-II, §§102.1-102.3 for situations where you may file a short period cost report.)

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

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

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

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

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

NOTE: Long term care hospitals are hospitals organized to provide long term treatment programs with lengths of stay greater than 25 days. These hospitals may be identified in 2 ways:

- o Those hospitals properly identified by a distinct type of facility code in the third digit of the Medicare provider number; or
- o Those hospitals that are certified as other than long term care hospitals, but which have lengths of stay greater than 25 days.

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

Line 21--Indicate if your hospital is either urban or rural **at the end of the cost reporting period**. Enter 1 for urban or 2 for rural.

Line 21.01--Does your facility qualify and is currently receiving payments for disproportionate share **hospital adjustment**, in accordance with 42 CFR 412.106? Enter "Y" for yes and "N" for no.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 28.02--Enter the updated hospital based SNF facility rate supplied by your fiscal intermediary **if you have not transitioned to 100 percent SNF PPS payment.** Enter in column 2 the classification of the SNF, either (1) for urban or (2) for rural. Enter in column 3 the SNF's MSA code. If you are located in a rural area enter your State code as your MSA code.

Line 29--Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional reimbursement method? Enter "Y" for yes and "N" for no.

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

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

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

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

Line 30.03--If this facility qualifies as an CAH is it eligible for cost reimbursement for ambulance services (12/21/00s). Enter a "Y" for yes or a "N" for no. If yes, enter in column 2 the date eligibility determination was issued. (See 42 CFR 413.70(b)(5))

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

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

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

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

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

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

Line 36--Do you elect the fully prospective payment methodology for capital costs? (See 42 CFR 412.340.) **(This also includes providers that were previously hold harmless, but are now considered 100 percent fully prospective for purposes of completing Worksheet L, Part I in lieu of Worksheet L, Part II.)** Enter "Y" for yes or "N" for no in the applicable columns. **(For cost reporting periods beginning on or after October 1, 2001, the response is always "Y", except for new providers with fiscal years beginning before October 1, 2002 under 42 CFR 412.300(b) which the response is "N" for the provider's first 2 years.)** Questions 36 and 37 are mutually exclusive.

Line 36.01--Does your facility qualify and receive payments for disproportionate share in accordance with 42 CFR 412.320? Enter "Y" for yes and "N" for no. If you are eligible as a result of the Pickle amendment, enter "P" instead of "Y." Do not complete this line if you answered no on line 36, **except for new providers certified prior to October 1, 2001.**

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

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

NOTE: Providers deemed to be new in accordance with 42 CFR 412.300(b) for cost reporting periods beginning prior to October 1, 2001, the response to questions 37 and 37.01 is "N" for the provider's first two cost reporting periods. For the third thru tenth cost reporting period the response is "Y".)

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

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

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

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

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

Line 39--Do not use this line.

Line 40--Are there any related organization or home office costs claimed? Enter "Y" for yes or "N" for no. If yes, complete Worksheet A-8-1. If you are claiming home office costs enter in column 2 the home office chain number (10/0).

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 52.01--If you are a fully prospective or hold harmless provider, are you eligible for the special exception payment pursuant to 42 CFR 412.348(g)? Enter "Y" for yes or "N" for no. If yes, complete Worksheet L, Part IV. (10/1/2001)

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

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

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

Line 56--Are you claiming ambulance costs? Enter a "Y" for yes or a "N" for no. If yes, enter in column 2, for services rendered on and after October 1, 1997, the ambulance payment per trip limit provided by your intermediary. The per trip rate is updated October 1st of each year. For cost reporting periods which overlap October 1, report the payment rate prior to October 1, on line 56, column 2 and the payment rate applicable for services on October 1 to the end of the cost reporting period on line 56.01. For cost reporting periods beginning October 1st no subscripting is required.

If this is your first year of providing and reporting ambulance services, you are not subject to the payment limit. Enter a “Y” for yes or an “N” for no in column 3 (10/97). For services beginning on or after January 1, 2001 the limit will be changed to a calendar year basis. There is an additional update established by regulation for July 1, 2001. Report your ambulance trip limits (column 2) chronologically, in accordance with your fiscal year. Applicable chronological dates (column 0) should be 1/1/2001, 7/1/2001, 1/1/2002, 4/1/2002 (effective date of blend), 1/1/2003, 1/1/2004, 1/1/2005, and 1/1/2006. For services rendered on or after 4/1/2002, enter in column 4 the gross fee schedule amounts (from the PS&R or your records) for the reporting period. For services on and after 4/1/2002 through 12/31/2005 ambulance services will be subject to a blend until 100% fee schedule amount is transitioned on 1/1/2006.

CAHs exempt from the ambulance limits (Worksheet S-2, line 30.03, column 1 equals “Y”) complete columns 1 and 2 only. (10/1/97b) If you are eligible for cost reimbursement of ambulance services for the entire cost reporting period complete line 56 only, no subscripts are required. A CAH exempt the ambulance limits is cost reimbursed and not subject to the fee/cost blend.

Line 57--Are you claiming nursing and allied health costs? Enter “Y” for yes and “N” for no. If yes you must subscript column 2 of Worksheet D, Parts III and IV to separately identify nursing and allied health (paramedical education) from all other medical education costs (1/1/00s).

Line 58--Are you an Inpatient Rehabilitation Facility (IRF) or do you contain an IRF subprovider? Enter in column 1 “Y” for yes and “N” for no. If you are an IRF or if the hospital complex contains an IRF subprovider, have you made the election for 100 percent Federal PPS reimbursement? Enter in column 2 “Y” for yes and “N” for no. This option is available only for cost reporting period beginning on or after 1/1/2002 and before 10/1/2002.

Line 59--Are you a Long Term Care Hospital (LTCH) or do you contain a LTCH subprovider? Enter in column 1 “Y” for yes and “N” for no. If you are a LTCH or if the hospital complex contains a LTC subprovider, have you made the election for 100 percent Federal PPS reimbursement? Enter in column 2 “Y” for yes and “N” for no. The election must be made in writing 30 days prior to the start of your cost reporting period. This option is only available for cost reporting period beginning on or after 10/1/2002 and before 10/1/06.

This worksheet consists of three parts:

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

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

Column Descriptions

Column 1--Indicate the number of beds available for use by patients at the end of the cost reporting period.

A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes. (See CMS Pub. 15-I, §2205.)

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

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

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

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

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

Column 7--Enter the number of intern and resident full time equivalents (FTEs) in an approved program determined in accordance with 42 CFR 412.105(g) for the indirect medical education adjustment.

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

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

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

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

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

Line Descriptions

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

Line 2--Enter title XVIII and XIX HMO days and Medicaid days eligible for DSH. (10/97)
| **Subscript this line for IRF subproviders to capture Medicaid HMO days in column 4. (1/1/02b)**

Line 3--Enter the SNF swing bed days for all programs where applicable.

Line 4--Enter the NF swing bed days unless State recognizes SNF care only.

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

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

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

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

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

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

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

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

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

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

Line 19--Do not use this line.

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

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

Line 22--Do not use this line.

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

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

Line 26--Enter the total observation bed days in column 6. Subscript this line for the subprovider(9/96) when both providers are claiming observation bed costs. Divide the total number of observation bed hours by 24 and round up to the nearest whole day. These total hours should include the hours for observation of patients who are subsequently admitted but only the hours up to the time of admission. 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 27--Enter in column 4 the number of ambulance trips, as defined by section 4531(a)(1) of the BBA, provided for Medicare patients for ambulance services on or after October 1, 1997. For cost reporting periods that overlap October 1 and July 1, 2001 see §3604, line 56 for proper subscripting (10/97). Effective for services rendered on or after December 21, 2000, ambulance costs for a CAH are reimbursed on costs if Worksheet S-2, column 1, line 30.03 is answered yes. If yes, separate the trips in accordance with Worksheet S-2, line 56 and subscripts.

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

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

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

Column 1

Line 1--Enter from Worksheet A, column 1, line 101, the wages and salaries paid to hospital

employees increased by amounts paid for vacation, holiday, sick, paid-time-off, severance, and bonus pay if not reported in column 1.

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

Lines 2 through 8.01--The amounts to be reported must be adjusted for vacation, holiday, sick, paid time off, severance, and bonus pay if not already included. Do not include in lines 2 through 6 the salaries for employees associated with excluded areas (report these costs on lines 8 and 8.01 (10/97)).

Line 2--Enter the salaries for directly-employed Part A, non-physician anesthetist salaries (for rural hospitals that have been granted CRNA pass through) to the extent these salaries are included in line 1. Add to this amount the costs for CRNA Part A services furnished under contract to the extent hours can be accurately determined. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 8 and 8.01. Additionally, contract CRNA cost must be included on line 9. Report in column 4 the hours that are associated with the costs in column 3 for directly employed and contract Part A CRNAs (10/97). Do not include nurse anesthetists, clinical nurse specialists, and nurse practitioner (10/00).

Line 3--Enter the non-physician anesthetist salaries included in line 1, subject to the fee schedule and paid under Part B by the carrier. Exclude nurse anesthetists, clinical nurse specialists, and nurse practitioners (10/99).

Line 4--Enter the physician Part A salaries, (excluding teaching physician salaries), which are included in line 1. Also do not include intern and resident (I & R) salary on this line. Report I & R salary on line 6. Subscript this line to 4.01 and report teaching physicians salaries, Part A included in line 1 above (10/97).

Line 5--Enter the total physician, physician assistant, nurse practitioner and clinical nurse specialist salaries billed under Part B that are included in line 1 (10/99). Under Medicare, these services are related to patient care and billed separately under Part B. Also include physician salaries for patient care services reported for rural health clinics and Federally qualified health clinics included on Worksheet A, column 1, line 63. Report on line 5.01 the non-physician salaries for patient care services reported for Hospital-based RHCs and FQHCs services included on Worksheet A, column 1, line 63 (10/99).

Line 6--For Cost reporting periods beginning before October 1, 2000, enter from Worksheet A the salaries reported in column 1 of line 22 for interns and residents. Add to this amount the costs for intern and resident services furnished under contract. For cost reporting periods beginning on or after October 1, 2000, do not report contract services on line 6; report contract services on line 6.01 only. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 8 and 8.01. Additionally, contract intern and resident costs must be included on line 9. DO NOT include contract intern and residents costs on line 10. Report in column 4 the hours that are associated with the costs in column 3 for directly employed and contract interns and residents.

Line 7--If you are a member of a chain or other related organization as defined in CMS Pub 15-I, §2150, enter, from your records, the wages and salaries for home office personnel that are included

in line 1.

Lines 8 and 8.01--Enter the amount reported on Worksheet A, column 1 for line 34 for the SNF. On line 8.01, enter from Worksheet A, column 1, the sum of lines 21, 24, 31, 35, 35.01, 36, 64, 65, 68 through 71, 82 through 86, 89, 92 through 94, and 96 through 100 (10/00).

Line 9--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, and management services as defined below. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. Do not include costs applicable to excluded areas reported on line 8 and 8.01 Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and 6 respectively). For cost reporting periods beginning before October 1, 2000, DO NOT include costs for pharmacy and laboratory services furnished under contract **and** subscript this line **to** report these costs on line 9.01 and 9.02 respectively (10/97). For cost reporting periods beginning on or after October 1, 2000, **DO NOT use lines 9.01 and 9.02, but include on line 9** contract pharmacy and laboratory **wage** costs as defined below in lines 9.01 and 9.02.

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

Include the amount paid for **management services**, as defined below, furnished under contract rather than by employees. Report only those personnel costs associated with the contract. Eliminate all supplies, travel expenses, and other miscellaneous items. Contract management is limited to the personnel costs for those individuals who are working at the hospital facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract management services DO NOT include the following: other management or administrative services, physician Part A services, consultative services, clerical and billing services, legal and accounting services, unmet physician guarantees, physician services, planning contracts, independent financial audits, or any services other than the management contracts listed above. Per instructions on the Form CMS-339, submit to your intermediary the following: for direct patient care, pharmacy and laboratory contracts, the types of services, wages, and associated hours; for management contracts, the aggregate wages and hours (10/00).

If you have no contracts for direct patient care or management services as defined above, enter a zero in column 1. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 1.

For cost reporting periods beginning on or after October 1, 2000, lines 9.01 and 9.02 are no longer required.

Line 9.01--Enter the amount paid for **pharmacy services** furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. Per instructions on Form CMS-339, submit

to your fiscal intermediary the following for direct patient care pharmacy contracts: the types of services, wages, and associated hours (10/97).

Line 9.02--Enter the amount paid for **laboratory services** furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. Per instructions on Form CMS-339, submit to your fiscal intermediary the following for direct patient care laboratory contracts: the types of services, wages, and associated hours (10/97).

Line 10--Enter from your records the amount paid under contract (as defined on line 9) for Part A physician services, excluding teaching physician services. Subscript this line and report Part A teaching physicians under contract on line 10.01. DO NOT include contract I & R services (to be included on line 6) (10/97). DO NOT include the costs for Part A physician services from the home office allocation and/or from related organizations (to be reported on line 12). Also, DO NOT include Part A physician contracts for any of the management positions reported on line 9.

Line 11--Enter the salaries and wage-related costs (as defined on lines 13 and 14) paid to personnel who are affiliated with a home office, who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office salaries **included** on line 7 and the associated wage-related costs. This figure must be based on recognized methods of allocating an individual's home office salary to the hospital. If no home office exists or if you cannot accurately determine the hours associated with the home office salaries that are allocated to the hospital, then enter a zero in column 1. All costs for any related organization must be shown as the cost to the related organization.

NOTE: Do not include any costs for Part A physician services from the home office allocation and/or related organizations. These amounts are reported on line 12.

If a wage related cost associated with the home office is not “core” (as described in Part I of Exhibit 7 of the Form-CMS -339) and is not a category included in “other” wage related costs on line 14 (see Part II of Exhibit 7 of Form CMS-339 and line 14 instructions below), the cost cannot be included on line 11. For example, if a hospital’s employee parking cost does not meet the criteria for inclusion as a wage-related cost on line 14, any parking cost associated with home office staff cannot be included on line 11 (10/97).

Line 12--Enter from your records the salaries and wage-related costs for Part A physician services, excluding teaching physician Part A services from the home office allocation and/or related organizations. Subscript this line and report separately on line 12.01 the salaries and wage-related costs for Part A teaching physicians from the home office allocation and/or related organizations (10/97).

Lines 13 through 20--For purposes of determining the wage related costs for the wage index, a hospital must use generally accepted accounting principles (GAAP).(Continue to use Medicare principles on all other areas to determine allowable fringe benefits.) Hospital are required to complete Form CMS-339, exhibit 7, section 3, a reconciliation worksheet to aid hospital and intermediaries in implementing GAAP when developing wage-related costs and Medicare principles when determining reimbursable costs. Additionally, upon request by the intermediary 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 Form CMS-339, exhibit 7, section 3, or, the hospital is unable, when requested, to provide a copy of the standard used in developing the wage-related costs, the intermediary may remove the cost from the hospital’s Worksheet S-3 due to insufficient documentation. As an alternative the amount could be allowed

based on the application of Medicare principles.

NOTE: Although GAAP allows hospitals to report their expenses at cost or at charge, for wage index purposes, hospitals must report their expenses at cost. **Although hospitals should use GAAP in developing wage related costs, the amount reported for wage index purposes must meet the reasonable costs provisions of Medicare. For example, the cost reported for self insurance must not exceed the cost of available comparable commercial insurance (see PRM, Part I, §2162).**

NOTE: All costs for any related organization must be shown as the cost to the related organization. (For Medicare cost reporting principles, see PRM 15-I, §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 intermediary, the intermediary may apply the hospital's cost to charge ratio to reduce the related party expenses to cost.

Line 13--Enter the core wage-related costs as described in Exhibit 7 of the Form CMS-339. (See note below for costs that are not to be included on line 13). Only the wage-related costs reported on Part I of Exhibit 7 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 8 and 8.01. Instead, these costs are reported on line 15. 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 11, 12, and 16 through 20.)

New Policy Regarding Health Insurance and Health-Related Wage Related Costs:

For cost reporting periods beginning on or after October 1, 1998, hospitals and fiscal intermediaries are no longer required to remove from domestic claims costs the personnel costs associated with hospital staff who deliver services to employees. Additionally, health related costs, that is, costs for employee physicals and inpatient and outpatient services that are not covered by health insurance but provided to employees at no cost or at a discount, are to be included as a core wage related cost. The 1 percent test no longer applies to health related costs for periods beginning on or after October 1, 1998.

Line 14--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 14.) A detailed list of each additional wage-related cost must be shown on Exhibit 7, Part II of Form CMS-339. 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 Exhibit 7, Part I of Form CMS-339,
- b. The wage-related cost has not been furnished for the convenience of the provider,
- c. The wage-related cost is a fringe benefit as defined by the Internal Revenue Service and, where required, has been reported as wages to IRS (e.g., the unrecovered cost of employee meals, education costs, auto allowances), and
- d. The total cost of the particular wage-related cost exceeds 1 percent of total salaries after the direct excluded salaries are removed (Worksheet S-3, Part III, column 3, line 3). Wage-related cost exceptions to the core list are not to include those wage-related costs that are required to be reported to the Internal Revenue Service as salary or wages (i.e., loan forgiveness, sick pay accruals). Include these costs in total salaries reported on line 1 of this worksheet.

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 8 and 8.01. Instead, these costs are reported on line 15. Also, do not include the wage-related costs for physician Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel.

Line 15--Enter the total (core and other) wage-related costs applicable to the excluded areas reported on lines 8 and 8.01.

Lines 16 through 20--Enter from your records the wage-related costs for each category of employee listed. The costs are the core wage related costs plus the other wage-related costs. Do not include wage-related costs for excluded areas reported on line 15. Do not include the wage related costs for Part A teaching physicians on line 18. These costs are reported separately on line 18.01 (10/97). On line 19, do not include wage-related costs related to non-physician salaries for patient care services reported for Hospital-based RHCs and FQHCs services included on Worksheet A, column 1, line 63. These wage-related costs are reported separately on line 19.01 (10/99).

Lines 21 through 35--Enter the direct wages and salaries from Worksheet A column 1 for the appropriate cost center identified on lines 21 through 35, respectively, increased by the amounts paid for vacation, holiday, sick, and paid-time-off if not reported in column 1 of these lines. These lines provide for the collection of hospital wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. These lines are completed by all hospitals if the ratio of Part II, column 4, sum of lines 8 and 8.01 divided by the result of column 4, line 1 minus the sum of lines 3, 5, and 7 equals or exceeds a threshold of 15 percent. For hospitals with less than 15 percent, these lines are optional. However, all hospitals with a ratio greater than 5 percent must complete line 13 of Part III for all columns. Calculate the percent to two decimal places for purposes of rounding.

Lines 22.01, 26.01, and 27.01--Enter the amount paid for services **under contract**, rather than by employees, for administrative and general, housekeeping, and dietary services, respectively. **DO NOT** include costs for equipment, supplies, travel expenses, and other miscellaneous or overhead items. Report only personnel costs associated with these contracts. Continue to report on the standard lines (line 22, 26, and 27), the amounts paid for services rendered by employees not under contract. (10/1/2003b)

NOTE: Do not include overhead costs on lines 8 and 8.01.

Column 2--Enter on each line, as appropriate, the **salary** portion of any reclassifications made on Worksheet A-6.

Column 3--Enter on each line the result of column 1 plus or minus column 2.

Column 4--Enter on each line the number of **paid** hours corresponding to the amounts reported in column 3. Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave hours, paid time-off hours, and hours associated with severance pay. For Part II, lines 1 through 12 (including subscripts) and Part III, line 13, if the hours cannot be determined, then the associated salaries must not be included in columns 1 through 3 (10/97).

NOTE: The hours must reflect any change reported in column 2; on call hours are not included in the total paid hours (on call hours should only relate to hours associated to a regular work schedule; and overtime hours are calculated as one hour when an employee is paid time and a half. No hours are required for bonus pay. The intern and resident hours associated with the salaries reported on line 6 must be based on 2080 hours per year for each full time intern and resident employee. The hours reported for salaried employees who are paid a fixed rate are recorded as 40 hours per week or the number of hours in your standard work week (10/97).

Column 5--Enter on all lines (except lines 13 through 20) the average hourly wage resulting from dividing column 3 by column 4.

Column 6--Enter on the appropriate lines the source used to determine the data entered in columns 1, 2, and 4, as applicable. If necessary, attach appropriate explanations. This column is used to provide information for future reference regarding the data sources and to assist intermediaries in verifying the data and method used to determine the data.

3605.3 Part III - Hospital Wage Index Summary--This worksheet provides for the calculation of the wage index update as well as analysis of the wage data.

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

Line 1--From Part II, enter the result of line 1 minus the sum of lines 2, 3, 4.01, 5, 5.01, 6, 6.01 (10/00), and 7 (10/97).

Line 2--From Part II, enter the sum of lines 8 and 8.01.

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

Line 4--From Part II, enter the sum of lines 9, 10, 11, and 12 and subscripts if applicable (10/97).

Line 5--From Part II, enter the sum of lines 13, 14, and 18. Enter on this line in column 5 the wage-related cost percentage computed by dividing Part III, column 3, line 5, by Part III, column 3, line 3. Round the result to 2 decimal places.

Line 6--Enter the sum of lines 3 through 5.

Lines 7 through 12--Do not complete these lines (10/97).

3606. WORKSHEET S-4 - HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

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

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

Line 2--Enter the unduplicated count of all individual patients and title XVIII patients receiving home visits or other care provided by employees of the agency or under contracted services during the reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count (column 5, line 2) may not equal the sum of columns 1 through 4, line 2. For purposes of calculating the unduplicated census, if a beneficiary has received healthcare in more than one MSA, 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. For cost reports that overlap October 1, 2000, subscript line 2 and enter the census count before October 1, 2000 on line 2 and on and after October 1, 2000 on line 2.01. For cost reporting periods that begin on or after October 1, 2000, no subscripting is required for line 2.

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

Enter the number of hours in your normal work week.

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

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

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

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

Line 19--Enter the number of Metropolitan Statistical Areas you serviced during this cost reporting period (10/97).

Line 20--Identify each MSA where the reported HHA visits are performed. Subscript the lines to accommodate the number of MSA's you service (10/97).

PPS Activity Data—Applicable for Medicare services rendered on or after October 1, 2000.

In accordance with 42 CFR §413.20 and §1895 of the Social Security Act, home health agencies are mandated to transition from a cost based reimbursement system to a prospective payment system (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 PRM II, chapter 32, §3205, page 32-13 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 4 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.

When a beneficiary experiences a significant change in condition (SCIC) and subsequently, but within the same 60 day episode, elects to transfer to another provider a SCIC within a PEP occurs.

A significant change in condition (SCIC) adjustment occurs when a beneficiary experiences a significant change in condition, either improving or deteriorating, during the 60 day episode that was not envisioned in the original plan of care. The SCIC adjustment reflects the proportional payment adjustment for the time both prior and after the beneficiary experienced the significant change in condition during the 60 day episode.

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 7 displays the sum total of data for columns 1 through 6. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report and only pertain to services rendered on or after October 1, 2000.

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-6, sum of columns 6 and 7 line 14.

Columns 1 through 6--Enter data pertaining to title XVIII patients only for services furnished on or after October 1, 2000. Enter, as applicable, in the appropriate columns 1 through 6, 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 5 (SCIC within a PEP) and vice versa. This is true for all episode of care payment categories in columns 1 through 6.

Line 33--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visits from lines 21, 23, 25, 27, 29 and 31.

Line 34--Enter in columns 1 through 6 for each episode of care payment category, respectively, the charges for services paid under PPS and not identified on any previous lines.

Line 35--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visit charges from lines 22, 24, 26, 28, 30, 32 and 34.

Line 36--Enter in columns 1 through 6 for each episode of care payment category, respectively, the total number of episodes of care rendered and concluded in the provider's fiscal year.

Line 37--Enter in columns 2 and 4 through 6 for each episode of care payment category identified, respectively, the total number of 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).

Line 38--Enter in columns 1 through 6 for each episode of care payment category, respectively, the total non-routine medical supply charges for services rendered and concluded in the provider's fiscal year.

Column 7--Enter on lines 21 through 37, respectively, the sum total of amounts from columns 1 through 6.

3608. STATISTICAL DATA OUTPATIENT PROVIDERS

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

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

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

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

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

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

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

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

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

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

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

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

Line 9--Subscript line 9 as needed to list all physicians furnishing services at the RHC/FQHC. Enter the physician's name in column 1, and the physician's Medicare billing number in column 2.

Line 10--Subscript line 10 as needed to list all supervisory physicians. Enter the physician's name in column 1, and the number of hours the physician spent in supervision in column 2.

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

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

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

Line 14--Is this a consolidated cost report as defined in the Rural Health Clinic Manual? If yes enter in column 2 the number of providers included in this report.

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

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

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

3609. WORKSHEET S-7 - NHCMQ DEMONSTRATION STATISTICAL DATA AND PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES (July 1, 1998)

NOTE: 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. Therefore, SNFs will not be reimbursed under demonstration procedures for cost reporting periods beginning on and after that date.

In accordance with 42 CFR 413.60(a), 42 CFR 413.24(a), and 42 CFR 413.40(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to hospital-based SNF facilities participating in the NHCMQ Demonstration, for cost reporting periods beginning prior to July 1, 1998. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ Demonstration.

Column Descriptions

Column 1--The case mix group designations are already entered in this column.

Column 2--The M3PI revenue code designations are already entered in this column.

Columns 3, 4, and 4.02--Enter the rate assigned to the provider for each applicable group. This rate is updated annually effective January 1. Providers with fiscal years other than a calendar year may have two rates to report. Enter the rate prior to January 1 in column 3 and the rate on or after January 1 in column 4 for the demonstration. Calendar year providers use column 4 only. For cost reporting periods beginning on or after July 1, 1998, no entry is required. The rate is automatically calculated when an entry is made on the appropriate lines of columns 3.01, 4.01, or 4.03 (10/00). This Federal rate is adjusted for the labor portion by the update factor specific to the provider's MSA plus applicable increase for the period. This update factor is reported on Worksheet S-2, line 28.01 columns 2 and 3.

For cost reporting periods beginning on or after July 1, 2001 or for providers who have elected 100 percent Federal rate the only data required to be reported are the days associated with each RUG. Those days will be reported in column 3.01 regardless of the periods designated. The calculation of the total payment for each RUG is no longer required. All payment data will be reported as a total amount paid under the RUG PPS payment system on Worksheet E-3, Part III, line 24 and will be generated from the PS&R or your records.

Columns 3.01 and 4.01--Enter the number of demonstration inpatient days prior to January 1 and on or after January 1 respectively. If you are a calendar year provider, report all inpatient days in column 4.01 for each applicable group. For cost reporting periods beginning on or after July 1, 1998, enter in column 3.01 the days of the period before October 1 and in column 4.01 for the days on and after October 1. Enter on column 4.03 the days for the period April 1, 2001 through September 30, 2001. Enter the total on line 46.

Columns 4.02 and 4.03--For services rendered on and after April 1, 2001 through September 30, 2001 enter the appropriate rate and days respectively for the period.

Column 4.05--For cost reporting periods that end prior to April 1, 2000, do not complete this column. For services rendered on April 1, 2000 through September 30, 2000, enter the days associated with the high cost RUGS paid at an increase of 20 percent.

Column 4.06--For cost reporting periods beginning on or after July 1, 2002, enter the days associated with the swing beds as reimbursement is based on SNF PPS.

Column 5--Calculate the amount attributable to the demonstration for each revenue group by multiplying the rate in column 3 by the days in column 3.01 (rounded to zero) plus the rate in column 4 multiplied by the days in column 4.01 (rounded to zero) (Column 4 times column 4.01 for calendar year providers). Enter the total on line 46. Transfer this amount to Worksheet E-3, Part V, line 6. For cost reporting periods beginning on or after July 1, 1998, multiply columns 3, 4, and 4.02 times columns 3.01, 4.01, and 4.03 (columns 4 times column 4.01 for cost reporting periods beginning

October 1) respectively, rounded to zero and add the three results. This becomes the Federal amount. For services rendered on and after April 1 through September 30, 2000, increase the Federal rate by 20 percent for the following RUGs: RHC, RMC, RMB, SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, and CA1. Multiply the Federal amount by the appropriate transition period percentage, i.e., 25 percent, 50 percent, 75 percent, or 100 percent identified on worksheet S-2 line 28.01, column 1. Add to the Federal amount the result of the calculation of (total days from columns 3.01, 4.01 and 4.03 multiplied by the facility specific rate (that result rounded to zero) identified on worksheet S-2, line 28.02, column 1) times the reciprocal percentage applied to the Federal rate, i.e., 75 percent, 50 percent, 25 percent, or 0 percent. Enter the result on the appropriate line for each RUG. Enter the total of column 5 on line 46. Transfer this amount to Worksheet E-3, Part III, column 2, line 24.

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

3609.1 Worksheet S-9 - Hospice Identification Data--In accordance with 42 CFR 418.310 hospice providers of service participating in the Medicare program are required to submit annual information for health care services rendered to Medicare beneficiaries. Also, 42 CFR 418.20 requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a hospital-based hospice. Complete a separate S-9 for each hospital-based hospice **effective for cost reporting periods ending on or after September 30, 2000.**

3609.2 Part 1-Enrollment Days Based on Level of Care--

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

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

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

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

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

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

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.

3609.4 Worksheet S-10-Hospital uncompensated Care Data--Section 112(b) of the Balance Budget Refinement Act (BBRA) requires that hospital 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. This mandate will be for cost reporting periods ending on or after April 30, 2003.

Uncompensated Care--Defined as charity care and bad debt.

Charity care—Health services for which hospital policies determine the patient is unable to pay. Charity care results from a provider’s policy to provide health care services free of charge (or where only partial payment is expected not to include contractual allowances for otherwise insured patients) to individuals who meet certain financial criteria. For the purpose of uncompensated care charity care is measured on the basis of revenue forgone, at full-established rates. Charity care does not include contractual write-offs.

Bad Debt--For the purpose of uncompensated care it is the unpaid dollar amount for services rendered from a patient or third party payer, for which the provider expected payment, excluding Medicare bad debt.

For the purpose of collecting data for uncompensated care, both charity care and bad debt should be combined and reported.

Line 1--Do you have a written charity care policy? Enter a “Y” for yes or an “N” for no.

Line 2--Are patients’ write-offs identified as charity? Enter a “Y” for yes or an “N” for no. If yes answer 2.01 through 2.04.

Line 2.01--Are patients’ write-offs identified as charity at the time of admission? Enter a “Y” for yes or an “N” for no.

Line 2.02--Are patients write-offs identified as charity at the time of first billing? Enter a “Y” for yes or an “N” for no.

Line 2.03--Are patients’ write-offs identified as charity after some collection effort has been made? Enter a “Y” for yes or an “N” for no.

Line 2.04--Other method-specify when are patients’ write-offs identified as charity?

Line 3--Are charity write-offs made for partial bill? Example: coinsurance and deductibles after insurance pay. Enter a “Y” for yes or an “N” for no.

Line 4--Are charity determination based upon administrative judgment without financial data? Enter a “Y” for yes or an “N” for no.

Line 5-- Are charity determination based upon income data only? Enter a “Y” for yes or an “N” for no.

Line 6--Are charity determination based upon net worth (assets) data only? Enter a “Y” for yes or an “N” for no.

Line 7--Are charity determination based upon income and net worth data? Enter a “Y” for yes or an “N” for no.

Line 8--Does your accounting system separately identify bad debt and charity care? Enter a “Y” for yes or an “N” for no. If yes, answer line 8.01.

Line 8.01--Do you separately account for inpatient and outpatient uncompensated care services? Enter a "Y" for yes or an "N" for no.

Line 9--Is discerning charity from bad debt a high priority in your institution? Enter a "Y" for yes or an "N" for no. If no, answer lines 9.01 through 9.04.

Line 9.01--Is it because there is not enough staff to determine eligibility? Enter a "Y" for yes or an "N" for no.

Line 9.02--Is it because there is no financial incentive to separate charity from bad debt? Enter a "Y" for yes or an "N" for no.

Line 9.03--Is it because there is no clear directive from policy administration as to how to make charity determination? Enter a "Y" for yes or an "N" for no.

Line 9.04--Is it because your facility does not think that discerning between charity and bad debt is important? Enter a "Y" for yes or an "N" for no.

Line 10--If charity determinations are made based upon income data, what is the maximum income that can be earned by a patient (single without dependents) and still be determined to be a charity write-off?

Line 11-- If charity determinations are made based upon income data, is the income directly tied to Federal poverty level? Enter a "Y" for yes or an "N" for no. If yes, answer lines 11.01 through 11.04.

Line 11.01--Is the percentage level used less than 100 percent? Enter a "Y" for yes or an "N" for no.

Line 11.02--Is the percentage level used equal to 100 percent and < 150 percent? Enter a "Y" for yes or an "N" for no.

Line 11.03--Is the percentage level used equal to 150 percent and < 200 percent? Enter a "Y" for yes or an "N" for no.

Line 11.04--Is the percentage level used equal to or greater than 200 percent? Enter a "Y" for yes or an "N" for no.

Line 12--Are Partial write-offs given to higher income patients on a gradual scale? Enter a "Y" for yes or an "N" for no.

Line 13--Is there charity consideration given to patients with higher income and assets who have catastrophic or other extraordinary medical expenses? Enter a "Y" for yes or an "N" for no.

Line 14--Is your Hospital State and local government owned? Enter a "Y" for yes or an "N" for no. If yes, answer lines 14.01 and 14.02.

Line 14.01--Do you receive direct financial support from that government entity for the purpose of proving uncompensated care? Enter a "Y" for yes or an "N" for no.

Line 14.02--What percentage of the amount on line 14.01 is from government funding?

Line 15--Do you receive restricted grants, i.e. governmental or private targeted toward indigent care excluding Medicare DSH for rendering care to charity patients? Enter a "Y" for yes or an "N" for no.

Line 16--Are other non-restricted grants used to subsidize charity care, i.e., private donations targeted toward indigent care excluding Medicare DSH for rendering care to charity patients? Enter a "Y" for yes or an "N" for no.

Uncompensated Care Revenues

Line 17--Enter from your records revenues from state and local indigent care programs.

Line 18--Enter from your records revenues from the State Children's Health Insurance Program (SCHIP). Created in 1997, SCHIP is a state and federal partnership to help children without health insurance, many of whom come from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance.

Line 19--Enter from your records Gross Medicaid revenues.

Line 20--Enter the amounts from your record for all the restricted grants public and private: patient specific (indigent) such as contractual agreement with the state or local government to pay for prisoner care

Line 21--Enter the amounts from your records for all non-restricted grants non-patient specific (not necessarily indigent).

Line 22--Total Uncompensated Care Revenue, add lines 17 thru 21.

Uncompensated Care Cost

Line 23--Total charges for patients covered by a State or Local indigent care program, such as general assistance days.

Line 24--Cost to charge ratio from Worksheet C, Part I, column 3, line 103, divided by column 8, line 103.

Line 25--Total State and Local indigent care program cost, multiply line 23 by line 24.

Line 26--Total Charges from your records for the SCHIP program.

Line 27--Total SCHIP cost, multiply line 24 by line 26.

Line 28--Total Gross Medicaid charges from your records.

Line 29--Medicaid cost, multiply line 24 by line 28.

Line 30--Total Gross total uncompensated care charges from your books and records.

Line 31--Uncompensated care cost, multiply line 24 by line 30.

Line 32--Total uncompensated care cost to the hospital. It is the sum of lines 25, 27, 29 and 31.

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3610. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve using data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications 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 A, B, C, and D, the line numbers are consistent). Not all of the cost centers listed apply to all providers using these forms. For example, where you furnish all radiological services in a single department and your records are maintained in that manner, enter a single entry identifying all radiological services on line 41 (Radiology-Diagnostic), and make no entry on lines 42 (Radiology-Therapeutic) and 43 (Radioisotope).

Do not include on this worksheet items not claimed in the cost report because they conflict with the regulations, manuals, or instructions but which you wish nevertheless to claim and contest. Enter amounts on the appropriate settlement worksheet (Worksheet E, Part A, line 30; Worksheet E, Part B, line 36; Worksheet E-2, line 22; and Worksheet E-3, Parts I, II, and III, lines 21, 34, and 59, respectively). For provider based facilities enter the protested amounts on line 27 of Worksheet H-7, Part II for home health agencies, line 29 of Worksheet J-3 for outpatient rehabilitation providers and line 25 of Worksheet M-3 for RHC/FQHC providers. (9/96)

If the cost elements of a cost center are separately maintained on your books, maintain a reconciliation of the costs per the accounting books and records to those on this worksheet. This reconciliation is subject to review by your intermediary.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If you need to use additional or different cost center descriptions, add additional lines to the cost report. Where an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line. The added line is identified as a numeric subscript of the immediately preceding line. For example, if two lines are added between lines 7 and 8, identify them as lines 7.01 and 7.02. If additional lines are added for general service cost centers, add corresponding columns for cost finding.

Also, submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and is used as a basic summary for financial statements.

Do not use lines 32, 72 through 81, 87, and 91.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. Form CMS-2552-96 provides for 90 preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These 90 cost center descriptions are hereafter referred to as the standard cost centers. An additional 57 nonstandard cost center descriptions have been identified through analysis of frequently used labels.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each provider label in their

Line 23--Enter the other costs applicable to interns and residents in an approved teaching program.

Line 24--This line is used for a hospital or subprovider which operates an approved paramedical education program that meets the criteria of 42 CFR 413.85 and 412.113(b). 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 24. If the direct costs are included in the costs of an ancillary cost center, reclassify them on Worksheet A-6 to line 24. Appropriate statistics are required on Worksheet B-1 to ensure that overhead expenses are properly allocated to this cost center.

Lines 25 through 36--These lines are for the inpatient routine service cost centers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTE: For lines 60 and 63, any ancillary service billed as clinic, RHC, and FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.

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-4, Part II.

Lines 72 through 81--Do not use these lines.

Lines 82 through 93--Use these lines for special purpose cost centers. Special purpose cost centers include kidney, heart, liver, and lung acquisition costs, 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.

Line 82--Record any costs in connection with lung acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 83--This cost center includes the cost of services purchased under arrangement or billed directly to the hospital in connection with kidney acquisition. Such direct costs include but are not limited to:

- o Fees for physician services (preadmission for transplant donor and recipient tissue-typing and all tissue-typing services performed on cadaveric donors);
- o Cost for kidneys acquired from other providers or kidney procurement organizations;
- o Transportation costs of kidneys;
- o Kidney recipient registration fees;
- o Surgeons' fees for excising cadaveric donor kidneys; and
- o Tissue-typing services furnished by independent laboratories.

NOTE: No amounts or fees paid to a donor, their estate, heirs, or assigns in exchange for a kidney or for the right to remove or transplant a kidney are included in kidney acquisition costs. Also, such amounts or fees are not included in any other revenue producing or general service cost center.

Only hospitals which are certified transplant centers are reimbursed directly by the Medicare program for organ acquisition costs. All such costs are accumulated on Worksheet D-6.

Hospitals which are not certified transplant centers are not reimbursed by the Medicare program for organ acquisition costs. Such hospitals sell any organs excised to a certified transplant center or an

organ procurement organization. The costs are accumulated in this cost center and flow through cost finding to properly allocate overhead costs to this cost center. However, only a certified transplant center completes Worksheet D-6.

Line 84--Record any costs in connection with liver acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 85--Record any costs in connection with heart acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 85.01--Record any costs in connection with pancreas acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs (8/99).

Line 86--Record any costs related to organ acquisitions which are not already recorded on lines 82, 83, 84, 85 and 85.01. This cost center flows through cost finding and accumulates any appropriate overhead costs (8/99).

Line 87--Do not use this line.

Line 88--Enter all interest paid by the facility. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

NOTE: If capital-related and working capital interest are commingled on this line, reclassify working capital interest to A & G expense. Reclassify capital-related interest to lines 1 through 4, as appropriate, in accordance with the instructions for those lines.

Line 89--Include only utilization review costs of the hospital-based SNF. All costs are either reclassified or adjusted in total depending on the scope of the review. If the scope of the review covers all patients, all allowable costs are reclassified in column 4 to A & G expenses (line 6). If the scope of the review covers only Medicare patients or Medicare, title V, and title XIX patients, then (1) in column 4, reclassify to A & G expenses all allowable costs other than physicians' compensation and (2) deduct in column 6 the compensation paid to the physicians for their personal services on the utilization review committee. The adjusted amount is then reinstated on Worksheet D-1, line 81 for each program. The sum of the amounts reported on each Worksheet D-1 and/or the amount reported on Worksheet E-2, column 1, line 7 must equal the amount adjusted on Worksheet A-8 (9/96).

Line 90--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.

A PPS hospital or a complex with a PPS excluded unit which is paid for PPS inpatient capital using the hold harmless method is required to allocate the costs in this cost center between old and new capital and between buildings and fixtures and movable equipment on the basis of the ratio of the hospital's gross old asset value to total asset value in each cost reporting period on Worksheet A-7, Part III.

For cost reporting periods beginning on or after October 1, 2001, PPS providers paid 100 percent Federal **do not** complete line 90 and Worksheet A-7.

o 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.

o 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.

o 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.

o 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, §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.

o 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 11, to the renal dialysis cost center, line 57.

o 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 42 CFR 413.85(d)(7) and 49 FR 296 dated January 3, 1984.)

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

o 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-I, §2109.)

o 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.

3612. WORKSHEET A-7 - ANALYSIS OF CAPITAL ASSETS

This worksheet consists of **four** parts:

- Part I - Analysis of Changes in Old Capital Asset Balances
- Part II - Analysis of Changes in New Capital Asset Balances
- Part III - Computation of Old Capital for Insurance, Taxes, and Other Capital-Related Costs.
- Part IV - Reconciliation of amounts from worksheet A, column 2, lines 1 through 4.**

See the instructions for Worksheet A for a definition of old and new capital. **A non-PPS provider does not have to complete Part I.** For cost reporting periods beginning on and after October 1, 2001, hospitals receiving 100 percent Federal prospective payment for capital are no longer required to complete Parts I through **IV** of this Worksheet if worksheet S-2, column 2, line 36 = "Y".

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, II, and III of this worksheet.

The intent of Worksheet A-7, Parts I and II, 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, Parts I and II, as appropriate, to properly allocate the related insurance, taxes, etc. This cost finding treatment must comply with the consistency rule in 42 CFR 412.302(d).

3612.1 Part I - Analysis of Changes in Old Capital Asset Balances and Part II - Analysis of Changes in New Capital Asset Balances.--These parts enable 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 Parts I and II 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 sum of Parts I and II, column 6, line 9, agree 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, represent transfers from obligated capital and/or a transfer 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.

The sum of columns 1 and 4 minus column 5 equals column 6.

Line Descriptions

Line 8--If you have included in lines 1 through 6 of Parts I and II any of the following, enter those amounts on line 8.

- o Capitalized a lease in accordance with generally accepted accounting principles (GAAP) and included it in the assets reported on Worksheet G,
- o 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
- o Construction in progress at the end of the cost reporting period.

Line 9--Enter line 7 minus line 8.

3612.2 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 through 4, column 7.

Lines 1 through 4--In accordance with 42 CFR 412.302(b)(4), allowable costs for other capital-related expenses (including but not limited to taxes, insurance, and license and royalty fees on depreciable assets) are apportioned to old capital by applying the ratio of the hospital's gross old 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 5--Enter the sum of lines 1 through 4. Column 4 must equal 1.000000.

Columns 1 through 4, Lines 1 through 4--Use these columns and lines to compute ratios of new and old 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 through 4).

Column 1--Enter on line 1 your gross asset value (asset value before accumulated depreciation) for old buildings and fixtures (which also includes old land and land improvements). Enter on line 2 your gross asset value for old movable equipment. Enter on line 3 your gross asset value for new buildings and fixtures (which also includes new land and land improvements). Enter on line 4 your gross asset value for new movable equipment.

NOTE: Part III, column 1, line 5, must agree with the sum of Parts I and II, column 6, line 7.

Column 2--Enter in column 2, line as appropriate, any amounts that you have included in column 1, lines 1 through 4, and which were reported on line 8 of Parts I and II, as appropriate.

Column 3--Enter column 1 less column 2.

Column 4--Enter on lines 1 through 4 the amount in column 3, lines as applicable, divided by the amount in column 3, line 5. Round the resulting ratio to six decimal places.

Columns 5 through 7--These columns provide for the allocation of other capital-related costs (taxes, insurance, and other) to the capital-related cost center lines (Worksheet A, lines 1 through 4).

Line 5--Enter in column 5 capital expenditures relating to insurance. Enter in column 6 capital expenditures relating to State and local taxes on property and equipment. Enter in column 7 other capital expenditures (not including taxes, insurance, depreciation, lease, and interest expense). Enter in column 8 the sum of the amounts reported in columns 5 through 7.

Lines 1 through 4--Apply the ratios developed in column 4, line as applicable, to allocate the other capital costs reported in line 5.

Column 8--Line 5 must be equal to or less than the amount on Worksheet A, line 90, column 3. The amount reported becomes the reclassification entry on Worksheet A, column 4 which will zero-out the balance on line 90. If you directly assign the capital related costs, see Part IV for proper disclosure of these costs.

Columns 9 through 15--These lines summarize the amounts in the capital-related cost centers (Worksheet A, lines 1 through 4, column 7).

NOTE: The amount entered in these columns must be net of reclassifications and adjustments identified on Worksheets A-6, A-8 and A-8-1.

Column 9--Enter the amount reported in Part IV below, from column 9, lines 1 through 4, adjusted by the amounts identified on Worksheets A-6, A-8 and A-8-1.

Column 10--Enter the amount reported in Part IV, column 10, lines 1 through 4, relating to capital-related lease expense, adjusted by the amounts identified on Worksheets A-6, A-8, and A-8-1. (See HCFA Pub. 15-1, §2806.1.) Report insurance, taxes, and license and royalty fees associated with leased assets in columns 12, 13, and 14 of this worksheet, respectively.

Column 11--Enter the amount reported in Part IV, column 11, lines 1 through 4, relating to capital-related interest expense, adjusted by the amounts identified on Worksheets A-6, A-8, and A-8-1

Column 12--Enter the amount from column 5 plus any additional amounts reported in Part IV, column 12 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 13--Enter the amount from column 6 plus any additional amounts reported in Part IV, column 13 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 14--Enter the amount from column 7 plus any additional amounts reported in Part IV, column 14 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 15--Enter the sum of columns 9 through 14. The amounts from column 15, lines 1 through 4, must equal the amounts on Worksheet A, column 7, lines 1 through 4.

3612.3 Part IV - Reconciliation of Amounts From Worksheet A, Column 2, Lines 1 Through 4--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 through 4.

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 through 4 must agree with the amounts reported on Worksheet A, column 2, lines 1 through 4.

3616.8 Worksheet A-8-4 - Reasonable Cost Determination for Therapy Services Furnished on and after April 10, 1998 by Outside Suppliers.--This worksheet provides for the computation of any needed adjustments to costs applicable to therapy services furnished by outside suppliers. The information required on this worksheet provides, in the aggregate, all data for therapy services furnished by all outside suppliers in determining the reasonableness of therapy costs. When reimbursement for such therapy services is subject to the provisions of PPS and TEFRA rate of increase ceiling, adjust costs subsequently on Worksheet C, Part I. (See PRM-I, chapter 14.) Prorate, based on total charges, any statistics and costs for purposes of calculating standards, allowances, or the actual reasonable cost determination, if your cost report overlaps April 10, 1998, i.e., overtime hours. This form is not applicable for services prior to April 10, 1998. Therapy services rendered on or after January 1, 1999, are subject to a fee schedule. Therefore, for cost reporting periods beginning on or after January 1, 1999, this form is no longer required for all hospitals except CAHs, hospitals with respiratory therapy services through **June 30, 2000**, and hospital complexes with hospital based-CMHCs and HHA's, through **June 30, 2000** and September 30, 2000, respectively (1/99).

If you contract with an outside supplier for therapy services, the potential for limitation and the amount of payment you receive depend on several factors:

- o An initial test to determine whether these services are categorized as intermittent part time or full time services;
- o The location where the services are rendered, i.e., at your site or HHA home visit;
- o Whether detailed time and mileage records are maintained by the contractor;
- o Add-ons for supervisory functions, aides, overtime, equipment and supplies; and
- o Intermediary determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

3616.9 Part I - General Information.--This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Line 1--Enter the number of weeks that services were performed on site. Count only those weeks during which a supervisor, therapist or an assistant was on site. For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the HHA. Weeks when services were performed both at your site and at the patients home are counted only once. (See PRM-I, chapter 14.)

Line 2--Multiply the amount on line 1 by 15 hours per week. This calculation is used to determine whether services are full-time or intermittent part-time.

Line 3--Enter the number of days in which the supervisor or therapist (only report the therapists for respiratory therapy) was on site. Count only one day when both the supervisor and therapist were at the site during the same day.

Line 4--Enter the number of days in which the therapy assistant (PT, OT, or SP only) was on site. Do not include days when either the supervisor or therapist was also at the site during the same day.

NOTE: Count an unduplicated day for each day the contractor has at least one employee on site. For example, if the contractor furnishes a supervisor, therapist and assistant on one day, count one therapist day. If the contractor provides two assistants on one day (and no supervisors or therapists), count one assistant day.

Line 5--Enter the number of unduplicated visits made by the supervisor or therapist. Count only one visit when both the supervisor and therapist were present during the same visit.

Line 6--Enter the number of unduplicated visits made by the therapy assistant. Do not include in the count the visits when either the supervisor or therapist was present during the same visit.

Line 7--Enter the standard travel expense rate applicable. (See CMS Pub. 15-I, chapter 14.)

Line 8--Enter the optional travel expense rate applicable. (See CMS Pub. 15-I, chapter 14.) Use this rate only for services for which time records are available.

Line 9--Enter in the appropriate columns the total number of hours worked for each category.

Line 10--Enter in each column the appropriate adjusted hourly salary equivalency amount (AHSEA). This amount is the prevailing hourly salary rate plus the fringe benefit and expense factor described in CMS Pub 15-I, chapter 14. This amount is determined on a periodic basis for appropriate geographical areas and is published as an exhibit at the end of CMS Pub. 15-I, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisory AHSEA, adjusted for administrative and supervisory responsibilities. Determine this amount in accordance with the provisions of PRM-I, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants, aides, and trainees respectively) the AHSEA from either the appropriate exhibit found in CMS Pub. 15-I, chapter 14 or from the latest publication of rates. If the going hourly rate for assistants in the area is unobtainable, use no more than 75 percent of the therapist AHSEA. The cost of services of a therapy aide or trainee is evaluated at the hourly rate, not to exceed the hourly rate paid to your employees of comparable classification and/or qualification, e.g., nurses' aides. (See CMS Pub. 15-I, §1412.2.)

Line 11--Enter the standard travel allowance equal to one half of the AHSEA. Enter in columns 1 and 2 one half of the amount in column 2, line 10. Enter in column 3 one half of the amount in column 3, line 10. (See CMS Pub 15-I, §1402.4.)

Lines 12 and 13--Enter the number of travel hours and number of miles driven, respectively, if time records of visits are kept. (See CMS Pub. 15-I, §§1402.5 and 1403.1.) Subscript this line into two categories of, provider site and provider offsite.

NOTE: There is no travel allowance for aides employed by outside suppliers.

3616.10 Part II - Salary Equivalency Computation--This part provides for the computation of the full-time or intermittent part-time salary equivalency.

When you furnish therapy services from outside suppliers to health care program patients but simply arrange for such services for non health care program patients and do not pay the non health care program portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of CMS Pub. 15-I, §2314, complete Part II, lines 14 through 20 and 23 in all cases and lines 21 and 22 where appropriate. See §2810 for instructions regarding grossing up costs and charges. However, where you cannot gross up costs and charges, complete lines 14 through 20 and 23.

Line 14 - 20--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 9) by the adjusted hourly salary equivalency amount for supervisors, therapists, assistants, aides and trainees (for respiratory therapy only).

Line 17--Enter the sum of lines 14 and 15 for respiratory therapy or sum of lines 14 through 16 for all others.

training program or did not participate in Medicare during the base period, but either condition changed in a cost reporting period beginning on or after July 1, 1985, a per resident amount must be established. If you begin a program after the first month of the cost reporting period, you are reimbursed for these costs based on reasonable cost. Do not include in column 26 the intern and resident costs from columns 22 and 23. If you qualify for the exception, annotate Worksheet S-2, line 25.02. For the first cost reporting period in which the program was in effect during the first month, you are paid for graduate medical education costs based on a per resident amount through Worksheet E-3, Part IV. Include in column 26 the costs from columns 22 and 23.

Worksheet B-1, Column 6A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, Part I, column 5A, line 103 and the accumulated cost reported on Worksheet B-1, column 6, line 6. Enter any amounts reported on Worksheet B, Part I, column 5A 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 6 the administrative and general costs reported on Worksheet B, Part I, column 6, line 6 since these costs are not included on Worksheet B-1, column 6 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 6.03 (Other A&G), the reconciliation column designation must be 6A.03.

Worksheet B-1, Column 6--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-1, column 6, line 6, is the difference between the amounts entered on Worksheet B, Part I, column 5A and Worksheet B-1, column 6A. 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 24--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.

3618. WORKSHEET B, PART II - ALLOCATION OF OLD CAPITAL-RELATED COSTS AND WORKSHEET B, PART III - ALLOCATION OF NEW CAPITAL-RELATED COSTS

These worksheets provide 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. For cost reporting periods beginning on and after October 1, 2001, hospitals receiving 100 percent Federal rate (Worksheet S-2, line 36 with a yes response) for PPS capital payments **only complete Worksheet B, Parts II and III, column zero (directly assigned old and new capital related costs), if applicable.**

NOTE: Except for non-PPS providers, unless there is a change in ownership or the provider has elected the alternative method described in §3617, the hospital must continue the same cost finding methods (including its cost finding bases) in effect in the hospital's last cost reporting period ending on or before October 1, 1991. (See 42 CFR 412.302 (d).) If there is a change in ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices. (See CMS Pub. 15-I, §2313.)

Parts II and III are completed by all PPS hospitals and excluded hospitals which were part of a complex subject to PPS. Freestanding hospitals excluded from PPS are not required to complete Part II. (See 42 CFR 412.23 for classification of excluded units.) Also, PPS hospitals claiming 100 percent Federal for capital payment are not required to complete Part II. Caution should be taken if the provider later determines an alternative method of capital payment, i.e. hold harmless, is appropriate and that adequate data for old and new capital is not maintained.

See the instructions for Worksheet A, lines 1 through 4, for a discussion of old and new 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, Parts II and III, in the same sequence.

Column O--Where capital-related costs have been directly assigned to specific cost centers on Worksheet A, column 7, in accordance with CMS Pub. 15-I, §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 1 through 4--Obtain the amounts entered in columns 1 through 4, lines 5 through 100, from the corresponding columns and lines on Worksheet B, Part I.

Column 4A--Enter the sum of columns 0 through 4 for each line.

Enter on line 105 of Worksheet B-1 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 105 of Worksheet B-1 by the statistic reported on the first line of the same column. Enter the unit cost multiplier

NOTE: If you qualify for the exception in 42 CFR 413.86(e)(4), all direct graduate medical education costs are reimbursed as a pass through based on reasonable cost. Enter the amount from Worksheet B, Part I, sum of columns 21 through 24 plus or minus post step down adjustments (reported on Worksheet B-2) applicable to medical education costs.

If you answered yes to question 57 on Worksheet S-2 subscript this column and report in column 2 nursing school, column 2.01 allied health costs (paramedical education) and column 2.02 all other medical education costs.

Column 3--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 sum of the amounts in columns 1 and 2 by the ratio of the amount entered on Worksheet D-1, line 26 to the amount entered on Worksheet D-1, line 21.

Column 4--Enter the sum of columns 1 and 2 minus column 3.

Column 5--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 7. For SNF cost reporting periods beginning on or after July 1, 1998, enter the program days from worksheet S-3, Part I, column 6, line 15.

Column 6--Divide the cost of each cost center in column 4 by the total patient days in column 5 for each line to determine the pass through cost. Enter the resultant per diem cost in column 6.

Column 7--Enter the program inpatient days for the applicable cost centers. Transfer these amounts from the appropriate Worksheet D, Part I, column 8. For SNF cost reporting periods beginning on or after July 1, 1998, enter the program days from worksheet S-3, Part I, column 4, line 15.

Column 8--Multiply the per diem cost in column 6 by the inpatient program days in column 7 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 25 through 30 and 33 to Worksheet D-1, line 50 for the hospital. Transfer the amount on line 31 to the appropriate Worksheet D-1, line 50 for the subprovider. If you are a title XVIII hospital or subprovider paid under PPS, also transfer these amounts to the appropriate Worksheet E, Part A, line 14. For SNF, NF or ICF/MR that follow Medicare principles for cost reporting periods beginning on or after July 1, 1998, transfer the amount on column 8, line 34 to Worksheet E-3, Part III, line 28.

3621.4 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 PPS must also exclude nonphysician anesthetist and direct medical education costs as these costs are reimbursed separately. Determine capital-related inpatient ancillary costs on Worksheet D, Part II. For cost reporting periods beginning on or after July 1, 1998, 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/ICFMR (if applicable). Beginning August 1, 2000, hospital payment for outpatient services will be made prospectively with the exception of certain pass through costs identified on this worksheet.

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 27.

Column 1--Enter on each line (after any adjustments made after cost finding) the nonphysician anesthetist cost for hospitals and components qualifying for the exception to the CRNA fee schedule. (See §3610, line 20 description for more information.) Obtain this amount from Worksheet B, Part I, column 20 plus or minus any adjustments reported on Worksheet B, Part I, column 26 for nonphysician anesthetist. For the hospital and subprovider (if applicable) components only, enter on line 62, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 88.

Column 2--Enter on each line (after taking into consideration any adjustments made in column 26 of Worksheet B, Part I) the direct medical education costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part I, sum of columns 21 and 24 plus or minus post step down adjustments made on Worksheet B, Part I, column 26 applicable to direct medical education costs. For SNFs enter the sum of columns 21 through 24 unless the hospital is receiving graduate medical education payments reported on worksheet E-3, Part IV (Worksheet S-2, line 25.02 with a yes response); then report the sum of columns 21 and 24 only (7/98). For the hospital and subprovider (if applicable) components only, enter on line 62, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 89.

NOTE: If you qualify for the exception in 42 CFR 413.86(e)(4), all direct graduate medical education costs for interns and residents in approved programs are reimbursed as a pass through based on reasonable cost. Enter the amount from Worksheet B, Part I, sum of columns 21 through 24 plus or minus post step down adjustments (reported on Worksheet B-2) applicable to medical education costs.

If you answered yes to question 57 on Worksheet S-2, subscript this column and report in column 2 nursing school, column 2.01 allied health costs (paramedical education) and column 2.02 all other medical education costs.

Enter the costs of administering blood clotting factors to hemophiliacs in column 2.03, **line 46.30** from Worksheet B, column 27, subscript of line 46 containing the corresponding costs. Complete only columns 2.03 and 3 through 7 for this entry. **(8/31/02)** (see §4452 of BBA 1997)

Column 3--Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 1 and 2.

Column 4--Enter on each line the charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 5--Divide the cost of each cost center in column 3 by the charges in column 4 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 5.

Column 6--Enter on each line titles V, XVIII, Part A, or XIX inpatient charges from Worksheet D-4. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 7--Multiply the ratio in column 5 by the charges in column 6 to determine the program's share of pass through costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

Column 8--Enter on each line titles XVIII, Part B, V or XIX (if applicable) outpatient charges from Worksheet D, Part V, column 5.01, **5.03, and 5.04, if applicable**. Do not include in Medicare charges any charges identified as MSP/LCC (8/00).

Column 9--Multiply the ratio in column 5 by the charges in column 8 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 (8/00).

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

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

For CAHs (BIPA §205), enter the charges for the period you are subject to the limit and/or blend and the subscripted line the charges for which you are exempt from the limit and/or blend (see Worksheet S-2, line 30.03). If you are exempt for the full cost reporting period only complete line 65, no subscripts are required.

For cost reporting periods overlapping 4/1/2002 and after subscript line 65 for ambulance services in accordance with the subscripts on Worksheet S-2, line 56 and report charges separately on line 65 and subscripts for the applicable periods.

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

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

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

Columns 9, 9.01, and 9.02--Multiply the charges in column 5 by the ratios in column 1, and enter the result. For hospitals subject to outpatient prospective payment, multiply the charges in column 5.01 and 5.02, or any additional subscripted column of column 5 by the ratios in column 1.01, and

enter the result in columns 9.01 and 9.02 or additional subscripts, respectively. For SNFs subscript this column and report the result of multiplying the ratio in column 1 by the charges in columns 5 and 5.01 for physical and occupational therapies, and speech pathology. For lines 50 through 52 only, for services rendered on and after January 1, 1998, enter in column 9.01, 90 percent of the result of multiplying the ratio in column 1 by the charges in column 5.01. For SNF services rendered on and after January 1, 1999, make no entry for therapy services paid under a fees schedule for lines

50 through 52. The amount entered on line 65 of this column, Ambulance, for all providers, cannot exceed the payment limit calculated from Worksheet S-2, column 2, lines 56 and 56.01 (if applicable), times the amount on Worksheet S-3, Part I, column 4, line 27 and 27.01 (if applicable) respectively, for ambulance services on or after October 1, 1997. For cost reporting periods which overlap the October 1, 1997, effective date, enter in column 9 the lower of the cost (column 1 times column 5, rounded to zero, or the limit (Worksheet S-2, Column 2, line 56, times, Worksheet S-3, Part I, column 4, line 27, rounded to zero), added to column 1 times column 5.01 rounded to zero). Hospitals with cost reporting periods that overlap August 1, 2000, subscript column 9 in accordance with column 5 instructions.

For cost reporting periods beginning on or after October 1, 1997, costs for ambulance services are calculated from column 5 charges only. For cost reporting periods which overlap August 1, 2000, to calculate the ambulance costs, multiply the charges reported in columns 5 and 5.02 by the appropriate ratio on Worksheet C, Part II and add the result. Compare that to the limit amount calculated as indicated above and enter the lesser of the two in column 9.02.

Ambulance services on or after 4/1/2002 through 12/31/2005 are reimbursed on a blend of the lesser of the cost (the lesser of the cost to charge ratio times charges or limit (**applicable limit from Worksheet S-2, line 56 and subscripts, column 2 times the corresponding trips from Worksheet S-3, line 27 and subscripts, column 4**)) times 80 percent plus the fee schedule amounts (from Worksheet S-2, line 56 and subscripts, column 4) times 20 percent for the calendar year services beginning 4/1/2002. Subsequent dates and blends (**cost percentage/fee percentage**) are: Calendar year 2003 is 60/40, 2004 is 40/60, 2005 is 20/80, and 2006 and after is 100 percent fee schedule amounts.

For CAHs follow the instructions for ambulance services subject to the limit (10/1/97b) and/or the blend (4/1/02s). For ambulance services eligible for cost reimbursement (Worksheet S-2, line 30.03, column 1 = "Yes") multiply column 1 times column 5 and enter the result. (12/21/00s)

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

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

Line Descriptions

Line 44--For title XVIII, do not include charges for outpatient clinical diagnostic laboratory services. For titles V and XIX purposes, follow applicable State program instructions.

Line 45--Enter the program charges for provider clinical laboratory tests for which the provider reimburses the pathologist. See §3610 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 45 are also included on line 44, laboratory, reduce the total charges to prevent double counting. Make this adjustment on line 103.

Line 55--Enter in columns 2 through 5 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 56--Enter the program charges for drugs charged to patients that are not paid a predetermined price. Do not include vaccine charges for pneumococcal, hepatitis B, influenza, and osteoporosis which were excluded from OPPS. These charges are reported on Worksheet D, Part VI.

Line 57--The only renal dialysis services entered on this line are for inpatients who 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 5. Enter the related costs in column 9.

Line 58--Enter in columns 2 and 2.01 the outpatient ASC facility charges for the hospital nondistinct part ambulatory surgery center. These charges represent the ASC facility charge only (i.e., in lieu of operating or recovery room charges), and do not include charges for the ancillary services provided to the patient. Enter in column 5 all other Part B charges applicable to services performed in the nondistinct ASC.

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

NOTE: For lines 60 and 63, any ancillary service billed as clinic, RHC, or FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.

Line 62--Enter in columns 2 through 5 the title XVIII Part B charges for observation beds. These are the charges for patients who were treated in the nondistinct observation beds and released. These patients were not admitted as inpatients.

Line 64--The only home program dialysis services which are cost reimbursed are those rendered to beneficiaries who have elected the option to deal directly with Medicare. Home program dialysis services reimbursed under the composite rate regulation (see 42 CFR 413.170) are not included on this line. This line includes costs applicable to equipment-related expenses only.

Line 65--Enter in column 5.02 the total ambulance charges for PPS hospital providers (column 5 for non PPS hospitals). (8/2000)

Line 66 and 67--For title XVIII, DME is paid on a fee schedule through the carrier and, therefore, is not paid through the cost report.

Line 101--Enter the sum of lines 37 through 68.

Line 102--Generally, nonphysician anesthetist services are not subject to the ASC payment methodology for outpatient ambulatory surgical procedures performed in hospitals and as such are not reported on this worksheet unless you meet the exception described in §3610. Do not complete this line if you do not qualify for the exception. If the services meet the criteria for continued cost reimbursement, exclude nonphysician anesthetist charges from ASC charges in columns 2 and 2.01, line 102 and add these charges to column 5, line 102. Do not reduce the charges reported in columns 2 and 2.01, lines 37 through 68 (nor do you increase the charges in column 5) for CRNA charges. The reduction and addition are done in total on line 102. However, if you have separate charges for nonphysician anesthetists reported in the ancillary service cost centers where the services were performed, and the apportionment between ASC and all other Part B is not necessary, enter those charges directly in column 5, line 102. For services rendered on or after August 1, 2000, do not report CRNA charges or cost on this worksheet. These costs are pass through costs when eligible for the exception and are reported on Worksheet D, Part IV.

EXAMPLE: If nonphysician anesthetist charges are included in operating room and anesthesiology charges reported on Worksheet D, Part V, column 2, lines 37 and 40,

respectively, eliminate the charges from columns 2 and 2.01 and report them in column 5. This is accomplished by developing a ratio of each affected cost center's nonphysician anesthetist cost allocated on Worksheet B, Part I, column 20, lines 37 and 40 to the total cost reported on Worksheet B, Part I, column 27, lines 37 and 40. Each ratio is then multiplied by the charges applicable to Worksheet D, Part V, columns 2 and 2.01, lines 37 and 40. The result represents the CRNA charges for operating room and anesthesiology. These charges are added together and reported on line 102 as a decrease in columns 2 and 2.01 and an increase to column 5. Attach a separate reconciliation to the cost report showing this computation.

Step Instructions

- 1 $\frac{\text{Worksheet B, Part I, column 20, line 37}}{\text{Worksheet B, Part I, column 27, line 37}} = \text{ratio (six decimal places)}$
- 2 $\frac{\text{Worksheet B, Part I, column 20, line 40}}{\text{Worksheet B, Part I, column 27, line 40}} = \text{ratio (six decimal places)}$
- 3 The ratio in step 1 multiplied by the charges reported on Worksheet D, Part V, columns 2 and 2.01, line 37 equals the CRNA operating room charges.
- 4 The ratio in step 2 multiplied by the charges reported on Worksheet D, Part V, columns 2 and 2.01, line 40 equals the CRNA anesthesiology charges.
- 5 Add the amounts in steps 3 and 4. Enter the total on line 102 as a decrease in columns 2 and 2.01 and as an increase in column 5, line 102.
- 6 To determine the costs reported in columns 6 and 9, line 102, multiply the ratio on Worksheet C, Part II, column 8, as applicable for each cost center (lines 37 and 40), by the charges computed in steps 3 and 4. Add these two costs together, and report the total as a decrease to columns 6 and 6.01 and an increase to column 9.

Line 103--Enter in column 5 program charges for provider clinical laboratory tests where the physician bills the provider for program patients only. Obtain this amount from line 45. Do not complete this line for column 9.

Line 104--Enter in columns 5 and 9, and subscripts, the amount on line 101 plus or minus the amounts on lines 102 and 103 if applicable.

Transfer Referencing: For title XVIII, transfer the sum of the amounts in columns 5 and subscripts and column 10, line 104 to Worksheet E, Part B, line 6. Make no transfers of swing bed charges to Worksheet E-2 since no LCC comparison is made.

For titles V and XIX (other than PPS), transfer the sum of the amounts in columns 5 and subscripts and column 10, line 104 plus the amount from Worksheet D-4, column 2, line 103 to the appropriate Worksheet E-3, Part III, column 1, line 11.

For titles V and XIX (under PPS), transfer the amount in column 5, line 104 to the appropriate Worksheet E-3, Part III, column 1, line 11.

NOTE: If the amount on line 104 includes charges for professional patient care services of provider-based physicians, eliminate the amount of the professional component charges from the total charges, and transfer the net amount as indicated. Submit a schedule showing these computations with the cost report.

Transfer References

<u>From Wkst. D, Part V</u>	<u>Title XVIII, Part B Swing Bed</u>	<u>To</u>	<u>Titles V or XIX or Title XVIII, Part B</u>
Columns 6 & 6.01, line 104	N/A		Wkst. E, Part C, col. 1& 1.01, line 6
Columns 2 & 2.01, line 104	N/A		Wkst. E, Part C, col. 1& 1.01, line 7
Columns 7 & 7.01, line 104	N/A		Wkst. E, Part D, col. 1& 1.01, line 6
Columns 3 & 3.01, line 104	N/A		Wkst. E, Part D, col. 1& 1.01, line 7
Columns 8 & 8.01, line 104	N/A		Wkst. E, Part E, col. 1 & 1.01, line 6
Columns 4 & 4.01, line 104	N/A		Wkst. E, Part E, col. 1 & 1.01, line 7
Columns 9 and subscripts & column 11, Line 104	N/A		Wkst. E, Part B, col. 1 (& subscripts), line 1 & 1.01
Sum of columns 5, 5.01 (SNF only) and 5.02, line 104	N/A		Wkst. E, Part B, line 6 or Wkst. E-3, Part III, col. 1, line 11 for titles V or XIX
Sum of columns 9 and 9.01 (SNF only) through 12/31/98 line 104	Wkst E-2 col. 2, line 3		Wkst. E, Part B, line 1 or Wkst. E-3, Part III, col. 1, line 2 for titles V or XIX

3621.6 Part VI - Vaccine Cost Apportionment.--This worksheet provides for the apportionment of costs applicable to the administration and cost of the drug for the following vaccines: Pneumococcal, Influenza, and Osteoporosis. These charges include, if applicable, vaccine services provided by hospital based RHC/FQHC which cannot be reported on Worksheet M-3 and M-4 (1/98). For services rendered on and after August 1, 2000 for vaccines provided by a RHC/FQHC will be reported on Worksheets M-3 and M-4. **Pneumococcal and Influenza vaccines rendered on or after January 1, 2003 have transitioned back to cost reimbursed.**

Line 1--Enter the cost to charge ratio from Worksheet C, Part I, column 9, line 56.

Line 2--Enter the program charges from the PS&R or from provider records. Effective for services rendered on or after April 1, 2001, subscript this line and report charges prior to April 1, 2001, on line 2 and on line 2.01 charges on or after April 1, 2001. For cost reporting periods beginning on or after **April 1, 2001**, no subscripting is required **except for cost reporting periods which overlap January 1, 2003.**

For CAHs effective for services rendered on or after November 29, 1999, enter on line 2 the program charges for pneumococcal, influenza, and osteoporosis vaccines and the charges for hepatitis B

vaccines on **worksheet D, Part V** as hepatitis B vaccine charges are subject to deductibles and coinsurance.

Line 3--Multiply line 1 times line 2, for hospital services rendered prior to April 1, 2001, and enter the result on line 3. For services rendered on or after April 1, 2001, subscript this line and enter on line 3.01 the result of line 1 times line 2.01. For cost reporting periods beginning on or after April 1, 2001, no subscripting is required, **except for cost reporting periods which overlap January 1, 2003**. For hospitals for title XVIII, transfer the amount on line 3 to Worksheet E, Part B, line 1 for services rendered prior to April 1, 2001 **and on or after January 1, 2003**. The amount on line 3.01 is added to the amount reported on Worksheet D, Part V, column 9.01, line 104 and transferred to Worksheet E, Part B, line 1.01 for services rendered on or after April 1, 2001. For SNFs transfer to Worksheet E, Part B, line 1, the sum of lines 3 and 3.01, but for reporting periods beginning on or after April 1, 2001, transfer the amount from line 3 only. For swing bed SNFs transfer the amount from line 3 to Worksheet E-2, column 2, line 3 and for NFs to Worksheet E-3, Part III, column 1, line 2, for titles V and XIX.

For CAHs effective for services rendered on or after November 29, 1999, enter on line 2 the program charges for pneumococcal, influenza, and osteoporosis vaccines. Transfer the **amount on line 3** to Worksheet E, Part B, line 1.

3622. 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, 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 and Other Nursing Facility Only
- Part IV - Computation of Observation Bed 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-I, §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 in documented 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-I, §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. If the State recognizes only SNF level of care, do not use the NF lines.

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-I, §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-I, §2217.)

Observation Beds--Observation beds, for purposes of this worksheet, are those beds in general routine areas of the hospital or subprovider 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 29)). If you have a distinct observation bed unit (an outpatient cost center), report the costs of this unit on the subscripted line 62.01 on Worksheet A.

3622.1 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/MR. 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 6 for the component and lines as indicated: hospitals from lines 5 and 26; subproviders from lines 14 and 26.01, if applicable; SNFs from line 15; and NFs from line 16. If you answered yes to line 38.03 of Worksheet S-2, the NF days come from line 15 for the SNF level of care and line 16 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.

NOTE: If you are a rural hospital with a certified SNF, have less than 50 beds in the aggregate for both components (excluding intensive care type and newborn beds), and have made an election to be reimbursed as though you were a swing bed hospital, treat the SNF total and SNF program patient days as though they were hospital swing bed-SNF days. Report them on lines 1, 5, 6, 10, and 11, as appropriate. (See 42 CFR 413.24(d)(5) and CMS Pub. 15-I, §2230.9.B.)

Line 2--Enter the total general routine inpatient days. Include private room days and exclude swing bed and newborn days. Hospitals and enter the sum of the days entered on Worksheet S-3, Part I, column 6, lines 1 and 26. 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.

Line 4--Enter the number of days reported on line 2 less the number of days reported on line 3.

NOTE: For purposes of this computation, the program does not distinguish between semi-private and ward accommodations. (See CMS Pub. 15-I, §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 3, column 6.

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 4, column 6.

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:

<u>Type of Provider</u>	<u>From</u>
Hospital	Wkst. S-3, Part I, cols. 3, 4, or 5, line 1
Subprovider	Wkst. S-3, Part I, cols. 3, 4, or 5, line 14
SNF	Wkst. S-3, Part I, cols. 3, 4, or 5, line 15
NF	Wkst. S-3, Part I, cols. 3, 4, or 5, for SNF only level of care; line 15. If line 38.03 of Wkst S-2 is a "Y", two D-1s must be completed for title XIX using line 15 for SNF level of care and line 16 for the NF level of care; or line 16 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-I, §2217.)

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 6, line 11.

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 3 and 5, respectively, line 11.

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 intermediary.

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-I, §2230ff.) Critical access hospitals do not complete this line (12/00).

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-I, §2230ff.) Critical access hospitals do not complete this line (12/00).

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 the mentally retarded) in that State in the calendar year preceding the calendar year in which inpatient days on line 7 occurred.

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 the mentally retarded) in that State in the calendar year preceding the calendar year in which inpatient days on line 8 occurred.

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 25 for adults and pediatrics or line 31 for the subprovider, as appropriate:

COST or OTHER	Inpatient - Column 1
TEFRA	Inpatient - Column 3, for IRFs & LTCHs if Wksht. S-2, line 58 (IRF) or 59 (LTCH), respectively, columns 1 and 2 are "Y" & "N", respectively.
PPS	Inpatient - Column 5, for IRFs & LTCHs if Wksht. S-2, line 58 (IRF) or 59 (LTCH), respectively, columns 1 and 2 are "Y" & "Y", respectively.

SNF/NF Inpatient Routine--For title XVIII, transfer this amount from Worksheet C, Part I, column 5, line 34 (SNF) (7/1/98b). For titles V and XIX, transfer this amount from Worksheet B, Part I, column 27, line 35 (NF) or 35.01 ICF/MR.

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 critical access hospitals, for cost reporting periods beginning on or after December 21, 2000, 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 (Retain this amount for the calculation required on lines 38, 60 and 61). 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 3 equals line 2 above 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 (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 (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 3 equals line 2, enter the amount from line 27 above.

3622.2 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.

NOTE: This is not completed for RPCH providers. (See Worksheet S-2, line 31ff.) RPCH providers complete Worksheet C, Part IV, in lieu of this part. For cost reporting periods beginning after October 1, 1997 CAHs will complete this worksheet.

Line Descriptions

Line 38--For non-PPS providers (includes IRFs and LTCHs during the TEFRA/PPS blend), 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 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.

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 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 33.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient	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 26 through 30, as appropriate.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient	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 6, lines 6 through 10, 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 3, 4, or 5, as appropriate, lines 6 through 10.

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-I, §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-4, column 3, line 101.

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 II, line 1 or Part III, column 1, line 1, as appropriate. Do not complete lines 50-59. For all inclusive rate providers (Method E) apply the percentage to the sum of the aforementioned lines based on the provider type designated on Worksheet S-2, line 19 (see PRM 15-I, section 2208).

Lines 50-53--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, columns 10 and 12, sum of lines 25 through 30 and line 33 for the hospital, and line 31 for the subprovider. Add that amount to the other pass through costs from Worksheet D, Part III, column 8, sum of lines 25 through 30 and line 33 for the hospital, and line 31 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, sum of columns 6 and 8, line 101. Add that amount to the other pass through costs from Worksheet D, Part IV, column 7, line 101.

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 59--Except for those hospitals specified below, all hospitals (and distinct part hospital units) excluded from prospective payment 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.) The following hospitals are reimbursed under special provisions and, therefore, are not generally subject to TEFRA or prospective payment:

- o Hospitals reimbursed under approved State cost control systems (see 42 CFR 403.205 through 403.258);

- o Hospitals reimbursed in accordance with demonstration projects authorized under §402(a) of the Social Security Amendments of 1967 or §222(a) of the Social Security Amendments of 1972; and
- o Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

For your components subject to the prospective payment system or not otherwise subject to the rate of increase ceiling as specified above, make no entries on lines 54 through 59.

NOTE: A new non-PPS hospital or subprovider (Lines 34 and/or 35 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. For cost reporting periods beginning on or after October 1, 1997, new providers will be paid the lower of their inpatient operating costs per case or 110 percent of the national median of the target amounts for similar provider types.

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 12 and 14 (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 intermediary. 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 58.04--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, for cost reporting periods beginning on or after October 1, 1997, 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 58.04. New providers skip lines 58 through 58.04 and go to line 59.

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 50 percent of line 57 or 5 percent of line 56. For cost reporting periods beginning on or after October 1, 1997, the percentages are 15 percent and 2 percent (3 percent for cost reporting periods beginning on or after October 1, 2000 for psychiatric hospital/subprovider only (see BIPA §306)) respectively. If line 57 is a negative amount (actual inpatient operating cost is greater than the target amount) for cost reporting periods beginning prior to October 1, 1997, enter on line 58, the lesser of 50 percent of the absolute value of line 57 or 10 percent of line 56. For cost reporting periods beginning on or after October 1, 1997, do not complete line 58 (leave blank) and complete line 58.04 for calculation of any adjustments to the operating costs when line 57 is negative.

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

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

Line 58.03--If (line 53/line 54) is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50 percent of the amount by which operating costs (line 53) are less than expected costs (line 54 times line 58.02), or **the applicable percent of the target amount (line 56) in fiscal years beginning and after as follows: 1 percent for 10/1/1999, 1.5 percent for 10/1/2000, and 2 percent for 10/1/2001 through 9/30/2002;** otherwise enter zero.

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

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

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

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

Line 62--Enter the sum of lines 60 and 61. Transfer this amount to the appropriate Worksheet E-2, column 1, line 1.

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

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

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

3622.3 Part III - Skilled Nursing Facility, Other Nursing Facility, and Intermediate Care Facility/Mental Retardation Only.--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX and the application of a limitation on reimbursable cost for these provider components. If the hospital-based SNF elects reimbursement under PPS for cost reporting periods beginning prior to July 1, 1998, complete lines 66 through 70 for data purposes only. For cost reporting periods beginning on or after July 1, 1998, complete lines 66 through 82 for data purposes only. 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 intermediate care facility/mental retardation unit.

NOTE: If you have made a swing bed election for your certified SNF and hospital complex, do not complete this part for the SNF (Worksheet S-2, line 29 response is "Y"). Treat all the days and costs as swing bed days and costs and include them with the hospital. (See CMS Pub. 15-I, §2230.9B.)

Line Descriptions

Line 66--Enter the SNF or other nursing facility routine service cost from Part I, line 37.

Line 67--Determine the adjusted general inpatient routine service cost per diem by dividing the amount on line 66 by inpatient days, including private room days, shown on Part I, line 2.

Line 68--Determine 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 67.

Line 69--Determine 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 70--Add lines 68 and 69 to determine the total program general inpatient routine service cost.

Line 71--Enter the capital-related cost allocated to the general inpatient routine service cost center. For title XVIII, transfer this amount from Worksheet B, sum of Parts II and III, column 27, line 34 (SNF). For titles V and XIX, transfer this amount from Worksheet B, sum of Parts II and III, column 27, line 35 (NF).

Line 72--Determine the per diem capital-related cost by dividing the amount on line 71 by the days in Part I, line 2.

Line 73--Determine the program capital-related cost by multiplying line 72 by the days in Part I, line 9.

Line 74--Determine the inpatient routine service cost by subtracting line 73 from line 70.

Line 75--Enter the aggregate charges to beneficiaries for excess costs obtained from your records.

Line 76--Enter the total program routine service cost for comparison to the cost limitation. Obtain this amount by subtracting line 75 from line 74.

NOTE: If you are a new provider not subject to the inpatient routine service cost per diem limitation, do not complete lines 77 and 78. (See 42 CFR 413.30(e)(2).)

Line 77--Enter the inpatient routine service cost per diem limitation. This amount is provided by your intermediary. This information is no longer required for cost reporting periods beginning on or after July 1, 1998.

Line 78--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 77. This computation is no longer required for cost reporting periods beginning on or after July 1, 1998.

Line 79--Enter the amount of reimbursable inpatient routine service cost determined by adding line 73 to the lesser of line 76 or line 78. If you are a new provider not subject to the inpatient routine service cost limit, enter the sum of lines 73 and 76. For title XVIII, for cost reporting periods beginning on or after July 1, 1998, enter the amount from line 70.

Line 80-- Enter the program ancillary service amount from Worksheet D-4, column 3, line 101.

Line 81--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. 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 82--Enter the total program inpatient operating cost by adding the amounts on lines 79 through 81. Transfer this amount to the appropriate Worksheet E-3, Part II, line 1 except for SNFs participating in the NHCQM demonstration and SNFs with cost reporting periods beginning on or after July 1, 1998. For NF and ICF/MR, transfer this amount to Worksheet E-3, Part III, column 1, line 1 for titles V and XIX.

3622.4 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 in the general acute care routine area of the hospital and/or subprovider. A separate computation must be made if a subprovider is claiming observation bed costs. For title XIX, insert the amount calculated for title XVIII for the hospital and subprovider, if applicable. To avoid duplication of reporting observation bed costs, do not transfer the title XIX amount to Worksheet C.

Line 83--Enter the total observation bed days from your records. Total observation days for the hospital and subprovider (if applicable) should equal the days computed on Worksheet S-3, Part I, column 6, line 26.

Line 84--Enter the result of general inpatient routine cost on line 27 divided by line 2.

Line 85--Multiply the number of days on line 83 by the cost on line 84 and enter the result. Transfer this amount to Worksheet C, Parts I and II, column 1, line 62. When transferring the amount to Worksheet C, be sure to combine with the subprovider if applicable.

Lines 86 through 89--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 and TEFRA providers.

Column 1--For line 86, transfer the amount from Worksheet D, Part I, column 1, line 25 for the hospital and line 31 for the subprovider, if applicable. For line 87, transfer the amount from Worksheet D, Part I, column 4, line 25 or line 31. For lines 88 and 89, enter on each line the cost from Worksheet D, Part III, columns 1 and 2 and subscripts respectively, line 25 or line 31. Subscript line 89 to agree with Worksheet D, Part III, columns 2, 2.01 and 2.02 (01/00).

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 85 on each line. 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:

<u>From</u>	<u>To</u>	<u>To</u>
<u>Wkst. D-1, Part IV</u>	<u>Wkst. D, Part II</u>	<u>Wkst D, Part IV</u>
Col. 5, line 86	Col. 1, line 62	
Col. 5, line 87	Col. 2, line 62	
Col. 5, line 88		Col. 1, line 62
Col. 5, line 89 and subscripts		Col. 2, line 62 and subscripts

Column 3--Enter on lines 26 and 35 the amounts in column 1 minus the amount in column 2. Enter on line 27 the amount from column 2. Enter on lines 29 through 33 and 37 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 27, 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 26, 27, 29 through 33, and 35 through 37, 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 27, or lines 35.01 or 35.02 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 34 the sum of the amounts on line 26 plus the sum of the amounts on lines 29 through 33.

Transfer the expenses on lines 34, 35, and 37 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 34, 35, and 37 to Worksheet E, Part B, line 2, as appropriate.

3623.3 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 graduate medical education payments in 42 CFR 413.86(e)(4)(I). 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.

<u>Description</u>	<u>From Column 6</u>		
Hospital	Line 41	TO	Worksheet E, Part B, line 2
Subprovider	Line 42	TO	Worksheet E, Part B, line 2
SNF	Line 44	TO	Worksheet E, Part B, line 2

3624. WORKSHEET D-4 - INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

All providers must complete this worksheet (including CAHs) with the exception of RPCH components. (See Worksheet S-2, line 30.) At the top of the worksheet, indicate by checking the appropriate lines the health care program, provider component, and the payment system for which the worksheet is prepared. When reporting Medicare charges on the appropriate lines and columns, do not include Medicare charges identified as MSP/LCC.

Line Descriptions

Lines 25 through 30--Enter the program charges from the PS&R or your records (hospital only).

Lines 37 through 68--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.

NOTE: The worksheet line numbers start with line 37 because of this referencing feature.

Line 101--Enter the total of the amounts in columns 2 and 3, lines 37 through 64 and 66 through 68.

In accordance with 42 CFR 413.53, this worksheet provides for the apportionment of cost applicable to hospital inpatient services reimbursable under titles V, XVIII, Part A, and XIX. Complete a separate copy of this worksheet for each subprovider, hospital-based SNF, swing bed-SNF, swing bed-NF, and hospital-based NF for titles V, XVIII, Part A, and XIX, as applicable. Enter the provider number of the component in addition to the hospital provider number when the worksheet is completed for a component.

NOTE: If you are a rural hospital with an attached SNF electing the optional swing bed reimbursement method, use the SNF component number. However, in this case, if you also have certified swing beds, use the swing bed-SNF component number instead of the SNF provider number on all applicable worksheets.

Column 1--Enter the ratio of cost to charges developed for each cost center from Worksheet C, Part I. The ratios in columns 10 and 11 of Worksheet C, Part I are used only 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) or PPS (see 42 CFR 412.1(a) through 412.125), respectively. Use the ratios in column 9 in all other cases.

NOTE: Make no entries in columns 1 and 3 for any cost center with a negative balance on Worksheet B, Part I, column 27. However, complete column 2 for such cost centers.

Column 2--Enter from the PS&R or your records the indicated program inpatient charges for the appropriate cost centers. The hospital program inpatient charges exclude inpatient charges for swing bed services. If gross combined charges for professional and provider components were used on Worksheet C, Part I to determine the ratios entered in column 1 of this worksheet, then enter gross combined charges applicable to each health care program in column 2. If charges for provider component only were used, then use only the health care program charges for provider component in column 2.

NOTE: Certified transplant centers (CTCs) have final settlement made based on the hospital's cost report. 42 CFR 413.40(c)(iii) states that organ acquisition costs incurred by hospitals approved as CTCs are reimbursed

Line 3--Enter the result obtained by dividing the cost of services on line 1 by the sum of the days on line 2 for each category of physicians.

Lines 4 through 13--Enter in column 1, on the appropriate line, the reimbursable days and outpatient visit days for titles V, XVIII, and XIX for the applicable component of the health care complex. Lines 10, 11, 12, and 13 contain the total of the title XVIII organ acquisition days and outpatient visit days. Enter in column 2 the same number of days as entered in column 1. Compute these days from your records in the manner described in CMS Pub. 15-I, §2218.C.

Lines 14 through 23--Enter on the appropriate line the result of multiplying the days entered on lines 4 through 13 by the average cost per diem from line 3. Enter the total of columns 1 and 2 in column 3 for each line. The total becomes a part of the reimbursement settlement through the transfers denoted on this worksheet.

3630. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E, Parts A and B, calculate title XVIII settlement for inpatient hospital services under PPS and title XVIII (Part B) settlement for medical and other health services. Worksheet E, Parts C, D, and E, calculate (for titles V, XVIII, and XIX) settlement for outpatient ambulatory surgery, radiology, and other diagnostic procedures. Worksheet E-3 computes title XVIII, Part A settlement for non-PPS hospitals, settlements under titles V and XIX, and settlements for title XVIII SNFs reimbursed under a prospective payment system.

Worksheet E consists of the following five parts:

- Part A - Inpatient Hospital Services Under PPS
- Part B - Medical and Other Health Services
- Part C - Outpatient Ambulatory Surgical Center
- Part D - Outpatient Radiology Services
- Part E - Other Outpatient Diagnostic Procedures

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

3630.1 Part A - Inpatient Hospital Services Under PPS.--

NOTE: For SCH/MDH status change and/or geographical reclassification (see 42 CFR 412.102/103) subscript column 1 for lines 1-2, 3.21-3.24, 4.03-4.04, and 5-7. (9/30/96)

Enter on lines 1 through 5 in column 1 the applicable payment data for the period applicable to SCH status. Enter on lines 1 through 5 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 5 must be obtained from the provider's records or the PS&R.

For cost reporting periods beginning on or after October 1, 2000, SCH providers must subscript column 1 for lines 1-2, 3.21-3.24, 4.03-4.04, and 5-7, for cost reporting periods overlapping 9/30/2001, 9/30/2002 or 9/30/2003. Enter in column 1 the applicable payment data for the period prior to October 1 and enter in column 1.01, the applicable payment data for the period on or after October 1.

Line Descriptions

Line 1--The amount entered on this line is computed as the sum of the Federal 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. Beginning October 1, 1997, the formula for calculating indirect medical education will be modified annually beginning October 1 of each year through October 1, 2001. To accommodate the change in the formula it is necessary to subscript line 1. On line 1 enter the payments for discharges occurring prior to October 1. (See the asterisks (*) below for any exceptions to the reporting of these payments.) If you answered yes to question

Line 1.05--Enter the total managed care "simulated payments" from the PS&R on or after January 1 but before April 1/October 1. Complete line 1.08 for cost reports that overlap April 1, 2001.

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

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

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

Line 2--Enter the amount of outlier payments made for PPS discharges during the period. See 42 CFR 412, Subpart F for a discussion of these items. Report only the outlier payments attributable to discharges occurring prior to October 1, 1997. Report on line 2.01 the outlier payments received for discharges occurring on and after October 1, 1997.

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

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

NOTE: Reduce the bed days available by nursery days (Worksheet S-3, Part I, column 2, line 11), swing bed days (Worksheet S-3, Part I, column 6, sum of lines 3 and 4), and the number of observation days (Worksheet S-3, Part I, column 6, line 26).

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

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

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

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

Line 3.04--Enter the FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. 42 CFR 412.105(f)(iv) Effective for discharges occurring on or after April 1, 2000, adjust this count for the 30 percent increase for qualified rural hospitals. For cost reporting periods beginning on or after November 29, 1999, adjust for any increases due to primary care residents that were on approved leaves of absence. (42 CFR 412.105(f)(1)(iv) and (xi) respectively)

Line 3.05--Enter the FTE count for allopathic and osteopathic programs which meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.86(g)(6). For hospitals qualifying for a cap adjustment under 42 CFR 413.86(g)(6)(i), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995. For hospitals qualifying for a cap adjustment under 42 CFR 413.86(g)(6)(ii), the cap for each new program accredited or begun on or after January 1, 1995 and before August 6, 1997, is effective in the fourth program year of each of those new programs (see 66 FR, August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTE's that were already included in the cap on line 3.04. Also enter here the allopathic or osteopathic FTE count for residents in all years of a rural track program that meet the criteria for an add-on to the cap under 42 CFR 412.105(f)(1)(x). (If the rural track program is a new program under 42 CFR 413.86(g)(12) and qualifies for a cap adjustment under 42 CFR 413.86(g)(6)(i) or (iii), do not report FTE residents in the rural track program on this line until the fourth program year. Report these FTEs on line 3.17).

Line 3.06--Enter the adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.86(b), (g)(4)(iv) and Vol. 64 **Federal Register**, page 26336, May 12, 1998.

Line 3.07--Enter the sum of lines 3.04 through 3.06. This is the adjusted cap.

Calculation of the allowable current year FTEs:

Line 3.08--Enter the FTE count for allopathic and osteopathic programs in the current year from your records for cost reporting periods beginning on or after October 1, 1997. Do not include residents in the initial years of the program. (42 CFR 412.105(f)(1)(iv) and/or (f)(1)(v).)

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

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

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

Line 3.11--Enter the FTE count net of dental and podiatry for the period identified in line 3.09. Use the actual count as if counting for the entire year, or what would have been reported on line 3.08. Do not include intern and residents in the initial years of the program 42 CFR 413.86(g)(5).

Line 3.12--Enter the FTE count net of dental and podiatry for the period identified in line 3.10. Use the actual count as if counting for the entire year, or what would have been reported on line 3.08. Do not include intern and residents in the initial years of the program 42 CFR 413.86(g)(5).

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

Line 3.14--Enter the result of the lesser of lines 3.07 or 3.08 added to line 3.13. If lines 3.09 through 3.12 are completed, enter the sum of (line 3.09 times line 3.11) plus the lesser of (line 3.10 times line 3.12) or (line 3.10 times line 3.07). Add that result to the amount on line 3.13.

Calculate the rolling average count for cost reporting periods beginning on or after October 1, 1997.

Line 3.15--Enter the total allowable FTE count from line 3.14 or line 3.01 of the prior year. Do not include residents in the initial years of the program. If you did not have any FTE's reported for this period but you did have an approved teaching program, enter a (1) in column 0. If you had no approved teaching program make no entry (10/97).

Line 3.16--Enter the total allowable FTE count for the penultimate year from line 3.14 if that year ended on or after September 30, 1997. If you did not have any FTE's reported for this period but you did have an approved teaching program, enter a (1) in column 0. If you had no approved teaching program make no entry. Do not include residents in the initial years of the program (42 CFR 413.86(g)(5)(v)). (10/97)

Line 3.17--Enter the sum of lines 3.14 through 3.16 and divide by the number of these lines greater than zero, unless a 1 is entered in column zero on lines 3.15 and 3.16 then count those lines. (See 42 CFR 413.86(g)(5).) Add to that result the number of FTE residents in the initial years of the program that meet the exception in 42 CFR 413.86(g)(5)(v) and (g)(6). Add to this amount any temporary adjustments for FTE residents that were displaced by program or hospital closure (42 CFR 412.105(f)(1)(ix)).

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

Line 3.19--Enter from the prior year cost report the intern and resident to bed ratio (if the allopathic and osteopathic FTE residents were subject to the FTE cap in the prior year, add to the numerator the FTE residents in the initial years of the program from line 3.17 of that year) adjusted for the number of current year residents that meet the exception for new programs and affiliations in 42CFR413.86(g)(6) and (g)(4)(iv) respectively. If the current year is the first cost reporting period in which a receiving hospital trains FTE residents displaced by the closure of another hospital or program, then also adjust the numerator of the prior year ratio for the number of current year FTE residents that meet the exception for residents that were displaced by hospital or program closure. If no intern and resident to bed ratio was reported in the prior year, calculate the ratio using the FTE count for residents in the initial years of the new program. For prior year cost reporting periods ending prior to October 1, 1997, compute the ratio by dividing line 3.01 by line 3. For cost reporting periods beginning on or after October 1, 1997, compute the ratio by dividing line 3.14 by line 3.

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

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

For cost reporting periods that overlap April 1, 2001, an additional computation will be required for discharges occurring on or after April 1, 2001 through September 30, 2001. See line 3.24 below and the revised payment chart on page 36-137 for completion of line 3.24.

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

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

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

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

Line 3.24--Enter the sum of lines 3.21 through 3.23. For cost reporting periods which overlap April 1, 2001 add to this result, the appropriate multiplier of the adjustment factor for the payment period identified on line 1.07 times $\{(1 + \text{line 3.14}/\text{line 3}^*) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{the sum of line 1.07} + (\text{line 1.08 times the appropriate percentage identified in the paragraph prior to line 1.03})\}$.

Disproportionate Share Adjustment--Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on lines 4 through 4.04. Complete this portion only if you answered yes to line 21.01 of Worksheet S-2. For cost reporting periods which overlap January 20, 2000, do not complete lines 4 through 4.03 and enter on line 4.04 the manually calculated DSH payment adjusted by the appropriate reduction. (See intermediary PM A-99-62 for proper determination of DSH adjustment.) For those hospitals experiencing a change in the DSH percentage as a result of the application of the BIPA provisions effective for services on and after April 1, 2001, i.e., geographic reclassification subscript column 1 for lines 1, 1.01, 1.02, 1.07, 4.03 and 4.04 apply the appropriate percentage for the DSH payment and reduction in accordance with the payment dates prescribed above. Review the payment chart on page 137 and lines 1, 1.01, 1.02 and 1.07 for proper reporting of payments. Do not subscript the column for lines 4.03 and 4.04, except as applicable for **SCHMDH** and geographic reclassification.

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

Line 4.01--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12 minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

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

Line 4.03--Compare the percentage on line 4.02 with the criteria described in 42 CFR 412.106(c) and (d). Enter the percentage identified in the CFR to be applied against PPS payments.

Line 4.04--Multiply line 4.03 by the sum of lines 1, 1.01, 1.02 and 2 and enter the result. For discharges occurring on or after October 1, 1997, multiply line 4.03 by the sum of lines 1, 1.01, 1.02, and 1.07 only. Reduce that amount for discharges occurring on or after October 1, 1997, by 1 percent; 2 percent for October 1, 1998, 3 percent for October 1, 1999; 3 percent for October 1, 2000 through March 31, 2001; 1 percent for April 1, 2001 through September 30, 2001; 3 percent for October 1, 2001 through September 30, 2002; and 0 (zero) percent thereafter. Review the payment chart on page 137 for the proper splitting of payments before and on or after October 1 and April 1 for those cost reports that overlap these dates in order to properly calculate the reduction.

High Percentage of ESRD Beneficiary Discharges Adjustment--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104.

Line 5--Enter total Medicare discharges reported on Worksheet S-3 excluding discharges for DRGs 302, 316, and 317 as reported on the PS&R or your records.

Line 5.01--Enter total ESRD Medicare discharges excluding DRGs 302, 316, and 317.

Line 5.02--Divide line 5.01 by line 5. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

Line 5.03--Enter the total Medicare ESRD inpatient days excluding DRGs 302, 316, and 317.

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

Line 5.05--Enter the average cost per dialysis treatment of \$335 (\$111.67 times the average number of treatments (3)).

Line 5.06--Enter the ESRD payment adjustment (line 5.04 times line 5.05 times line 5.01).

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

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

For sole community hospitals only, the hospital-specific payment amount entered on this line is supplied by your fiscal intermediary. 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 higher of the hospital-specific rate based on cost reporting periods beginning in FY 1982 or FY 1987. Use the hospital-specific rate (operating cost per discharge divided by the case mix index for 1982 or 1987, as applicable) updated to the beginning of the cost reporting period and adjusted for budget neutrality, if applicable, in this calculation. **For cost reporting periods beginning on or after October 1, 2003, use**

the hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, or 1996.

Line 7.01--In addition to the comparison of 1982 and 1987, hospitals can compare the hospital specific rate for cost reporting periods beginning in FY 1996. For SCHs with cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003, enter on this line the hospital-specific payment amount based on the cost reporting period beginning in FY 1966 as supplied by your fiscal intermediary.

Line 8--For SCHs, enter the greater of line 6 or 7. For MDHs (for discharges occurring on or after 10/1/1997 and before 10/1/2006), If line 6 is greater than line 7, enter the amount on line 6. Where line 7 is greater than line 6, enter the amount on line 6, plus 50 % of the amount that line 7 exceeds line 6. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 6.

For hospitals subscribing column 1 of line 6 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.

For SCHs with cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003 - The transition into the FY 1996 rate actually a blend based on discharges for FY 2001 (October 1, 2000 - September 30, 2001) of 75 percent of the higher of the 1982, 1987, or Federal amount and 25 percent of 1996. For FY2002 (October 1, 2001 - September 30, 2002), the blend is 50/50, and for FY 2003 (October 1, 2002 - September 30, 2003) the blend is 25/75.

If line 7.01 is greater than line 7, enter the higher of lines 7 or 6, multiplied by the appropriate blend percentage. Add to this amount, the amount on line 7.01, multiplied by the appropriate FY 1996 HSR blend percentage. (42 CFR 412.92) If line 7.01 is not greater than line 7, enter the greater of lines 6 or 7.

Line 9--Enter the payment for inpatient program capital costs from Worksheet L, Part I, line 6; Part II, line 10; or Part III, line 5, as applicable.

Line 10--Enter the exception payment for inpatient program capital, if applicable, from Worksheet L, Part IV, line 13 for cost reporting periods beginning before October 1, 2001. For cost reporting periods beginning on and after October 1, 2001, enter the result of Worksheet L, Part IV, line 13 less Worksheet L, Part IV, line 17. If this amount is negative, enter zero on this line.

Line 11--Enter the amount from Worksheet E-3, Part IV, line 24. Complete this line only for the hospital component.

Line 11.01--Enter the amount of Nursing and Allied Health Managed Care if applicable.

Line 11.02--Enter the special add-on payment for new technologies (see change request 2301).

Line 12--Enter the net organ acquisition cost from Worksheet(s) D-6, Part III, column 1, line 61.

Line 13--Enter the cost of teaching physicians from Worksheet D-9, Part II, column 3, line 16.

Line 14--Enter on the appropriate Worksheet E, Part A, the routine service other pass through costs from Worksheet D, Part III, column 8, lines 25 through 30 for the hospital and line 31 for the subproviders.

3630.2 Part B - Medical and Other Health Services--Use Worksheet E, Part B, to calculate reimbursement settlement for hospitals, subproviders, and SNFs.

Use a separate copy of Worksheet E, Part B, for each of these reporting situations. If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. Enter check marks in the appropriate spaces at the top of each page of Worksheet E to indicate the component program for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers. OPD PPS services furnished on or after 8/1/2000 is only applicable for hospital title XVIII providers. (See BBRA §202) For services rendered on or after August 1, 2000, for purposes of prospective payment for outpatient services, if the cost reporting periods overlap any of the effective dates, complete subscribed column 1.01 for lines 1.01 through 1.06 only and make a separate transitional corridor or geographic reclassification (urban to rural only) (42 CFR 412.103 and 412.230) payment calculation for the appropriate periods. This may result in multiple subscribed columns. Order the subscribed columns chronologically as the transition dates or geographic reclassification relate to your fiscal year. The dates should also agree with the format on Worksheet D, Part V, columns 9, 9.01, 9.02 and 9.03, etcetera

Line Descriptions

Line 1--Enter the cost of medical and other health services for title XVIII, Part B. This amount also includes the cost of ancillary services furnished to inpatients under the medical and other health services benefit of Medicare Part B. These services are covered in this manner for Medicare beneficiaries with Part B coverage only when Part A benefits are not available. Obtain this amount from Worksheet D, Part V, line 104, columns 9, 9.02 and 11, for hospitals and enter in column 1. Add to the amount reported in column 1 the amount from Worksheet D, VI, line 3 (and/or 3.01 as applicable) for services rendered through March 31, 2001 and on or January 1, 2003. For SNFs transfer the amount from Worksheet D, Part V, column 9 plus Worksheet D, Part VI, lines 3. For RPCH/CAH providers electing the all-inclusive method of payment for outpatient services prior to October 1, 1997 (see Worksheet S-2, lines 30 through 30.02), obtain this amount from Worksheet C, Part V, column 7, line 108.

CAHs are not subject to transitional corridor payments, therefore lines 1.01 through 1.07 do not apply to CAHs. Transfer Worksheet D, Part V, column 9, line 104 and Worksheet D, Part VI, lines 3 and 3.01.

Line 1.01--Enter the medical and other health services for services rendered on or after April 1, 2001, from Worksheet D, Part V, column 9.01, line 104 added to the amount reported on Worksheet D, Part VI, line 3.01; line 3 for cost reporting periods beginning on or after April 1, 2001.

Line 1.02--Enter the gross PPS payments received including payment for drugs, device pass through payments, and outliers.

Line 1.03--Enter the hospital specific payment to cost ratio provided by your intermediary. If a new provider does not file a full cost report for a cost reporting period that ends prior to January 1, 2001, the provider is not eligible for transitional corridor payments and should enter zero (0) on this line. (See PM A-01-51)

Line 1.04--Line 1.01 times line 1.03.

If line 1.02 is < line 1.04 complete lines 1.05 and 1.06. Otherwise do not complete lines 1.05 and 1.06.

Line 1.05--Line 1.02 divided by line 1.04.

Line 1.06--Enter the transitional corridor payment amount calculated based on the following:

For services rendered August 1, 2000 through December 31, 2001:

- a. Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y", and Worksheet S-3, Part I, column 1, line 1 is ≤ 100 , enter the difference of line 1.04 minus line 1.02; or
- b. Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the difference of line 1.04 minus line 1.02.

For all other hospitals enter one of the following:

- c. If line 1.05 is ≥ 90 percent but < 100 percent, enter 80 percent of (line 1.04 minus line 1.02).
- d. If line 1.05 is ≥ 80 percent but < 90 percent, enter the result of 71 percent of (line 1.04) minus 70 percent of (line 1.02).
- e. If line 1.05 is ≥ 70 percent but < 80 percent, enter the result of 63 percent of (line 1.04) minus 60 percent of (line 1.02).
- f. If line 1.05 is < 70 percent, enter 21 percent of line 1.04

For services rendered January 1, 2002, through December 31, 2002:

- a. If line 1.02 is $<$ line 1.04, Worksheet S-2, line 21 response is 2 (rural hospital) or if 21.02 equals "Y", and Worksheet S-3, Part I, column 1, line 1 is ≤ 100 , enter the result of line 1.04 minus line 1.02; or
- b. If line 1.02 is $<$ line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the difference of line 1.04 minus line 1.02.

For all other hospitals enter one of the following:

- c. If line 1.05 is ≥ 90 percent but < 100 percent, enter 70 percent of the result of line 1.04 minus line 1.02.
- d. If line 1.05 is ≥ 80 percent but < 90 percent, enter the result of 61 percent of (line 1.04) minus 60 percent of (line 1.02).
- e. If line 1.05 is < 80 percent, enter 13 percent of line 1.04 .

For services rendered January 1, 2003, through December 31, 2003:

- a. If line 1.02 is $<$ line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y" and Worksheet S-3, Part I, column 1, line 1 is ≤ 100 enter the result of line 1.04 minus line 1.02; or
- b. If line 1.02 is $<$ line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the result of line 1.04 minus line 1.02.

For all other hospital enter one of the following:

- c. If line 1.05 is ≥ 90 percent but < 100 percent, enter 60 percent of the result of line 1.04 minus line 1.02.
- d. If line 1.05 is < 90 percent, enter 6 percent of line 1.04.

For services rendered on or after January 1, 2004 for cancer or children's hospitals only:

- a. If line 1.02 is < line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the result of line 1.04 minus line 1.02.

Line 1.07--Enter the pass through amount from worksheet D, Part IV, column 9, line 101.

Line 2--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

<u>Provider/Component</u>	<u>Title XVIII Hospital</u>	<u>Title XVIII Subprovider</u>	<u>Title XVIII Skilled Nursing Facility</u>
Hospital	Part I, col. 9, line 9 plus line 24; or Part II, col. 7, line 34; or Part III, col. 6, line 41	Part I, col. 9, line 10; or Part II, col. 7, line 35, or Part III, col. 6, line 42	Part I, col. 9, line 12; or Part II, col. 7, line 37; or Part III, col. 6, line 44

Line 3--If you are an approved CTC, enter the cost of organ acquisition from Worksheet D-6, Part III, column 2, line 61 when Worksheet E 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--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost (see CMS Pub. 15-I, §2148), enter the amount from Worksheet D-9, Part II, column 3, line 17.

Line 5--Enter the sum of lines 1 through 4 excluding subscripts in column 1.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e).

NOTE: RPCHs/CAHs are not subject to the computation of the lesser of reasonable costs or customary charges. If the component is an RPCH/CAH, do not complete lines 6 through 16. Instead, enter on line 17 the amount computed on line 5.

Line Descriptions

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter the total reasonable cost from line 5 directly on line 17. Still complete lines 6 through 16 to insure that you meet one of the criteria for this exemption.

Lines 6 through 10--These lines provide for the accumulation of charges which relate to the reasonable cost on line 5.

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

Line 6--For total charges for medical and other services, enter the sum of Worksheet D, Part V, columns 5 and 5.01 (for hospitals and subproviders with cost reporting periods which overlap October 1, 1997, for ambulance services, and SNFs with cost reporting periods beginning prior to

January 1, 1998), line 104 and Worksheet D, Part VI, line 2. For cost reporting periods overlapping 8/1/2000 and after, for hospital and subprovider services, enter the sum of D, Part V, columns 5, 5.02, and 10, line 104, plus D, Part VI, line 2.

For cost reporting periods beginning 1/1/99 for SNF services enter the sum of Worksheet D, Part V, column 5, line 104 and D, Part VI, line 2.

NOTE: If the amounts on Worksheet D, Part V include charges for professional services, eliminate the amount of the professional component from the charges entered on line 6. Submit a schedule showing these computations with the cost report.

Line 7--Enter from your records the total billed charges for services of interns and residents not in an approved program furnished to program beneficiaries.

Line 8--When Worksheet E is completed for a CTC hospital component for title XVIII, enter the organ acquisition charges from Worksheet D-6, Part III, column 4, line 61.

Line 9--Enter your charges for the services for which the cost is entered on line 4.

Line 10--Enter the sum of lines 6 through 9.

Lines 11 through 14--These lines provide for the reduction of program charges when you do not actually impose such charges in the case of most 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 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 over the reasonable cost. If line 14 exceeds line 5, enter the difference.

Line 16--Enter the excess of reasonable cost over the customary charges. If line 5 exceeds line 14, enter the difference.

Line 17-- Enter the lesser of the reasonable cost on line 5 or the customary charges on line 14.

Line 17.01-- Enter the sum of lines 1.02, 1.06, and 1.07, all columns.

NOTE: If these services are exempt from LCC, i.e., CAH or charges are equal to or less than 60 percent of cost, (refer to Worksheet S-2, lines 47-51, columns 1-5, as applicable), enter on line 17 the reasonable costs from line 5.

Line 18--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 18.01--Enter the deductible and coinsurance relating to the amounts reported on line 17.01.

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, lines 47-51, columns 1-5, as applicable), enter the Part B deductibles billed to program beneficiaries only. Do not enter any Part B coinsurance. For CAHs with cost reporting periods beginning on or after 7/1/2002, enter the deductibles on line 18 and the coinsurance on line 18.01.

Line 19--Subtract line 18 and 18.01 from line 17 and 17.01 respectively.

NOTE: If these services are exempt from LCC, line 17 minus line 18 times 80 percent. Add to that result line 17.01 minus line 18.01.

For critical access hospitals, exempt from LCC, multiply 80 percent times the result of line 17 minus (sum of line 18 plus Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus Worksheet D, Part VI, line 3). Add back Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus Worksheet D, Part VI, line 3. Prorate on a days to days basis lab services for cost reporting periods overlapping 11/29/99. For cost reporting periods beginning on or after 11/29/99, no proration is required. (11/29/99s)

For CAHs with cost reporting periods beginning on or after July 1, 2002, enter the lesser of (line 17 minus the sum of lines 18 and 18.01) or 80 percent times the result of (line 17 minus line 18 minus lab cost (Worksheet D, Part V, column 9, lines 44, 45, and subscripts) minus vaccine cost (Worksheet D, Part VI, line 3). Add back the aforementioned lab and vaccine cost). (7/1/02b)

Line 20--This line is used to combine the amounts for medical and other health services, outpatient ambulatory services, outpatient radiology services, and other outpatient diagnostic procedures, for services rendered prior to August 1, 2000. Enter in column 1 only the sum of the amounts from Worksheet E, Part C, columns 1 plus 1.01, line 21; Part D, columns 1 plus 1.01, line 21; and Part E, columns 1 plus 1.01, line 21. For services after August 1, 2000, make no entry.

Line 21--Enter in column 1 the amount from Worksheet E-3, Part IV, line 25. Complete this line for the hospital component only.

Line 22--Enter in column 1 the amount from Worksheet E-3, Part IV, line 11. Complete this line for the hospital component only.

Line 23--Enter in column 1 the sum of columns 1 and 1.01, lines 19 through 22 .

Line 24--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- o Workmens' compensation,
- o No fault coverage,
- o General liability coverage,
- o Working aged provisions,
- o Disability provisions, and
- o 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 26. 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 26 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 26.

Line 25--Enter line 23 minus line 24.

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

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

Line 27.01--Multiply reimbursable bad debts on line 27 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; and 55 percent for October 1, 1999; 70 percent for October 1, 2000 and thereafter (hospitals and subproviders only). The reduction does not apply to Critical Access Hospitals. If line 27 is a negative (recoveries exceeded bad debts) enter that amount with no reduction.

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

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

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

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

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

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

Line 34--Enter interim payments from Worksheet E-1, column 4, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 34.01. For intermediary purposes it will be necessary to make a reclassification of the bi-weekly pass through payments from Part A to Part B and report that Part B portion on line 34.01. Maintain the necessary documentation to support the amount of the reclassification.

3632. 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. When a hospital with a certified SNF component has made an election to use the swing bed optional method for the SNF, the SNF component uses this worksheet to compute the swing bed-SNF reimbursement. (See 42 CFR 413.24(d)(5) and CMS Pub. 15-I, §2230.5.B.)

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--Enter the cost of swing bed-SNF inpatient routine services transferred from Worksheet D-1, Part II, line 62 (title XVIII only). **Effective for cost reporting periods beginning on or after July 1, 2002 swing beds are paid on the basis of SNF PPS and are required to input the total PPS payments in column 1 or 2, as applicable, from the provider's books and records or the PS&R. (See Vol. 67 FR 147 dated July 31, 2002 and PM A-02-016, change request 1666)** For RPBH providers, enter this amount from Worksheet C, Part IV, column 2, line 9. Make no entry on line 1 when Worksheet E-2 is used for swing bed-NF unless your State recognizes only SNF level of care. Then do not use lines designated as NF.

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

Line 2--Enter the cost of swing bed-NF inpatient routine services transferred from Worksheet D-1, Part II, line 65 (titles V and XIX only). For RPBH providers, enter this amount from Worksheet C, Part IV, columns 1 or 3, line 9, for titles V or XIX. Make no entry on line 2 when Worksheet E-2 is used for swing bed-SNF.

Line 3--Enter the amount of ancillary services:

Title V	from	Worksheet D-4, col. 3, line 101
Title XVIII, Part A	from	Worksheet D-4, col. 3, line 101
Title XVIII, Part B	from	The sum of Worksheet D, Part V, cols. 9 and 11, line 104 and Worksheet D, Part VI, line 3
Title XIX	from	Worksheet D-4, col. 3, line 101

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 or line 10, as appropriate.

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.

3633. WORKSHEET E-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT

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

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

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

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

Line Descriptions

Lines 1.01, 1.02, 1.05, and 1.06 pertain only to inpatient rehabilitation facilities' (IRF) cost reporting periods beginning on or after January 1, 2002 and long term care hospitals' (LTCH) cost reporting periods beginning on or after October 1, 2002. Line 1.03 and 1.04 pertain only to IRFs with cost reporting periods beginning on or after January 1, 2002. (See §1886(j) of the Act and PMs A-01-110 and A-01-131).

Line 1--Enter (for TEFRA hospitals, IRFs, LTCH, and subprovider) the amount from Worksheet D-1, Part II, line 59. For IRFs, if Worksheet S-2, line 58, column 2 is yes, or for cost reporting period beginning on or after 10/1/2002, enter zero on this line. For LTCH, if Worksheet S-2, line 59, column 2 is yes, enter zero on this line.

Line 1.01--For IRFs enter hospital specific amount by multiplying line 1 times 33 1/3 percent. For LTCH enter the hospital specific amount by multiplying line 1 times the blended TEFRA rate percentage (see Vol. 67 FR 169 dated August 30, 2002 page 55976 for rates) for the appropriate cost reporting period.

Line 1.02--Enter the Net Federal IRF PPS payment for cost reporting periods beginning on or after January 1, 2002. Exclude low income patient (LIP) and outlier payments. Obtain this information from the PS&R and/or your records. If line 1.01 is greater than zero, enter 66 2/3 percent of the Federal IRF PPS payment amount (excluding LIP and outlier payments).

Enter the Net Federal LTCH PPS payment for cost reporting periods beginning on or after October 1, 2002, including short stay outlier payments. Obtain this information from the PS&R and/or your records. If line 1.01 is greater than zero for discharges occurring from October 1, 2002 through September 30, 2003, enter 20 percent of the PPS payment (40 percent from October 1, 2003 – September 30, 2004, 60 percent from October 1, 2004 - September 30, 2005, 80 percent from October 1, 2005 - September 30, 2006, and 100 percent on or after October 1, 2006). (See Vol. 67 FR 169 dated August 30, 2002 page 55976 for rates.)

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

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

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

Line 1.06--Enter the sum of lines 1.01, 1.02, 1.04, and 1.05.

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

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

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

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

- o Workmens' compensation,
- o No fault coverage,
- o General liability coverage,
- o Working aged provisions,
- o Disability provisions, and
- o 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 0paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

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

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

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

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

Line 11--Enter program reimbursable bad debts reduced by recoveries.

Line 11.01--Multiply allowable bad debts from Line 11 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999; and 70 percent for October 1, 2000 and all subsequent periods.

Line 12--Enter the sum of lines 10 and 11.01. If line 11 is negative, recoveries exceed bad debts; add the amount reported on line 11.

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

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

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

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

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

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

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

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

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

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

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

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs:

Hospital(CAH) or Subprovider - Worksheet D-1, Part II, line 49
Skilled Nursing Facility - Worksheet D-1, Part III, line 82
RPCH - Worksheet C, Part IV, line 6 (Not applicable for cost reporting periods beginning after October 1, 1997)

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

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

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

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

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but not in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system. However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible

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

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

Line 6--Enter the amount on line 4 minus the amount on line 5.

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

Line Descriptions

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

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

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-1, §§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-4, column 2, sum of lines 37 through 68.

NOTE: If the amounts on Worksheet D-4 include charges for professional services, eliminate the amount of the professional component from the charges entered on line 11. Submit a schedule showing these computations with the cost report.

Line 9--When Worksheet E-3 is completed for a CTC hospital component, enter the organ acquisition charges from Worksheet D-6, Part III, line 61, column 3.

Line 10--Enter your charges for the services for which the cost is entered on line 3.

Line 11--Enter the sum of lines 7 through 10.

Lines 12 through 15--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most 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 14 is greater than zero, multiply line 11 by line 14, and enter the result on line 15. 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 12 through 14. Enter on line 15 the amount from line 11. In no instance may the customary charges on line 15 exceed the actual charges on line 11. (See 42 CFR 413.13(e).)

Line 16--Enter the excess of the customary charges on line 15 over the reasonable cost on line 6.

Line 17--Enter the excess of reasonable cost on line 6 over the customary charges on line 15. Transfer line 17 to line 21.

Computation of Reimbursement Settlement

Line 18--Enter the amount from Worksheet E-3, Part IV, line 24. Complete for the hospital component only.

Line 19--Enter the sum of lines 6 and 18.

Line 20--Enter the Part A deductibles billed to Medicare beneficiaries.

Line 21--Enter the amount, if any, recorded on line 17. If you are a nominal charge provider, enter zero.

Line 22--Enter line 19 less the sum of 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 program reimbursable bad debts net of recoveries.

Line 25.01--Multiply allowable bad debts included on Line 25 by 100 percent for cost reporting periods beginning on or after October 1, 1996, 75 percent for October 1, 1997, 60 percent for October 1, 1998 and 55 percent for October 1, 1999; 70 percent for October 1, 2000 and all subsequent periods. No reduction is required for critical access hospitals. If line 25 is negative, recoveries exceed bad debts; enter that amount with no reduction.

Line 26--Enter the sum of lines 24 and 25 or 25.01(hospitals and subproviders only).

Line 27--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 28--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-I, §2146.4.) Specify the adjustment in the space provided.

For SNFs only, include the title XVIII portion of the amount of the State's bill for determining the validity of nurse aide training and testing under §4211(b)(5) of P.L. 100-203. This adjustment includes the State's cost of deeming individuals to have completed training and testing requirements and the State's cost of determining the competency of individuals trained by or in a facility based program.

Line 29--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.)

Line 30--Enter line 26, plus or minus lines 28 and 29, minus line 27.

Line 31--Enter the sequestration adjustment amount, if applicable.

Line 32--Enter interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlement, report on line 32.01 the amount from line 5.99.

Line 33--Enter line 30 minus the sum of lines 31 and 32. Transfer this amount to Worksheet S, Part II, line as appropriate.

Line 34--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.

3633.3 Part III - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services and Part A Services for Title XVIII PPS SNFs.--Worksheet E-3 calculates reimbursement for titles V or XIX services for hospitals, subproviders, other nursing facilities and ICF/MRs. For titles V and XIX, complete column 1. For title XVIII SNFs reimbursed under PPS, complete this part for settlement of Part A services using column 2. For Part B services, all SNFs complete Worksheet E, Part B.

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., PPS, TEFRA, OTHER).

If the State program is under PPS for inpatient hospital services, do not complete line 1. Complete lines 24 through 32 for services covered by PPS. Complete lines 2 through 8, 9 through 15, and 16 through 23 only for services not covered by PPS. If the State program follows TEFRA for inpatient hospital services, do not complete lines 24 through 29. If the State program follows cost reimbursement, do not complete lines 15 and 24 through 29.

Line 16--Enter the sum of the amounts recorded on lines 10 through 15.

Lines 17 through 20--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most 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 19 is greater than zero, multiply line 16 by line 19, and enter the result on line 20. 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 17 through 19. Enter on line 20 the amount from line 16. In no instance may the customary charges on line 20 exceed the actual charges on line 16. For title XVIII SNFs reimbursed under PPS, lines 18 through 20 apply to Part A ancillary services only. For SNFs for cost reporting periods beginning on or after July 1, 1998, no entry is required.

Line 21--Enter the excess of the customary charges over the reasonable cost. If the amount on line 20 is greater than the amount on line 9, enter the excess.

Line 22--Enter the excess of total reasonable cost over the total customary charges. If the amount on line 9 exceeds the amount on line 20, enter the excess. Transfer this amount to line 34.

Line 23--Enter in columns 1 and 2 the amount from line 9.

Prospective Payment Amount

Line 24--Compute in column 1 the sum of the following amounts supplied by the intermediary:

- o The DRG payments made for PPS discharges during the cost reporting period, and
- o The DRG payments made for PPS transfers during the cost reporting period.

For title XVIII SNFs reimbursed under PPS (less than 1500 days), multiply the number of Medicare days by the prospective payment rate, and enter the result in column 2. If the SNF is participating in the demonstration, transfer the amount reported on Worksheet E-3, Part V, line 25. For cost reporting periods beginning on or after July 1, 1998, transfer the amount from Worksheet S-7, column 5, line 46. SNFs electing 100 percent Federal rate for cost reporting periods beginning on or after July 1, 2001, providers are required to input the total RUG payments. **Obtain this from your books and records or the PS&R.**

Line 25--Enter in column 1 the amount of outlier payments made for PPS discharges during the period. See CMS Pub. 15-I, chapter 28 for a discussion of these outlier payments.

Line 26--Enter in column 1 the payment for inpatient program capital costs from Worksheet L, Part I, line 6; Part II, line 10; or Part III, line 5, as applicable.

Line 27--Enter the amount from Worksheet L, Part IV, line 13, as applicable **for cost reporting periods beginning before October 1, 2001. For cost reporting periods beginning on and after October 1, 2001, enter the result of Worksheet L, Part IV, line 13 less Worksheet L, Part IV, line 17. If this amount is negative, enter zero on this line.**

Line 28--Enter the routine service other pass through costs from Worksheet D, Part III, column 8, lines 25 through 30 and 33 for hospital and from line 31 for the subprovider. For cost reporting periods beginning on or after July 1, 1998, for title XVIII SNFs, enter in column 2 the amount from Worksheet D, Part III, column 8, line 34.

Line 29--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101. For cost reporting periods beginning on or after July 1, 1998, for title XVIII SNFs, enter the amount from Worksheet D, Part IV, column 7, line 101.

Line 30--Enter the sum of lines 23 through 29.

Line 31--For titles V and XIX only, enter the customary charges for PPS.

Line 32--For titles V and XIX PPS, enter the lesser of lines 30 or 31. For non PPS, enter the amount from line 30. For title XVIII, enter the amount from line 30.

Line 33--Enter any deductible amounts imposed.

Computation of Reimbursement Settlement

Line 34--Enter the amount, if any, from line 22. For SNFs with cost reporting periods beginning on or after July 1, 1998, do not complete this line.

Line 35--Enter line 32 less the sum of lines 33 and 34.

Line 36--Enter any coinsurance amounts.

Line 37--For titles V and XIX, enter in column 1 the sum of the amounts from line 19 of Worksheet E, Parts C, D, and E. Do not complete this line for title XVIII.

Line 38--Enter program reimbursable bad debts for deductibles and coinsurance net of bad debt recoveries.

Line 38.01--Multiply allowable bad debts reported on line 38 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999; 70 percent for October 1, 2000 and all subsequent periods. If line 38 is negative, (recoveries exceed bad debts), enter that amount with no reduction. (hospitals and subproviders only if title V or XIX follow Medicare principles).

Line 39--Enter the title XVIII 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, line 81.

Line 40--Enter the sum of lines 35, 37, 38 or 38.01 and 39, minus line 36.

Lines 41 through 48--Do not complete these lines.

Line 49--Enter in column 1, for titles V and XIX, and in column 2, for title XVIII SNFs reimbursed under PPS, the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination of a decrease in program utilization.

NOTE: For titles V or XIX PPS providers for whom capital is included in PPS, the prior periods are only those paid under reasonable cost or the hold harmless methodology under capital PPS.

Line 50--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-I, §2146.4.) Specify the adjustment in the space provided.

413.86(g)(6)(ii), the cap for each new program accredited or begun on or after January 1, 1995 and before August 6, 1997, is effective in the fourth program year of each of those new programs (see 66 FR August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 3.01. Also enter the unweighted allopathic or osteopathic FTE count for residents in all years of the rural track program that meet the criteria for an add-on to the cap under 42 CFR 413.86(g)(11). If the rural track program is a new program under 42 CFR 413.86(g)(12) and qualifies for a cap adjustment under 413.86(g)(6)(i) or (g)(6)(iii), do not report FTE residents in the rural track program on this line until the fourth program year of the rural track program. Report these FTEs on line 3.16 or line 3.22 (04/01).

Line 3.03--Enter the adjustment (increase or decrease) for the unweighted resident FTE count for allopathic or osteopathic programs for affiliated programs in accordance with 42 CFR 413.86(b), (g)(4), and (63 FR 26 336 May 12, 1998).

Line 3.04--Enter the sum of lines 3.01 through 3.03, which is the FTE adjusted cap.

Line 3.05--Enter the unweighted resident FTE count for allopathic or osteopathic programs for the current year from your records, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules.(42 CFR 413.86(g)(5) and or (g)(6).

Line 3.06--Enter the lesser of lines 3.04 or 3.05.

Line 3.07--Enter the weighted FTE count for primary care physicians and OB/GYN residents in an allopathic or osteopathic program for the current year other than those in the initial years of the program that meet the criteria for an exception to the averaging rules. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero.(42 CFR 86(g)(5) and/or (g)(6).

Line 3.08--Enter the weighted FTE count for all other physicians in an allopathic or osteopathic program for the current year other than those in the initial years of the program that meet the criteria for an exception to the averaging rules. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero. (42 CFR 86(g)(5) and/or (g)(6) (10/97)).

Line 3.09--Enter the sum of lines 3.07 and 3.08.

Line 3.10--For cost reporting periods beginning prior to October 1, 2001, if line 3.05 is less than or equal to line 3.04, enter the amount from line 3.09, otherwise multiply line 3.09 by (3.04/line 3.05). (10/97) For cost reporting periods beginning on or after October 1, 2001, if line 3.05 is less than or equal to line 3.04; multiply line 3.07 by (line .04/line 3.05) and multiply line 3.08 by (line 3.04/3.05) and add the results. (42 CFR 413.86(g)(4)(iii)).

Line 3.11--Enter the weighted dental and podiatric resident FTE count for the current year. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero (10/97).

Line 3.12--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.10 and 3.11 for column 1 or column 0, if applicable. For cost reporting periods beginning on or after October 1, 2001, if the amount from line 3.09 is reported on line 3.10 enter the sum of lines 3.11 and 3.08. Otherwise, enter the sum of line 3.11 and (3.08 times (line 3.04/line 3.05)).

Line 3.13--For cost reporting periods beginning prior to October 1, 2001, enter the total weighted FTE resident count for the prior cost reporting year (if subject to the cap in the prior year, report the sum of lines 3.10 and 3.11 of the prior year), other than those in the initial years of the program that meet the criteria for an exception to the averaging rules. If a zero is entered on this line, enter in

column zero a 1 if the hospital did not report FTEs this period, but did have an approved program. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE count for nonprimary care residents for the prior year (if subject to the cap in the prior year, report the result of line 3.08 times (line 3.04/line 3.05) plus line 3.11, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.86 (g)(5)(v)).

Line 3.14--For cost reporting periods beginning on or after October 1, 1998, but prior to October 1, 2001, enter the total weighted FTE resident count for the cost reporting year before last (if subject to the cap in the year before last, report the sum of lines 3.10 and 3.11 of the year before last) other than those in the initial years of the program that meet the exception to the averaging rules. If zero is entered on this line, enter in column zero a 1 if the hospital did not report FTEs but did have an approved program. For cost reporting periods beginning on or after October 1, 2001, enter the total weighted FTE resident count for nonprimary care residents for the cost reporting year before last (if subject to the cap in the year before last, report the result of line 3.08 times (line 3.04/line 3.05) plus line 3.11 other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.86 (g)(5)(v)).

Line 3.15--For cost reporting periods beginning prior to October 1, 2001, enter the rolling average FTE count by adding lines 3.12 through 3.14 and divide by 3 (See 42 CFR 413.86(g)(5)(v)) unless column zero is completed for any of these lines. For cost reporting periods on or after October 1, 2001, this will be the nonprimary care rolling average count.

Line 3.16--For cost reporting periods beginning prior to October 1, 2001, enter the weighted number of FTE residents in the initial years of a primary care and OB/GYN program that meets the exception. For cost reporting periods beginning on or after October 1, 2001 enter the sum of line 3.15 and the weighted number of nonprimary care FTE residents in the initial years of new allopathic and osteopathic programs (42 CFR 413.86.(g)(5)(v) and/or (g)(6). Also add the temporary weighted adjustments for nonprimary care FTE residents that were displaced by program or hospital closure (42 CFR 413.86(g)(8)).

Line 3.17--For cost reporting periods beginning prior to October 1, 2001, enter the weighted number of FTE residents in the initial years of all other programs that meet the exception criteria in 42 CFR 413.86(g)(6). For cost reporting periods beginning on or after October 1, 2001 enter the nonprimary care per resident amount.

Line 3.18--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.15 through 3.17. For cost reporting periods beginning on or after October 1, 2001, enter the result of multiplying lines 3.16 times line 3.17.

Line 3.19--For cost reporting periods beginning prior to October 1, 2001, enter the primary care and OB/GYN physician per resident amount. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE resident count for primary care and OB/GYN residents for the prior year cost report (if subject to the cap in the prior year, report the result of line 3.07 times (line 3.04/line 3.05)) other than those in the initial years of the program that meet the criteria for an exception to the averaging rules 42 CFR 413.86(g)(5)(v).

Line 3.20--For cost reporting periods beginning prior to October 1, 2001, enter the all other program per resident amount. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE resident count for primary care and OB/GYN residents in the cost reporting year before last (if subject to the cap in the year before last, report the product of line 3.07 times (line 3.04/line 3.05) from the 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 413.86(g)(5)(v).

For cost reporting periods beginning prior to October 1, 2001, in order to generate a weighted payment amount for lines 3.21 and 3.22, if lines 3.07 and/or 3.08 of column 1 are zero substitute the

count for lines 3.07 and/or 3.08 for the current period with the counts entered in column zero for those lines. (10/01) For cost reporting periods beginning on or after October 1, 2001 this instruction no longer applies (10/01).

Line 3.21--For cost reporting periods beginning prior to October 1, 2001, enter the primary care unadjusted approved amount by multiplying the sum of lines 3.07 and 3.16 by line 3.19. For cost reporting periods beginning on or after October 1, 2001, if the amount from line 3.09 was reported on line 3.10, enter the rolling average primary care and OB/GYN count by adding the sum of (lines 3.07, 3.19 and 3.20)/3) (the denominator corresponds to amounts greater than zero), otherwise, calculate the rolling average for primary care and OB/GYN FTE count as follows (line 3.07 times (line 3.04/line 3.05)), plus line 3.19, and 3.20) and divide the result by 3 (the denominator corresponds to amounts greater than zero).

Line 3.22--For cost reporting periods beginning prior to October 1, 2001, enter the other unadjusted approved amount by multiplying line 3.20 by the sum of lines 3.08, 3.11, and 3.17. For cost reporting periods beginning on or after October 1, 2001 enter the sum of line 3.21 and the weighted number of primary care and OB/GYN FTE residents in the initial years of new allopathic and osteopathic programs 42 CFR 413.86(g)(5)(v) and/or (g)(6). Also add any temporary weighted adjustments for primary care and OB/GYN FTE residents that were displaced by program or hospital closure. 42 CFR 413.86(g)(8).

Line 3.23--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.21 and 3.22. For cost reporting periods beginning on or after October 1, 2001 enter the primary care and OB/GYN per resident amount.

Line 3.24--For cost reporting periods beginning prior to October 1, 2001, divide line 3.23 by the sum of lines 3.07, 3.08, 3.11, 3.16, and 3.17. For cost reporting periods beginning on or after October 1, 2001 multiply line 3.23 by 3.22 and enter the result.

Line 3.25--For cost reporting periods beginning prior to October 1, 2001, enter the total approved amount for resident costs, line 3.24 times line 3.18. For cost reporting periods beginning on or after October 1, 2001 enter the sum of lines 3.18 and 3.24.

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

Line Descriptions

Line 4--For title XVIII, enter the sum of the days reported on Worksheet S-3, Part I, column 4, lines 1, 6 through 10, and 14. For titles V or XIX, enter the amounts from columns 3 or 5, respectively, sum of lines 1, 6 through 10, and 14.

Line 5--Enter the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 6 through 10, and 14 and subscripts as applicable.

Line 6--Divide line 4 by line 5 and enter the result (expressed as a decimal).

Lines 6.01 through 6.08 are completed for cost reports that end on or after January 1, 1998.

Line 6.01--Enter the total GME payment for non-managed care days. For 12 month cost reporting periods which end between January 1, 1998 and September 29, 1998, multiply line 6 times line 3.

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Otherwise multiply line 6 times line 3.25. (Including a short period cost report which begins on or

after October 1, 1997 and ends prior to January 1, 1998.)

Computation of Program Patient Load - Managed Care Days.--Effective January 1, 1998, hospitals will report managed care days to allow for a Medicare plus Choice direct GME payment 42 CFR 413.86(d)(3).

Line 6.02--Enter Medicare managed care days occurring on or after January 1 of this cost reporting period. **These days are included in the days reported on Worksheet S-3, Part I, column 4, line 2. The balance of the days prior to January 1 are entered on line 6.06. (4/30/03)**

Line 6.03--Enter total inpatient days from line 5 above.

Line 6.04--Enter the appropriate percentage for inclusion of the managed care days, beginning January 1 of each year, i.e. 20 percent for 1998, 40 percent for 1999, 60 percent for 2000, 80 percent for 2001, and 100 percent for 2002 and after.

Line 6.05--Calculate the Graduate Medical Education payment for managed care days on or after January 1 through the end of the cost reporting period, $\{(line\ 6.02/line\ 6.03)\ times\ (line\ 6.04)\}$ times line 3, for cost reporting periods beginning before October 1, 1997, otherwise times line 3.25. For services rendered on or after January 1, 2000, and before January 1, 2001, reduce the amount by the factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. Future updates will be published by CMS for services rendered on and after January 1, 2001.

Line 6.06--Enter the Medicare managed care days occurring before January 1 of this cost reporting period. Make no entry prior to January 1, 1998. **This line equals Worksheet S-3, Part I, column 4, line 2 minus line 6.02 above. (4/30/03)**

Line 6.07--Enter the percentage using the criteria identified on line 6.04 above. For years prior to January 1, 2003, the percentage is always 20 percent less than the amount reported on line 6.04.

Line 6.08--Calculate the Graduate Medical Education payment for managed care days prior to January 1 of this cost reporting period: $\{(line\ 6.06/line\ 6.03)\ times\ line\ 6.07\}$ times line 3.25. For services rendered on or after January 1, 2000, and prior to January 1, 2001, reduce the amount by the factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. For services on or after January 1, 2001, updates will be published by CMS.

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 7--Enter the amount from Worksheet B, Part I, sum of columns 21 and 24, lines 57 and 64.

Line 8--Enter the amount from Worksheet C, Part I, column 8, sum of lines 57 and 64. This amount represents the total charges for renal and home dialysis.

Line 9--Divide line 7 by line 8, and enter the result. This amount represents the ratio of ESRD direct medical education costs to total ESRD charges.

Line 10--Enter from your records the Medicare outpatient ESRD charges.

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Line 11--Enter the result of multiplying line 9 by line 10. This represents the Medicare outpatient ESRD costs. Transfer this amount to Worksheet E, Part B, line 22.

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

Line Descriptions

Line 12--Include the Part A reasonable cost for the entire hospital complex computed by adding the following amounts:

- o Hospital and Subprovider(s) - Sum of each Worksheet D-1, line 49;
- o Hospital-Based HHAs - Worksheet H-7, Part I, column 1, line 1;
- o Swing Bed-SNF - Worksheet D-1, line 62;
- o Hospital-Based Non-PPS SNF - Worksheet D-1, line 82; and
- o Hospital-Based PPS SNF - Sum of Worksheet D-1, line 70 and Worksheet E-3, Part III, column 2, line 6.

Line 13--Enter the organ acquisition costs from Worksheet(s) D-6, Part III, column 1, line 61.

Line 14--Enter the cost of teaching physicians from Worksheet(s) D-9, Part II, column 3, line 16.

Line 15--Enter the total Medicare Part A primary payer amounts for the hospital complex from the applicable worksheets.

- o PPS hospital and/or subproviders - Worksheet E, Part A, line 17;
- o TEFRA hospital and/or subproviders - Worksheet E-3, Part I, line 5;
- o Cost reimbursed hospital and/or subproviders and Non-PPS SNFs - Worksheet E-3, Part II, line 5;
- o Hospital-based HHAs - Each Worksheet H-7, Part I, column 1, line 9;
- o Swing Bed SNF and/or NF - Worksheet E-2, column 1, line 9; and
- o Hospital-based PPS SNF - Worksheet E-3, Part III, column 2, line 7.

Line 16--Enter the sum of lines 12 through 14 minus line 15.

Line 17--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, 1.01, 2 through 4; Worksheet E, Parts C, D, and E, columns 1 and 1.01 line 6; Worksheet E-2, column 2, line 8; Worksheet H-7, Part I, sum of columns 2 and 3, line 1; Worksheet J-3, columns 1 and 1.01 if applicable, lines 1 and 1.01; and Worksheet M-3, line 16.

Line 16--Enter line 10 less line 13. This is the physical therapy indirect cost for the entire reporting unit.

Line 17--Enter line 11 less line 14. This is the occupational therapy indirect cost for the entire reporting unit.

Line 18--Enter line 12 less line 15. This is the speech therapy indirect cost for the entire reporting unit.

Line 19--Enter the charge to charge ratio for physical therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 50 by the amount on Worksheet C, Part I, column 8, line 50.

Line 20--Enter the charge to charge ratio for occupational therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 51 by the amount on Worksheet C, Part I, column 8, line 51.

Line 21--Enter the charge to charge ratio for speech therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 52 by the amount on Worksheet C, Part I, column 8, line 52.

Line 22--Calculate the physical therapy demonstration indirect cost by multiplying line 16 by line 19.

Line 23--Calculate the occupational therapy demonstration indirect cost by multiplying line 17 by line 20.

Line 24--Calculate the speech therapy demonstration indirect cost by multiplying line 18 by line 21.

Line 25--Enter the sum of lines 6, 9, 22, 23, and 24. Transfer this amount to Worksheet E-3, Part III, line 24.

3634. 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. **Effective for cost reporting periods ending on or after September 30, 2000, 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 & II, the line numbers are consistent, and the total line is set at 34). 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 3-33.

Column 2--Obtain employee benefits to be reported from Worksheet K-2 column 9, lines 3-33.

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 22.

Column 4--Obtain the contracted services to be reported from Worksheet K-3, col. 9, lines 3-33.

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 34 must equal the total of column 6, line 34.

Column 9--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §3613.)

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 33 to the corresponding lines on Worksheet K-4, Part I, column 0, lines 1 through 33.

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.

3647. WORKSHEET H-6 - 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.

3647.1 Part I - Computation of Lesser of Aggregate Program Cost, Aggregate of Program Limitation Cost, or Per Beneficiary Cost Limitation--This part provides for the computation of the reasonable cost limitation to designated program patient care visits and is required by 42 CFR 413.30 and 42 CFR 413.53. For cost reporting periods beginning on or after October 1, 1997, §4601 of the Balanced Budget Act requires a home health agency to be paid based on the lesser of aggregate Medicare cost, aggregate Medicare limitation or the agency specific per beneficiary annual cost limit applied to the unduplicated census count.

Cost Per Visit ComputationColumn Descriptions

Column 1--Enter the cost for each discipline from Worksheet H-5, Part I, column 29, lines as indicated. Enter the total on line 7.

Column 2--Where the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the hospital's HHA, complete the amounts entered on lines 2 through 4 in accordance with the instructions contained in §3647.2. 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 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 16, 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 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.

For cost reporting periods that overlap October 1, 2000:

Columns 6, 7, 9, 10 and 12--Subscript these columns and report visits and cost for services rendered prior to October 1, 2000 in columns 6, 7, 8, 9, 10, and 12. For services rendered on and after October 1, 2000 enter visits and costs in columns 6.01, 7.01, 9.01, 10.01, and 12.01. No subscripting

is required for cost reporting periods beginning on or after October 1, 2000.

NOTE: For cost reporting periods which overlap October 1, 2000, the sum of visits reported in columns 6 and 7 and subscripts (if applicable) may not equal the corresponding amounts on Worksheet S-4, column 7, lines 21, 23, 25, 27, 29 and 31, respectively since those visits are reported based upon the completion of the episode during the fiscal year. However, for cost reporting period beginning on or after October 1, 2000, sum of visits reported in columns 6 and 7 must equal the corresponding amounts on Worksheet S-4, column 7, lines 21, 23, 25, 27, 29 and 31, respectively. These visits are reported for episodes completed during the fiscal year.

Columns 8 and 11--Do not use these columns.

Column 12 and 12.01--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.

Cost Limitation Computation--Enter for each Metropolitan Statistical Area (MSA) the payment limitation for each discipline for lines 8 through 13. This is supplied by your intermediary. Subscript each discipline line to accommodate multiple MSAs serviced by your home health agency. For cost reporting periods beginning on and after October 1, 2000, the completion of the cost limitation section is no longer required.

Column Descriptions

Column 5--Enter the program limitation (see §1814(b)(1) of the Act) for each discipline on lines 8 through 13. Your fiscal intermediary furnishes these limits to you.

Columns 6 and 9--To determine the program cost limitation for title XVIII, Part A, V, and XIX cost of services, multiply the number of covered visits made to beneficiaries (column 6, lines 1 through 6) (from your records) by the program cost limit amount in column 5 for each discipline. Enter the product in column 9.

Columns 7 and 10--To determine the Medicare cost limitation for Part B cost of services, not subject to deductibles and coinsurance, multiply the number of visits to Part B beneficiaries (column 7, lines 1 through 6) (from your records) by the Medicare cost limit amount in column 5 for each discipline. Enter the product in column 10.

NOTE: Enter in columns 6, 7, 9, and 10 only, the visits rendered through September 30, 2000.

Columns 8 and 11--Do not use these columns for lines 1 through 14.

Column 12--Enter the total program cost limitation for each discipline and subscripts (sum of columns 9 and 10). Add 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 the cost limit per visit 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. **Effective for services rendered on or after January 1, 2003, pneumococcal vaccines and its administration and influenza vaccine and its administration are cost reimbursed not subject to deductibles and coinsurance.**

Column 1--Enter the facility costs in column 1, lines 15 and 16, from Worksheet H-5, Part I, column 29, lines 8 and 9, respectively. For cost reports that overlap October 1, 2000 subscript lines 15 and 16. For cost reporting periods beginning on or after October 1, 2000, **do not subscript lines 15 and 16.**

Column 2--Enter the shared ancillary costs from Worksheet H-6, Part II, column 3, lines 4 and 5, respectively.

Columns 3 through 5--In column 3, enter the total for each line of columns 1 and 2. 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 and not subject to reimbursement on the basis of a fee schedule.

Line Descriptions for Columns 6 through 8

Line 15--Enter the program covered charges for services rendered prior to October 1, 2000, for medical supplies charged to patients for items not reimbursed on the basis of a fee schedule.

Line 15.01-- Enter the program covered charges for services rendered on or after October 1, 2000, for medical supplies charged to patients for items not reimbursed on the basis of a fee schedule. Only report charges for the services rendered in that fiscal year end regardless of when the episode is concluded.

Line 16--Enter the program covered charges for services rendered prior to October 1, 2000, for drugs charged to patients for items not reimbursed on the basis of a fee schedule. Report program charges for injectable drugs for osteoporosis in column 7.

For services cost beginning on and after January 1, 2003, continue to enter in column 7 program charges for hepatitis vaccines and its administration (fee reimbursed). Enter in column 7.01 program charges for pneumococcal vaccines and its administration and influenza vaccine and its administration (cost reimbursed) for services rendered on or after January 1, 2003. Enter in column 8 the program charges for injectable osteoporosis drugs (cost reimbursed).

Line 16.01-- Enter the program covered charges for services rendered on or after October 1, 2000 for drugs charged to patients for items not reimbursed on the basis of a fee schedule. Report program charges for injectable drugs for osteoporosis only in column 7.

NOTE: For lines 15.01 and 16.01 use the same cost to charge ratio reported for lines 15 and 16 respectively.

Columns 6 and 9--To determine the program cost, multiply the program charges (column 6) by the ratio (column 5) for each line. Enter the product in column 9.

Columns 7 (and subscripts) and 10 (and subscripts)--To determine the Medicare Part B cost, multiply the Medicare charges (column 7) by the ratio (column 5) for each line. **Follow the same procedure for the corresponding subscripts.** Enter the product in column 10 (and 10.01 as applicable).

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.

Per Beneficiary Cost Limitation

Line 17--Enter the Medicare unduplicated census count for services prior to October 1, 2000 only, from Worksheet S-4, column 2, line 2, for Medicare for cost reporting periods that overlap October 1, 2000. Subscript the line for multiple MSAs as they were reported on S-4 line 20. For cost reporting periods beginning on or after October 1, 2000, completion of the per beneficiary cost limitation data is no longer required.

Line 18--Enter the agency specific per beneficiary annual limitation supplied by your intermediary

for each MSA.

Line 19--Multiply line 17 and subscripts by line 18 and subscripts. If there are multiple MSAs and lines 17 and 18 are subscripted, add them together and enter the result.

3647.2 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 this worksheet, and the departments provide services to patients of the hospital's HHA. Subscript lines 1-5, 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-6, Part I as indicated. If lines 1-5 are subscripted, transfer the aggregate of each line.

3647.3 Part III - Outpatient Therapy Reduction Computation--Services are subject to deductible and coinsurance net of operating and capital reductions. This section computes the payment and reduction (for services rendered on or after January 1, 1998) for Part B visit costs subject to deductibles and coinsurance for various home health services provided. For cost reporting periods that overlap the January 1, 1998 effective date, subscripting of columns 2 and 3 is required. For cost reporting periods beginning on or after January 1, 1998, no subscripting is required. For services rendered on and after January 1, 1999, these services are paid under a fee schedule. Report the visits incurred for purposes of balancing total visits with the cost report.

Column 2--Enter in column 2 the average cost per visit amount from Part I, column 5, lines 2 through 4 above.

Column 2.01--Enter in this column the number of visits rendered for each service prior to January 1, 1998.

Column 3 --Enter the number of visits applicable to each service on and after January 1, 1998.

Column 3.01--Enter the result of multiplying column 2 by column 2.01.

Column 4--Multiply column 2 by column 3. Enter 90 percent of the result.

Column 5--Enter the number of visits on or after January 1, 1999.

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

3648. WORKSHEET H-7 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

This worksheet applies to title XVIII only and provides for the reimbursement calculation of Part A and Part B. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

Worksheet H-7 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

3648.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--Services not paid based on a fee schedule 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 as defined in 42 CFR 413.13(b) or customary charges as defined in the 42 CFR 413.13(e).

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 of program services. Enter the cost of services from Worksheet H-6, Part I as follows:

For cost reporting periods beginning prior to October 1, 1997:

If Worksheet H-6, Part I, column 12, line 7 is less than column 12, line 14, transfer (aggregate program cost):

<u>To Worksheet H-7, Line 1</u>	<u>From Worksheet H-6,</u>
Col. 1, Part A	Part I, col. 9, sum of lines 7, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 7, 15, and 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, sum of lines 7, 15, and 16

If column 12, line 14 is less than column 12, line 7, transfer (aggregate program limitation):

<u>To Worksheet H-7, Line 1</u>	<u>From Worksheet H-6</u>
Col. 1, Part A	Part I, col. 9, sum of lines 14, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 14, 15, and 16
Col. 3, Part B - Subject to deductible and coinsurance	Part I, col. 11, sum of lines 14, 15, and 16

For cost reporting periods beginning on or after October 1, 1997:

If Worksheet H-6, Part I, column 12, line 7 plus the sum of columns 9, 10, and 11, line 15 is less than column 12, line 14 plus the sum of columns 9, 10, and 11, line 15 or column 2, line 19, transfer (aggregate program cost): Do not include in the calculations below the subscripted columns reported on Worksheet H-6 for services rendered on and after October 1, 2000 except for line 16 or 16.01, column 11, osteoporosis drug costs.

For cost reporting periods beginning on or after October 1, 2000, enter on line 1 only the osteoporosis drug costs reported on Worksheet H-6, line 16.01, column 10.

For the following vaccines administered on or after January 1, 2003, enter on line 1, only the cost of pneumococcal and influenza vaccines and their administration reported on Worksheet H-6, line 16, column 10.01 and osteoporosis drug costs reported on Worksheet H-6, line 16, column 11. Enter no other costs on this line as drugs for hepatitis are fee reimbursed, and all other services are PPS reimbursed.

<u>To Worksheet H-7, Line 1</u>	<u>From Worksheet H-6,</u>
Col. 1, Part A	Part I, col. 9, sum of lines 7, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 7, 15, and 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, lines 15 and 16 added to Part III, sum of columns 3.01 and 4, line 4 for services rendered prior to January 1, 1999

If column 12, line 14 plus the sum of columns 9, 10, and 11 line 15 is less than column 12, line 7 plus the sum of columns 9, 10, and 11 line 15 or column 2, line 19, transfer (aggregate program limitation):

<u>To Worksheet H-7, Line 1</u>	<u>From Worksheet H-6,</u>
Col. 1, Part A	Part I, col. 9, sum of lines 14, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 14, 15, and 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, lines 15 and 16 Part III, sum of columns 3.01 and 4, line 4 for services rendered prior to January 1, 1999

If Column 2, line 19 is less than column 12, line 7 or line 14 plus the sum of columns 9, 10, and 11 line 15 apportion the amount to Part A and Part B in proportion to the Part A and Part B costs reported in columns 9 and 10, line 7 of Worksheet H-6, Part I. Add the amount reported in columns 9 and 10, line 16 to Parts A and B (Not subject to deductible and coinsurance). Enter in column 3 (subject to deductible and coinsurance) the sum of Worksheet H-6, Part I, column 11, lines 15 and 16 and Part III, columns 3.01 and 4, line 4.

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-I, chapter 21) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §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. For cost reports that overlap October 1, 2000, enter only

the charges for services rendered prior to October 1, 2000. For cost reporting periods beginning on or after October 1, 2000, enter only the charges associated with osteoporosis drugs which continue to be 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.

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 workmens' 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:

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

3648.2 Part II - Computation of HHA Reimbursement Settlement.--

Line 10--Enter in column 1 the amount in Part I, column 1, line 1 less the amount in column 1, line 9. Enter in column 2 the sum of the amounts from Part I, columns 2 and 3, line 1 less the sum of the amounts in columns 2 and 3 on line 9. For services rendered on or after October 1, 2000 this line will only include the osteoporosis drug reduced by primary payor amounts.

Lines 10.01 through 10.14—Enter in column 1 only for lines 10.01 through 10.06, as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 only on lines 10.07 through 10.10, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter on lines 10.12 through 10.14 the total DME, oxygen, prosthetics and orthotics payments, respectively, associated with home health PPS services (bill types 32 and 33). For lines 10.12 through 10.14 do not include any payments associated with services paid under bill type 34X. Obtain these amounts from your PS&R report.

Line 11--Enter in column 2 the Part B deductibles billed to program patients. Include any amounts of deductibles satisfied by primary payer payments.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 11 and primary payment amounts in column 3, line 9 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 13—If there is an excess of reasonable cost over customary charges in any column on line 8, enter the amount of the excess in the appropriate column.

Line 15—Enter in column 2 all coinsurance billable to program beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of the costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 11 and primary payment amounts in column 3, line 9 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 17--Enter the reimbursable bad debts in the appropriate columns.

Line 19--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §132.) Enter the amount of any excess depreciation taken as a negative amount.

Line 20--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in program utilization. Submit the work papers which have developed this amount. (See CMS Pub. 15-I, §132.)

Line 21--Enter any other adjustments. For example, enter an adjustment from changing the recording of vacation pay from the cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.) Include on this line, for cost reporting periods beginning in Federal fiscal year 2000 only, the special

payment for Outcome and Assessment Information Set (OASIS) determined by multiplying the Medicare unduplicated census count on Worksheet S-4, column 2, line 2 times \$10 reduced by the amount received on April 1, 2000. Do not include this interim payment on Worksheet H-8 but attach separate documentation supporting the payment.

Line 22--Enter the result of line 18 plus or minus lines 19 and 21, minus line 20.

Line 23--Using the methodology explained in §120, enter the sequestration adjustment.

Line 24--Enter line 22 minus line 23.

Line 25--Enter the interim payment amount from Worksheet H-8, line 4. For intermediary final settlement, report on line 25.01 the amount from line 5.99. For titles V and XIX, enter the interim payments from your records.

Line 26--The amounts show the balance due the provider or the program. Transfer to Worksheet S, Part II.

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

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

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

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

Do not include on this worksheet any payments made for DME or medical supplies charged to patients that are paid on the basis of a fee schedule.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA for cost reimbursement prior to October 1, 2000. Also include the PPS payments received on and after October 1, 2000 for all episodes concluded in this fiscal year as well as any payments received for osteoporosis drugs. Do not include any payments received for fee scheduled services. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from your interim payments due to an offset against overpayments applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

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

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

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to the appropriate column on Worksheet H-7, Part II, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET H-8. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR FISCAL INTERMEDIARY.

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

Line 6--Enter in column 2 the amount on Worksheet H-7, Part II, column 1, line 26. Enter in column 4 the amount on Worksheet H-7, Part II, column 2, line 26.

Line 7--Enter the net settlement amount (balance due to you or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening. Enter the total of the amounts on lines 4, 5.99, and 6.

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

		education only)
26	Central Services & Supplies	15
27	Pharmacy	16 and 26 (EPO only)
28	Other Allocated Costs	Sum of 9, 11, 12, 13, 14, 17, 18, 19, and 20

Line 29--Add lines 18 through 28. This total should agree with the total on Worksheet B, column 27, line 57 or line 64 if a home dialysis cost center was established.

Lines 30, 31, and 32--These lines provide for the allocation of costs associated with routine dialysis services furnished to renal patients from other ancillary departments. Multiply charges by the cost to charge ratio from Worksheet C, Part II for the appropriate department. For cost reporting periods beginning on and after August 1, 2000, enter the cost to charge ratio from Worksheet C, Part I, column 9. Payment for routine laboratory services, as defined in §E202 of the ESRD Appendix of the Hospital Manual, is paid for under the composite payment rate. No separate payment is made for routine laboratory tests. The costs of these services are allocated to the renal department based on the provider's laboratory cost to charge ratio as computed on Worksheet C, Part II, column 8, line 44. For cost reporting periods beginning on and after August 1, 2000, enter the cost to charge ratio from Worksheet C, Part I, column 9, line 44. Providers must maintain a log of routine laboratory charges for allocating routine laboratory costs to the renal department. The lab charges reported on Worksheet C do not include the lab charges for ESRD therefore those charges must be grossed up in accordance with PRM-1, § 2314. The cost to charge ratio must be recalculated and applied against the charges reported in column 3 of this worksheet.

Line 33—Enter the sum lines 29 through 32.

3652. WORKSHEET I-2 - ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

The purpose of this schedule is to allocate costs to the different services furnished in the renal department. Line 1 combine the costs reported on Worksheet I-1 for allocating costs to the different services furnished in the renal department.

Line 1--Add the costs from Worksheet I-1, and transfer these amounts to line 1 in the following manner:

<u>Worksheet I-2</u>	<u>Worksheet I-2 Column</u>	<u>Worksheet I-1</u>
Capital & Main Building Costs	1	Sum of lines 11, 18, 20, and 24
Capital, Machine & Repair Costs	2	Sum of lines 12, 13, 19, and 21
Registered Nurses Direct Patient Care Salary	3	Line 1
Other Direct Patient Care Salary	4	Sum of lines 2, 3, 4, 5, and 6
Employee Benefits	5	Sum of lines 10 and 22
Drugs	6	Sum of lines 15 and 27
Medical Supplies	7	Sum of lines 14 and 26
Routine Ancillary Services	8	Sum of lines 30, 31, and 32
Subtotal	9	Not applicable
Overhead	10	Sum of lines 7, 8, 16, 23, and 28

Complete columns 1 through 8 and 10 in conjunction with Worksheet I-3, which contains the statistical bases for allocating costs to the proper lines. For each line item in columns 1 through 8 and 10, multiply the statistic entered in the corresponding line and column of Worksheet I-3 by the unit cost multiplier on line 17.

Lines 2 through 11--These lines identify the type of dialysis treatments that are paid for under the composite payment rate system. The total costs (column 11) for these individual dialysis services are transferred to Worksheet I-4.

Transfer the total on Worksheet I-2, column 11 to Worksheet I-4 per the following instructions.

<u>From Worksheet I-2, Column 11</u>	<u>To Worksheet I-4, Column 2</u>
Line 2	Line 1
Line 3	Line 2
Line 4	Line 3

Line 5	Line 4
Line 6	Line 5
Line 7	Line 6
Line 8	Line 7
Line 9	Line 8
Line 10	Line 9
Line 11	Line 10

If you complete a Worksheet I-2 for the renal department and the home program dialysis department, complete a separate Worksheet I-4.

Lines 12 through 15--These services are not paid for under the composite payment rate system. Therefore, the costs of these services are not transferred to Worksheet I-4. Exclude these costs in the calculation of reimbursement composite payment rate bad debts. (See 42 CFR 413.170(e).)

Line 12--Report inpatient costs. Inpatient dialysis services are paid under the DRG system for Medicare patients.

Line 13--Report the costs of support services furnished to Method II home patients. Payment for Method II home patient dialysis services are subject to the rules in 42 CFR 414.330. Under Method II, a renal provider is only allowed to bill for support services and not dialysis equipment or supplies. Payment for support services is limited to the lower of the provider's reasonable cost or the payment limit as defined in the regulation, which is \$125 per patient per month. This amount includes payment for support services and routine laboratory tests furnished to home patients.

Line 14--Report the direct costs of EPO net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Payment for EPO administered to an end stage renal disease patient is subject to payment limitation of \$10 per 1000 units, rounded to the nearest 100 units. **Enter EPO amount for informational purposes only. This amount is not included in the total on line 16.**

Line 15--Report the costs of other services furnished and billed in the renal department that are paid for outside the composite payment rate.

Line 16--Add columns and enter totals. Since line 14, column 9 is shaded, no costs for EPO are included in the total for line 16, column 9 and column 6, line 14 should be excluded from total.

Line 17--Enter the amount of medical educational program costs from Worksheet I-1, line 25. Payment for medical educational program costs allocated to the renal department is not included in the composite payment rate.

Line 18--Add lines 16 and 17. This total agrees with the sum of Worksheet I-1, column 1, line 33.

Column Description

Columns 1 through 8--For each line, multiply the unit cost multiplier on Worksheet I-3, line 17 by the statistical base, and enter the result on the corresponding line and column on Worksheet I-2.

Column 9--Add columns 1 through 8 for each line, except line 14 (EPO), and enter the total.

Column 10--Multiply the unit cost multiplier on Worksheet I-3, column 10, line 17 by the line amounts in column 9 of Worksheet I-2, and enter the amount in column 10.

Column 11--Add columns 9 and 10 for each line, and enter the result.

3653. WORKSHEET I-3 - DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

To accomplish the allocation of your direct and indirect costs reported on Worksheet I-1 to the different services provided in the department, you must maintain renal department statistics. To facilitate the allocation process, the format of Worksheets I-2 and I-3 is identical.

Line 1--Transfer the amounts on Worksheet I-2, line 1, columns 1 through 10 to Worksheet I-3, line 1, columns 1 through 10.

Lines 2 through 15--Enter on these lines and in the appropriate columns, the statistic for allocating costs to the appropriate line item. The statistical basis used in each column is defined in the column heading and on Worksheet I-1.

NOTE: If you wish to change your allocation basis for a particular general cost center, you must receive written approval from your intermediary before the start of your cost reporting period for which the alternative method is used. (See §3617 for Worksheets B and B-1.)

Line 12--Enter, in the area provided, the number of inpatient dialysis treatments furnished during the cost reporting period.

Line 16--Add the statistical basis for each column, except columns 9 and 10.

Line 17--Calculate the unit cost multiplier by dividing the amount on line 1 by the total statistical basis on line 16 for each column. Multiply the unit cost multiplier by the statistical base, and enter the cost on the appropriate line and column number on Worksheet I-2.

Column Descriptions

Column 1--Use the square footage of the renal department to allocate capital and maintenance building costs.

Column 2--Use percentage of time to allocate capital and maintenance equipment costs.

Columns 3 and 4--Use paid hours to allocate registered nurses and direct patient care salary.

Column 5--Use total direct patient care salaries in columns 4 and 5 of Worksheet I-2 to allocate employee benefits.

Columns 6 and 7--Use cost of requisitions to allocate drug and medical supply costs.

Column 8--Use routine laboratory charges to allocate laboratory costs.

Column 10--Use subtotal costs in column 9, Worksheet I-2 to allocate overhead cost. To compute the unit cost multiplier, transfer the amount from Worksheet I-2, line 16, column 9 to Worksheet I-3, line 16, column 10. Do not allocate overhead costs to line 14 (EPO).

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

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

Line 5.01--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12, plus line 2, minus the sum of lines 3 and 4) divided by total days reported on Worksheet S-3, column 6, line 12, minus the sum of lines 3 and 4. Increase total patient days by any employee discount days reported on Worksheet S-3, Part I, line 28.

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

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

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

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

3660.2 Part II - Hold Harmless Method--This part computes settlement under the hold harmless method only as defined in 42 CFR 412.344. Use the hold harmless method for PPS capital settlement when the hospital's base year hospital-specific rate exceeds the established Federal rate. Do not complete this part for cost reporting periods beginning on and after October 1, 2001 for hospitals paid 100 percent, **except for new providers as defined in 42 CFR 412.300(b) (response to Worksheet S-2, line 33, column 1 is "Y" and column 2 is either "Y" or "N"). Formerly hold harmless providers (other than new providers) should consider themselves fully prospective for purposes of completing Part I of the Worksheet.**

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

Line Descriptions

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

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

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

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

Line 5--Enter the amount of payments that would have been made for inpatient program capital costs if the provider were paid at 100 percent of the Federal rate throughout the cost reporting period. This amount is provided by the fiscal intermediary. Compute this amount by grossing up the Federal payments made for new capital by multiplying each part of the capital Federal payment (capital DRG, capital outlier, capital DSH, and capital IME) by a ratio. The numerator of the ratio is 100 and the denominator is the new capital ratio used for interim payment during the period. When there has been any change to the new capital ratio during the period, make a separate computation for each period for which there was a separate new capital ratio. For example, if a 15 percent ratio was used for the first three months and a 20 percent ratio was used for the last nine months, divide the four components of the capital Federal rate data for the first three months by .15 and divide the four components of the capital Federal rate data for the last nine months by .20. Use the interim payment new capital ratio since grossed up payments made during the period were based on the interim ratio payment.

NOTE: If it is necessary to make a year end adjustment to the DSH or IME amounts on Worksheet E, Part A, lines 3 and 4, respectively, to reflect more current data than was used for payment purposes, then also make these adjustments to the data on this line.

Line 6--Hospitals that did not qualify as sole community providers during the cost reporting period enter a reduction factor of 85 percent. SCHs enter 100 percent. If you were an SCH during a portion of the cost reporting period, compute the hold harmless old capital cost reduction percentage by dividing the number of days in your cost reporting period for which you were not a sole community hospital (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 hold harmless old capital cost reduction percentage as a percentage.

Line 7--Multiply line 2 by line 6.

Line 8--Multiply line 5 by line 4.

Line 9--Enter the sum of lines 7 and 8.

Line 10--Enter the greater of line 5 or line 9. If the provider has elected payment based on 100 percent of the Federal rate (see Worksheet S-2, line 37.01), enter the amount from line 5. For title XVIII, transfer this amount to Worksheet E, Part A, line 9. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, column 1, line 26.

3660.3 Part III - 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 as defined by 42 CFR 412.300(b) or for titles V or XIX determinations, if applicable. Do not complete this part for cost reporting periods beginning on and after October 1, 2001, **except for new providers as defined in 42 CFR 412.300(b) (response to Worksheet S-2, line 33, 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, sum of columns 10 and 12, sum of the amounts on lines 25 through 30 and 33 for the hospital (line 31 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, columns 6 and 8, line 101.

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 9. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, column 1, line 26.

3660.4 Part IV - Computation of Exception Payments.--This part computes minimum payment levels by class of provider with an additional payment exception for extraordinary circumstances for hospitals paid under either the fully prospective method or the hold harmless method pursuant to 42 CFR 412.348(g). Complete this part only if the provider component completed Parts I or II of this worksheet. For cost reporting periods beginning on or after October 1, 2001, complete this part only if the provider qualifies for the special exceptions payment pursuant to 42 CFR 412.348(g).

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, sum of columns 10 and 12, sum of lines 25 through 30 and 33 for the hospital, line 31 for the subprovider, and program inpatient ancillary service capital costs from Worksheet D, Part II, sum of columns 6 and 8, line 101.

Line 2--Enter program inpatient capital costs for extraordinary circumstances as provided by 42 CFR 412.348(e), if applicable, from Worksheet L-1, sum of Part II, column 7, sum of lines 25 through 30 and 33 for the hospital, line 31 for the subproviders, and Part III, column 5, line 101.

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 occurring during FY 1992 are:

- o SCHs (located in either an urban or a rural area) - 90 percent;
- o Urban hospitals with at least 100 beds and a disproportionate patient percentage of at least 20.2 percent - 80 percent; and
- o All other hospitals - 70 percent.

For cost reporting periods beginning on or after October 1, 2001, the percentage for all hospitals paid 100 percent of the Federal rate is 70 percent.

The minimum payment levels in subsequent transition years 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 sole community providers during the cost reporting period enter a reduction factor of 85 percent. SCHs enter 100 percent. If you were a sole community hospital 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 sole community hospital (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 6 or Part II, line 10, as 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.

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 following cost reporting period.

Line 11--If applicable, enter the amount from the prior year's Worksheet L, Part IV, line 14.

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.

For cost reporting periods beginning on and after October 1, 2001, **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 6, 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 4.04.

Line 16--Current years operating and capital costs from worksheet D-1, line 49 minus the sum of D, Part III, lines 25 through 30, column 8 (PPS subproviders use line 31, column 8), and D, Part IV, column 7, line 101.

Line 17--Enter on this line the current year's exception offset amount. This is computed as line 16 minus line 15. If this amount is negative, enter zero on this line. Transfer the amount on line 13, less any reported amount on line 17, to Worksheet E, Part A, line 10.

3661. WORKSHEET L-1 - ALLOCATION OF ALLOWABLE 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(e).

3661.1 Part I - Allocation of Allowable Capital Costs for Extraordinary Circumstances.--Use this part in conjunction with Worksheet B-1. 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 III. Enter on lines 3 and 4, as applicable, the remaining capital expenditure amounts relating to extraordinary costs which have not been directly assigned.

NOTE: Recognize capital expenditures relating to extraordinary costs as new capital-related costs.

Columns 1 through 24--Transfer amounts on the top lines of columns 3 and 4 from column 0, line as applicable. For example, transfer line 3, column 0 to line 3, column 3. For all other columns, the top line represents the cross total amount.

For each column, enter on line 104 of this worksheet, Part I, the total statistics of the cost center being allocated. Obtain this amount from Worksheet B-1 from the same column and line number used to allocate cost on this worksheet. (For example, obtain the amount of new capital-related costs - buildings and fixtures from Worksheet B-1, column 3, line 3.)

Divide the amount entered on line 104 by the total capital expenses entered in the same column on the first line. Enter the resulting unit cost multiplier on line 105. 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. Report applicable cost center statistics on Worksheet B-1. Enter the result of each computation on this worksheet in the corresponding column and line. (See §3600.1 for rounding standards.)

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 103) 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 25 the sum of columns 4A through 24 for lines 25 through 102. (See §3617 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 26. Submit a supporting schedule showing the computation of the adjustment.

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

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

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

Line descriptions

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

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

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

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

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

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

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

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

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

NOTE: If you are based in a small rural hospital with less than 50 beds, Worksheet S-3, Part I, column 1, line 12 minus the sum of (line 11 plus the sum of (column 6, line 26/(**))) in accordance with 42 CFR §412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2. (* Substitute for the asterisk in the denominator for the number of days in the cost reporting period.)

NOTE: For services rendered on or after July 1, 2001, RHCs that are based in small urban hospital with less than 50 beds (as calculated above) will also be exempt from the per visit limit. RHCs based in a small urban hospital with cost reporting periods overlapping July 1, 2001, will add a column 3 for lines 9 through 14 and complete according to the instructions. Enter in column 3, line 9 the amount from line 7. Column 3, line 10 through 14 will be completed in accordance with the instructions. For RHCs based in small urban hospitals with cost reporting periods beginning on or after July 1, 2001, transfer the adjusted cost per visit (line 7) to line 9, column 1 and/or 2.

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

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

Line descriptions

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

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

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

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

Line 14--Enter the limit adjustment. This is computed by multiplying the amount on line 13 by the outpatient mental health service limit of 62 ½ percent. This limit applies only to therapeutic services not initial diagnostic services.

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

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

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

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

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

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

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

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

Line 22--Enter your total reimbursable bad debts, net of recoveries, from your records.

Line 23--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see CMS Pub. 15-I §2146.4), enter the adjustment. Specify the adjustment in the space provided.

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

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

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

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

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

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of these vaccines for services rendered on and after August 1, 2000. Prior to that date all vaccines were reimbursed through the provider based hospital and could not be claimed by the RHC and FQHC.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Transfer the result to Worksheet M-3, line 20.

3666. WORKSHEET M-5 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

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

Line Descriptions

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

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

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

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

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

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

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

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

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

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EXHIBIT 1 - Form CMS-2552-96 Worksheets

The following is a listing of the Form CMS-2552-96 worksheets and the page number location. Changes to worksheets are indicated by redline on this and the subsequent page for this transmittal. Where only the page number changes, no redlining is indicated.

<u>Worksheets</u>	<u>Page(s)</u>
Wkst. S, Parts I & II	36-503
Wkst. S-2	36-504 - 36-506
Wkst. S-3, Parts I-III	36-506.1 - 36-506.3
Wkst. S-4	36-507
Wkst. S-5	36-508
Wkst. S-6	36-509
Wkst. S-7	36-510
Wkst. S-8	36-511
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