

Medicare

Provider Reimbursement Manual

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

Department of Health and
Human Services (DHHS)
HEALTH CARE FINANCING
ADMINISTRATION (HCFA)

Transmittal 7

Date: NOVEMBER 30, 2000

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
3600 – 3600 (Cont.)	36-7 – 36-8 (2pp.)	36-7 – 36-8 (2pp.)
3603.2 (Cont.) – 3605.3 (Cont.)	36-23 – 36-36 (16 pp.)	36-23 – 36-36(16 pp.)
3608.2 – 3610	36-39 – 36-42 (4 pp.)	36-39 – 36-42 (4 pp.)
3610 (Cont.) – 3610 (Cont.)	36-53 – 36-56 (4 pp.)	36-53 – 36-56 (4 pp.)
3615 – 3615 (Cont.)	36-67 – 36-68 (2 pp.)	36-67 – 36-68 (2 pp.)
3616.9 – 3616.9 (Cont.)	36-74.1 – 36-74.2 (2 pp.)	36-74.1 – 36-74.2 (2 pp.)
3616.15	36-74.5 (1 p.)	36-74.5 (1 p.)
3617 (Cont.) - 3618	36-79 – 36-80 (2 pp.)	36-79 – 36-80 (2 pp.)
3620.1 – 3620.1 (Cont.)	36-87 – 36-88 (2 pp.)	36-87 – 36-88 (2 pp.)
3620.2 – 3620.2 (Cont.)	36-91 – 36-92 (2 pp.)	36-91 – 36-92 (2 pp.)
3621.4 – 3622	36-99 – 36-106 (9 pp.)	36-99 – 36-106 (8 pp.)
3622.2 (Cont.) – 3622.4 (Cont.)	36-113 – 36-118 (6 pp.)	36-113 – 36-118 (6 pp.)
3625.4 – 3626	36-131 – 36-132 (2 pp.)	36-131 – 36-132 (2 pp.)
3626.2 (Cont.) – 3630.1 (Cont.)	36-135 – 36-137.4 (7 pp.)	36-135 – 36-137.4 (7pp.)
3630.1 (Cont.) – 3631 (Cont.)	36-139 – 36-150 (15 pp.)	36-139 – 36-150(15 pp.)
3633.1 – 3633.1 (Cont.)	36-155 – 36-156 (2 pp.)	36-155 – 36-156 (2 pp.)
3633.2 (Cont.) – 3633.3	36-159 – 36-160 (2 pp.)	36-159 – 36-160 (2 pp.)
3633.3 (Cont.) – 3633.3 (Cont.)	36-163 – 36-164 (2 pp.)	36-163 – 36-164 (2 pp.)
3633.4 (Cont.) – 3640	36-167 – 36-172 (8 pp.)	36-167 – 36-172 (8 pp.)
3647.3 – 3648.2	36-189 – 36-192 (4 pp.)	36-189 – 36-192 (4 pp.)
3651 – 3651 (Cont.)	36-195 – 36-196 (2 pp.)	36-195 – 36-196 (2 pp.)
3657.2 – 3660.2	36-207 – 36-212.1 (7 pp.)	36-207 – 36-212 (6 pp.)
3663 – 3666	36-221 – 36-225 (5 pp.)	36-221 – 36-225 (5 pp.)
3690 (Cont.) – 3690 (Cont.)	36-503 – 36-506.2 (6 pp.)	36-503 – 36-506.2 (6 pp.)
	36-509 – 36-512 (4 pp.)	36-509 – 36-512 (4 pp.)
	36-519 – 36-520 (2 pp.)	36-519 – 36-520 (2 pp.)
	36-571 – 36-578 (8 pp.)	36-571 – 36-578 (8 pp.)
	36-587.2 (1 p.)	36-587.2 (1 p.)
	36-595 – 36-598.1 (5 pp.)	36-595 – 36-598.1 (5 pp.)
	36-617 – 36-620 (4 pp.)	36-617 – 36-620 (4 pp.)
	36-633 – 36-634 (2 pp.)	36-633 – 36-634 (2 pp.)
	36-649 – 36-650 (2 pp.)	36-649 – 36-650 (2 pp.)
3695 (Cont.)	36-705 – 36-706 (2 pp.)	36-705 – 36-706 (2 pp.)
	36-713 – 36-716 (4 pp.)	36-713 – 36-716 (4pp.)
	36-719 – 36-730 (12 pp.)	36-719 – 36-730 (12 pp.)
	36-733 – 36-742 (10 pp.)	36-733 – 36-742 (10 pp.)
	36-743.2 – 36-744 (2 pp.)	36-743.2 – 36-744 (2 pp.)
	36-747 – 36-755 (9 pp.)	36-747 – 36-755 (9 pp.)
	36-759 – 36-762 (4 pp.)	36-759 – 36-762 (4 pp.)
	36-765 – 36-778 (16 pp.)	36-765 – 36-778 (16 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates Chapter 36, Hospital and Hospital Health Care Complex Cost Report, Form HCFA-2552-96 to reflect the changes required by the Balanced Budget Refinement Act (BBRA), as well as further clarification of existing instructions. The effective date for these instructional changes will vary due to various implementation dates established by the BBRA.

HCFA-Pub. 15-2-36

ELECTRONIC REPORTING SPECIFICATIONS EFFECTIVE DATE: Changes to the Electronic Reporting Specifications are Effective for Cost Reporting Periods Ending On or After September 30, 2000.

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.

3600. GENERAL

The Paperwork Reduction Act of 1980 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, Form HCFA-2552-96 must be completed by all hospitals and hospital health care complexes to determine program payment. 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 HCFA-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 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 Health Care Financing Administration
P.O. Box 26684
Baltimore, MD 21207
- 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 HCFA. The legislation allows HCFA 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 subscribing 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 subscribing 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, **payment to cost ratios**
2. Round to 4 decimal places:
 - a. Wage adjustment factor
3. 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)

<u>Hospital/ Hospital Component</u>	<u>FROM</u>			
	<u>Title V</u>	<u>Title XVIII Part A</u>	<u>Title XVIII Part B</u>	<u>Title XIX</u>
SNF	Wkst. E-3, Part III, Line 58	Wkst. E-3, Part II, line 33 or Wkst. E-3, Part III line 58	Wkst. E, Part B, line 35	Wkst. E-3, Part III, line 58
NF, ICF/MR (9/96)	Wkst. E-3, Part III, line 58	N/A	N/A	Wkst. E-3, Part III, line 58
Home Health Agency	Wkst. H-7, Part II, sum of cols. 1&2, line 26	Wkst. H-7, Part II, col.1, line 26	Wkst. H-7, Part II, col. 2, line 26	Wkst. H-7, Part I, sum of cols. 1 & 2, line 26
Outpatient Rehabilitation Providers	Wkst. J-3, line 28	N/A	Wkst. J-3, line 28	Wkst. J-3, line 28
Rural Health Clinic/ Federally Qualified Health Clinic (1/98)	Wkst. M-3 line 25	N/A	Wkst. M-3 line 25	Wkst. M-3 line 25

3604. WORKSHEET S-2 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

The information required on this worksheet is needed to properly identify the provider.

Lines 1 and 1.01--Enter the street address, post office box (if applicable), the city, state, zip code, and county of the hospital.

Lines 2 through 17--Enter on the appropriate lines and columns indicated the names, provider identification numbers, and certification dates of the hospital and its various components, if any. Indicate for each health care program the payment system applicable to the hospital and its various components by entering P, T, O, or N in the appropriate column to designate PPS, TEFRA, OTHER (including RPCH/CAH or cost reimbursement), and NOT APPLICABLE, respectively. A new non-PPS hospital or subprovider checks O 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, check O through the end of the exemption period. The last 12 month period of the exemption is the TEFRA base period. **This is no longer applicable for periods beginning on or after October 1, 1997.**

Line 2--This is an institution which meets the requirements of ' 1861(e) of the Act and participates in the Medicare program or is a Federally controlled institution approved by HCFA.

Line 3--This is a portion of a general hospital which has been issued a subprovider identification number because it offers a clearly different type of service from the remainder of the hospital, e.g., long term psychiatric. See HCFA Pub. 15-I, chapter 23, for a complete explanation of separate cost entities in multiple facility hospitals. While an excluded unit in a hospital subject to PPS may not meet the definition of a subprovider, treat it as a subprovider for cost reporting purposes. If you have more than one subprovider, subscript this line.

Line 4--This is a rural hospital with fewer than 100 beds that is approved by HCFA to use these beds interchangeably as hospital and skilled nursing facility beds with payment based on the specific care provided. This is authorized by ' 1883 of the Act. (See HCFA Pub. 15-I, ' 2230-2230.6.)

Line 5--This is a rural hospital with fewer than 100 beds that has a Medicare swing bed agreement approved by HCFA and that is approved by the State Medicaid agency to use these beds interchangeably as hospital and other nursing facility beds, with payment based on the specific level of care provided. This is authorized by ' 1913 of the Act. Swing bed-NF services are not payable under the Medicare program but are payable under State Medicaid programs if included in the Medicaid State plan.

Line 6--This is a distinct part skilled nursing facility that has been issued an SNF identification number and which meets the requirements of ' 1819 of the Act. For cost reporting periods beginning on or after October 1, 1996, a complex can not contain more than one hospital-based SNF or hospital-based nursing facility.

Line 7--This is a distinct part nursing facility which has been issued a separate identification number and which meets the requirements of ' 1905 of the Act. (See 42 CFR 442.300 and 42 CFR 442.400 for standards for other nursing facilities, for other than facilities for the mentally retarded, and for facilities for the mentally retarded.) If your state recognizes only one level of care, i.e., skilled, do not complete any lines designated as NF and report all activity on the SNF line for all programs. The NF line is used by facilities having two levels of care, i.e., either 100 bed facility all certified for NF and partially certified for SNF or 50 beds certified for SNF only and 50 beds certified for NF only. If the facility operates an Intermediate Care Facility/Mental Retarded (ICF/MR) subscript line 7 to 7.01 and enter the data on that line Note: Subscribing is allowed only for the purpose of reporting an ICF/MR. FIs will reject a cost report attempting to report more than one nursing facility. (9/96)

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

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

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 HCFA 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. Enter 1 for urban or 2 for rural.

Line 21.01--Does your facility qualify and is currently receiving payments for disproportionate share in accordance with 42 CFR 412.106? Enter AY@ for yes and AN@ for no.

Line 21.02--Has your facility received a geographic reclassification? Enter AY@ for yes and AN@ for no. If yes report in column 2 the effective date. If the effective date is not at the beginning of the year, subscript column 1 of Worksheet E, Part A and Worksheet E, Part B if applicable. (1/00)

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? Enter "Y" for yes and "N" for no.

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 this is a Medicare certified pancreas transplant center, for services rendered on or after July 1, 1999, 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? Enter "Y" for yes and "N" for no.

Line 25.01--Is this a teaching program approved in accordance with HCFA Pub. 15-I, chapter 4? Enter AY@ for yes and AN@ 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 AY@ for yes and complete Worksheet E-3, Part IV or AN@ for no and complete Worksheet D-2, Part II, if applicable.

Line 25.03--As a teaching hospital, did you elect cost reimbursement for teaching physicians as defined in HCFA 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)

Line 27--If this hospital has an agreement with HCFA 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 AY@ for yes or AN@ 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. 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 AN@ 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)

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 HCFA 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.

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.) Enter "Y" for yes or "N" for no in the applicable columns.

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.

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.

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.

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 AY@ for yes and AN@ 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 AY@ for yes and AN@ 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.

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 AY@ for yes or an AN@ for no.

Line 45.02--Was there a change in the order of allocation? Enter a AY@ for yes or an AN@ for no.

Line 45.03--Was there a change to the simplified cost finding method? Enter a AY@ for yes and an AN@ 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 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 AY@ for yes and AN@ for no. (10/97)

Line 56--Are you claiming ambulance costs? Enter a **AY@** for yes or an **AN@** 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 **AY@** for yes or an **AN@** for no in column 3. (10/97)

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. (1/00)

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

This worksheet consists of three parts:

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

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

Column Descriptions

Column 1--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 HCFA 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.

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.

Report the program days for PPS providers in the cost reporting period in which the discharge is reported. 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)

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)

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, see ' 3604, line 56 for proper subscripting. (10/97)

Line 28--Enter in column 6 the employee discount days if applicable.

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, 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, bonus, and award pay** if not reported in column 1.

Lines 2 through 8.01--The amounts to be reported must be adjusted for vacation, holiday, sick, paid

time off, severance, bonus, and award 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 Part B salaries 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 Part B salaries reported for Hospital-based RHCs and FQHCs services included on Worksheet A, column 1, line 63.** (10/99)

Line 6--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 report contract services on line 6.01. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 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 HCFA 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 lines 8 and 8.01. Include costs for contract CRNA Part A and intern and resident services (these costs are also to be reported on lines 2 and 6 respectively). DO NOT include costs for pharmacy and laboratory services furnished under contract. Subscript this line and report these costs on line 9.01 and 9.02 respectively. (10/97)

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), 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, 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 HCFA-339, submit to your intermediary the following: for direct patient care contracts, the types of services, wages, and associated hours; for management contracts, the aggregate wages and hours.

In addition, 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.

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), consultant contracts, 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 HCFA-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), consultant contracts, 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 HCFA-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 excluded on line 7 and the associated wage-related costs excluded on line 7. 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-HCFA -339) and is not a category included in “other” wage related costs on line 14 (see Part II of Exhibit 7 of Form HCFA-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)

Line 13--Enter the core wage-related costs as described in Exhibit 7 of the Form HCFA-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.) 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 payment principles on all other areas to determine allowable fringe benefits.

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.)

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 HCFA-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 HCFA-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. Form HCFA-339, Exhibit 7, Part III must be completed by all hospitals reconciling the wage-related costs reported on lines 13 through 20 to the fringe benefits reported using Medicare principles.

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)

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.

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; 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, 6, 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)

Line 13--Enter, from Part II above, the sum of lines 21 through 35. If the hospital's ratio for excluded area salaries to net salaries is greater than 5 percent, the hospital must complete all columns for this line. (See instructions in Part II, lines 21 through 35 for calculating the percentage.)

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.

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.

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 AN@ 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 AN@ 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)

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. The data to be maintained for title XVIII demonstration days include, by group, the M3PI revenue code, the rate, the number of inpatient days, and the dollar amount for Medicare residents during this cost reporting period.

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 and 4--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 lines 3.01 or 4.01. (10/00)** This Federal rate is adjusted for the labor portion by the update factor specific to the provider's MSA. This update factor is reported on Worksheet S-2, line 28.01 columns 2 and 3.

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 the total on line 46.

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 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 and 4 times columns 3.01 and 4.01 (columns 4 times column 4.01 for cost reporting periods beginning October 1) respectively, rounded to zero and add the two 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, SC, 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 and 4.01 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.

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) HCFA 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 HCFA-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 HCFA 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 61--Enter the costs of the emergency room cost center.

Line 62--Do not use this line on this worksheet. If you have an area specifically designated for observation (e.g., observation patients are not placed in a general acute care area bed), report this on a subscripted line 62.01.

NOTE: It is possible to have both a distinct observation bed area and a non-distinct part. For example, your distinct part observation bed area is only staffed from 7:00 AM - 10:00 PM. Patients entering your hospital needing observation bed care after 10:00 PM and before 7:00 AM are placed in a general inpatient routine care bed. If patients entering the distinct part observation bed area are charged differently than the patients placed in the general inpatient routine care bed, separate the costs into distinct observation bed costs and non-distinct observation bed costs. However, if the charge is the same for both patients, report all costs and charges as distinct part observation beds.

Line 63--Use this line to report the costs of provider-based RHCs and FQHCs. If more than one are maintained and/or other services are reported on this line, subscript the line. See Table 5 in '3695 for the proper cost center code for RHCs and FQHCs. When reporting RHCs and FQHCs on this line, subscript the line beginning with line 63.50 and ending with 63.99. (9/00)

In accordance with HCFA Pub. 27, '501, compensation paid to a physician for RHC services rendered in a hospital-based RHC is cost reimbursed. Where the physician agreement compensates for RHC services as well as non-RHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B carrier. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Lines 64 through 68 and 70--Use these lines for other reimbursable cost centers (other than HHA, CORF, and CMHC).

Line 64--Use this line to accumulate the direct costs incurred for self-care home dialysis.

A Medicare beneficiary dialyzing at home has the option to deal directly with the Medicare program and make individual arrangements for securing the necessary supplies and equipment to dialyze at home. Under this arrangement, the beneficiary is responsible for dealing with the various suppliers and the Medicare program to arrange for payment. The beneficiary is also responsible to the suppliers for the deductible and 20 percent Medicare coinsurance requirement. You do not receive composite rate payment for a patient who chooses this option. However, if you provide any direct home support services to a beneficiary who selects this option, you are reimbursed on the same reasonable cost basis for these services as for other outpatient services. These costs are entered on line 63 and are notated as cost reimbursed. You may service Medicare beneficiaries who elect this option and others who deal directly with you. In this case, set up two home program dialysis cost centers (using a subscript for the second cost center) to properly classify costs between the two categories of beneficiaries (those subject to cost reimbursement and those subject to the composite rate).

Line 65--Report all ambulance costs on this line for both owned and operated services and services under arrangement. No subscripting is allowed for this line. (9/96)

Lines 66 and 67--Use these lines to report durable medical equipment rented or sold, respectively.

For the hospital-based SNF, report support surfaces by subscribing line 67 and use the proper cost center code.

Line 69--This cost center accumulates the direct costs for outpatient rehabilitation providers, CORF, CMHC, OPT, OOT, and OSP. If you have multiple components, subscript this line using the proper cost center code.

Line 70--Use this line if your hospital operates an intern and resident program not approved by Medicare.

Line 71--This cost center accumulates costs specific to HHA services. If you have more than one certified hospital-based HHA, subscript line 71 for each HHA.

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

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

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

When the provider-based HHA can identify discrete management and administrative costs from its books and records, these costs are included on line 71.

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

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

center. Make a similar reclassification to the appropriate line for other ancillaries when the HHA costs are readily identifiable.

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

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 subscribed.

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

3615. WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 405.480, 42 CFR 405.481, 42 CFR 405.482, and 42 CFR 405.550(e), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider or which represent availability services in a hospital emergency room under specified conditions. (See 42 CFR 405.465 and 42 CFR 405.466 for an exception for teaching physicians under certain circumstances.) 42 CFR 405.482 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost you incur. 42 CFR 405.481 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services such as research. Only provider services are reimbursable to you through the cost report. This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 405.482. The methodology used in this worksheet applies the RCE limit to the total physician compensation attributable to provider services reimbursable on a reasonable cost basis. Enter the total provider-based physician adjustment for personal care services and RCE limitations applicable to the compensation of provider-based physicians directly assigned to or reclassified to general service cost centers. RCE limits are not applicable to a medical director, chief of medical staff, or to the compensation of a physician employed in a capacity not requiring the services of a physician, e.g., controller. **RCE limits do not apply to Critical Access Hospitals.** (10/97)

NOTE: 42 CFR 405.482(a)(2) provides that limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services paid for under the prospective payment system implemented under 42 CFR Part 412.

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

Since the methodology used in this worksheet applies the RCE limit in total, make the adjustment required by 42 CFR 405.482(a)(2) on Worksheet C, Part I. Base this adjustment on the RCE disallowance amounts entered in column 17 of Worksheet A-8-2.

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

NOTE: The adjustments generated from this worksheet for physician compensation are limited to the cost centers on Worksheet A, lines 5-69, 82-86, and 92 and subscripts as allowed. (9/96)

Column Descriptions

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

Columns 2 and 11--Enter the description of the cost center used on Worksheet A. When RCE limits are applied on an individual basis to each physician in a department, list each physician on successive lines directly under the cost center description line, or list the first physician on the same line as the cost center description line and then each successive line below for each additional physician in that cost center. (10/97)

List each physician using an individual identifier (not necessarily either the name or social security number of the individual, e.g., Dr. A, Dr. B). However, the identity of the physician must be made available to your fiscal intermediary upon audit. When RCE limits are applied on a departmental basis, insert the word "aggregate" (instead of the physician identifiers) on the line below the cost center description.

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

Column 3--Enter the total physician compensation paid by you for each cost center. Physician compensation means monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services) that you or other organizations furnish a physician in return for the physician's services. (See 42 CFR 405.481(a).) Include the compensation in column 3 of Worksheet A or, if necessary, through appropriate reclassifications on Worksheet A-6 or as a cost paid by a related organization through Worksheet A-8-1.

Column 4--Enter the amount of total remuneration included in column 3 applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B carrier in accordance with 42 CFR 405.550(b). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 405.481(f).)

Column 5--Enter the amount of the total remuneration included in column 3, for each cost center, applicable to general services to you (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 405.481(f).)

NOTE: 42 CFR 405.481(b) requires that physician compensation be allocated between physician services to patients, the provider, and nonallowable services such as research. Physicians' nonallowable services must not be included in columns 4 or 5. The instructions for column 18 insures that the compensation for nonallowable services included in column 3 is correctly eliminated on Worksheet A-8.

Column 6--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the Federal Register before any allowable adjustments. The final notice on the annual update to RCE limits published in the Federal Register, Vol. 50, No. 34, February 20, 1985, on page 7126 contains Table 1, Estimates of FTE Annual Average Net Compensation Levels for 1984. An update was published in the Federal Register on May 5, 1997. Obtain the RCE applicable to the specialty from this table. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable: non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million.

Column 7--Enter for each line of data the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040 in this column. The hours entered are the actual hours for which the physician is

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. (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 critical access hospitals, **hospitals with respiratory therapy, and hospital complexes with hospital based home health agencies and community mental health centers.** (1/99)

NOTE: If you furnish therapy services under arrangement with outside suppliers, complete this worksheet. When reimbursement for such therapy services is subject to the provisions of PPS or the TEFRA rate of increase ceiling, adjust costs subsequently on Worksheet C, Part I.

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 HCFA Pub. 15-I, chapter 14.)

Line 8--Enter the optional travel expense rate applicable. (See HCFA 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 HCFA 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 HCFA 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 HCFA 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 HCFA 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 HCFA 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 HCFA 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 HCFA 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.

supplier (as specified in HCFA Pub 15-I, ' 1412.1) is considered an additional allowance in computing the limitation.

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

Line 65--Enter the excess cost over the limitation, i.e., line 64 minus line 63. If the amount is negative, enter a zero.

3616.15 Part VII - Allocation of Therapy Excess Cost Over Limitation for Non-Shared Therapy Department Services.--This part provides for the computation of the excess cost over the limitation for outside suppliers of hospital services and other providers within the complex.

Line 66--Enter on line 66 the total cost of services supplied by the outside suppliers for the hospital services and subscript line 66 to report the other provider costs within the complex. Subscript as follows: lines 66.01 to 66.10 for CORF; 66.11 to 66.20 for CMHC; 66.21 to 66.30 for OPT; 66.31 through 66.40 for HHA services; 66.41 to 66.50 for OOT; and 66.51 to 66.60 for OSP respectively, from your records.

Line 67--Enter the sum of line 66 and subscripts.

Line 68--Enter the result of dividing the amount on line 66 and subscripts by the amount on line 67. Subscript this line in the same manner as line 66.

Line 69--Enter the amount of excess applicable to each provider within the complex by multiplying the ratio for each provider on line 68 and subscripts by the excess reported on line 65. Subscript this line in the same manner as line 66 above. Transfer this amount to Worksheet A-8, line 25 for respiratory therapy; line 26 for physical therapy; line 35 for occupational therapy; and line 36 for speech pathology. **Except for respiratory therapy, do not transfer any excess adjustment for hospital, hospital-based SNF, CORF, OOT, OSP, OPT for services rendered on and after January 1, 1999 since therapy services are paid based on a fee schedule. Respiratory therapy for services rendered on and after July 1, 2000 is subject to payment based on the fee schedule, therefore no transfer will be required after that date. CAHs transfer the excess always, and hospital based home health agencies continue for services rendered through September 30, 2000. CAHs therapy services under arrangement are not subject to the payment of the fee schedule. Home health agencies are paid under a prospective payment system beginning October 1, 2000.**

Line 70--Enter the total of line 69 through 69.60. This line should agree with line 65.

Employee Benefits	X	X
Administrative and General	X	X
Maintenance and Repair		X
Operation of Plant		X
Housekeeping		X
Cafeteria	X	X
Maintenance of Personnel		X

After the costs of the general service cost center have been allocated on Worksheet B, Part I, enter in column 25 the sum of the costs in **columns 5a through 24** for lines 25 through 102. Once overhead is allocated to these cost centers, they are closed and the costs are not further allocated to the revenue producing cost centers.

Since costs applicable to direct graduate medical education costs (inpatient and outpatient in approved programs) are reimbursed based on a specific amount per resident, exclude these costs from the total costs in column 27. Enter on each line in column 26 the sum of the amounts shown on each line in columns 22 and 23. If you qualify for the exception, enter only the amounts from Worksheet B-2.

In addition, when an adjustment to expenses is required after cost allocation, enter the amount applicable to each cost center in column 26 of Worksheet B, Part I. Corresponding adjustments to Worksheet B, Parts II and III, may be applicable for capital-related cost adjustments. However, if a capital-related cost adjustment was not made prior to October 1, 1991, then the rules of capital consistency prohibit an adjustment during the transition period. (See 42 CFR 412.302(d).) Submit a supporting worksheet showing the computation of the adjustments in addition to completing Worksheet B-2.

NOTE: The amount reported in column 26 must equal both the sum of the amounts shown in columns 22 and 23 and the amount on Worksheet B-2, unless you qualify for the exception. See the instructions for column 26 for a more detailed explanation.

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

After the adjustments have been made on Worksheet B, Part I, column 26, adjust the amounts in column 25 by the amounts in column 26, and extend the net balances to column 27 for each line. The total costs entered in column 27, line 103 must equal the total costs entered in column 0, line 103.

Transfer the totals in column 27, lines 25 through 36 (inpatient routine service cost centers), lines 37 through 59 (ancillary service cost centers), lines 60 through 63 (outpatient service cost centers), and lines 64 through 68 (other reimbursable cost centers) to Worksheet C, Parts I and II, column 1, lines **25 through 68**. (9/96) For provider based RHC/FQHCs with cost reporting periods that overlap January 1, 1998, transfer the total costs to Worksheets C, Parts I and II and M-1 for the same amount. **For cost reporting periods beginning on or after January 1, 1998 transfer the total costs to Worksheet M-1 only.**

NOTE: If you are a rural hospital with a certified SNF with less than 50 beds in the aggregate for both components (excluding intensive care type and newborn beds) and have made an election to use the swing bed optional reimbursement method for the SNF, the SNF 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 HCFA Pub. 15-I, ' 2230.9B.) Reclassify the SNF direct costs from line 34 to line 25 through Worksheet A-6. On Worksheet B-1, the statistics for line 25 must include the statistics for line 34. On Worksheet D, Part III, and Worksheet D-4, record the SNF ancillary services as swing bed-SNF ancillary services.

Transfer the direct hospital-based HHA costs in column 27, line 71, to Worksheet H-4, Part I, column 1, lines as indicated. If you have multiple HHAs, line 71 must be subscripted and transferred to a separate Worksheet H-4 for each HHA.

Only approved certified transplant centers transfer the amount in column 27, lines 73 through 76 to Worksheet D-6, Part III, column 1, line 50. If you are not certified as a transplant center, do not carry forward lines 73 through 76, column 27. Do not carry forward column 27, line 77, as Medicare either does not reimburse for these services or does not reimburse for these services as a pass through cost.

Transfer the total cost in column 27, line 70 (intern/resident services not in approved teaching program) to Worksheet D-2, Part I, column 2, line 1.

The total outpatient rehabilitation costs in column 27, line 69 and subscripts, must agree with Worksheet J-1, Part I, column 27, line 12, for each provider type.

Do not transfer ASC costs from column 27, line 92. Do not transfer the nonreimbursable cost center totals (lines 95 through 99).

NOTE: Do not transfer negative numbers.

Column Descriptions

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

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

Column 3--Include only new capital costs. See the instructions for Worksheet A, lines 3 and 4, for a discussion of new capital-related costs.

Column 4--Include only new capital costs. See the instructions for Worksheet A, lines 3 and 4, for a discussion of new capital-related costs.

Worksheet B, Part I, Column 26--Accumulate in this column the costs for interns and residents and post step down adjustments. The costs of interns and residents (direct graduate medical education costs for inpatient and outpatient in approved programs) are paid on a per resident amount. The intern and resident costs are paid through Worksheet E-3, Part IV. In order to avoid duplicate payments, enter the sum of the amounts reported on each line in columns 22 and 23 in the appropriate line of column 26. In addition, enter the amounts from Worksheet B-2, lines as appropriate. The total of columns 22 and 23 and the appropriate lines on Worksheet B-2 must equal the total of column 26.

NOTE: 42 CFR 413.86(e)(4)(I) provides for an exception to the base period for certain hospitals. If you did not have an approved medical residency

3620. WORKSHEET C - COMPUTATION OF RATIO OF COST TO CHARGES AND OUTPATIENT CAPITAL REDUCTION

This worksheet consists of five parts:

- Part I - Computation of Ratio of Cost to Charges
- Part II - Computation of Outpatient Services Cost to Charge Ratios Net of Reductions
- Part III - Computation of Total Inpatient Ancillary Costs - Rural Primary Care Hospitals
- Part IV - Computation of Inpatient Operating Costs - Rural Primary Care Hospitals
- Part V - Computation of Outpatient Cost Per Visit - Rural Primary Care Hospitals

NOTE: Rural Primary Care designation is replaced with Critical Access Hospital beginning October 1, 1997. For cost reporting periods beginning after October 1, 1997, Parts III through V are not applicable.

3620.1 Part I - Computation of Ratio of Cost to Charges.--This worksheet computes the ratio of cost to charges for inpatient services and, for providers not subject to the outpatient capital reduction, the outpatient ratio of cost to charges. This ratio is used on Worksheet D, Part V, for titles V and XIX and for title XVIII costs not subject to the outpatient capital reduction; Worksheet D-4; Worksheet D-6; Worksheet H-4, Part II; and Worksheet J-2, Part II, to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1 because of your status as PPS, TEFRA, or other.

42 CFR 413.106(f)(4) provides that the costs of therapy services furnished under arrangements to a hospital inpatient are exempt from the guidelines for physical therapy and respiratory therapy if such costs are subject to the provisions of 42 CFR 413.40 (rate of increase ceiling) or 42 CFR Part 412 (prospective payment).

42 CFR 405.482(a)(2) provides that RCE limits do not apply to the costs of physician compensation attributable to furnishing inpatient hospital services (provider component) paid for under 42 CFR Part 412ff.

To facilitate the cost finding methodology, apply the therapy limits and RCE limits to total departmental costs. This worksheet provides the mechanism for adjusting the costs after cost finding to comply with 42 CFR 413.106(f)(4) and 42 CFR 405.482(a)(2). This is done by computing a series of ratios in columns 9 through 11. In column 9, a ratio referred to as the "cost or other ratio" is computed based on the ratio of total reasonable cost to total charges. This ratio is used by you or your components not subject to PPS or TEFRA (e.g., hospital-based SNFs). Also use this ratio for Part B services still subject to cost reimbursement but not subject to outpatient capital reduction. In column 10, compute a TEFRA inpatient ratio. This ratio reflects the add-back of RT/PT limitations to total cost since TEFRA inpatient costs are not subject to these limits. (TEFRA inpatient services are subject to RCE limits.) In column 11, compute a PPS inpatient ratio. This ratio reflects the add-back of RT/PT and RCE limitations to total cost since inpatient hospital services covered by PPS are not subject to any of these limitations.

Column Descriptions

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

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

All components or portions of components not subject to PPS or TEFRA, e.g., outpatient services costs not subject to outpatient capital reduction, are classified as "Cost or Other."

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

<u>Type of Service</u>	<u>Columns</u>		
	<u>Cost or Other</u>	<u>TEFRA Inpatient</u>	<u>PPS Inpatient</u>
Inpatient routine service cost centers (lines 25-36)	1	1-3	1-5
Inpatient ancillary (lines 37-68)	1, 8, 9	1-3, 8-10	1-9, 11
Outpatient ancillary and outpatient cost centers (for costs not subject to capital reduction)	1, 8, 9	1-3, 8-10	1-9, 11

Column 1--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 27. Transfer the amount on line 62 from Worksheet D-1, Part IV, line 85, if you do not have a distinct observation bed area. If you have a distinct observation bed area, subscript line 62 into line 62.01, and transfer the appropriate amount from Worksheet B, Part I, column 27. In a complex comprised of an acute care hospital with an excluded unit, the acute care hospital reports the observation bed costs. Subproviders (hospital only, i.e. psychiatric, rehabilitation, or long term care facility) with separate provider numbers from the main hospital may report observation bed costs if a separate outpatient department is maintained within the subprovider unit. If the subprovider is reporting observation bed days (Worksheet S-3, line 26.01), add the amount reported by both the hospital and the subprovider from Worksheet D-1, line 85, and enter the sum on line 62. The RHC/FQHC costs on lines 63.50 through 63.99, for cost reporting periods which overlap the January 1, 1998 effective date will be transferred to this worksheet from Worksheet B, column 27. **For cost reporting periods beginning on or after January 1, 1998, no cost or charges are reported on this worksheet for the RHC/FQHC. However, any services provided by the RHC/FQHC outside the benefits package for those clinics are reported by the hospital in its appropriate ancillary cost center, but not in the RHC/FQHC cost center lines 63.50 through 63.99 (1/98).** Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 27. However, report the charges applicable to such cost centers with a credit balance in column 6 of the appropriate line on Worksheet C, Part I.

Column 2--Enter the amount of therapy limits applied to the cost center on lines 49 to 52. Obtain these amounts from Worksheet A-8, lines 25, 26, 35 and 36 respectively.

NOTE: Complete this column only when the hospital or subprovider is subject to PPS (see 42 CFR 412.1(a) through 412.125) or the TEFRA rate of increase ceiling. (See 42 CFR 413.40.) If the hospital and all subproviders have correctly indicated that their payment system is in the "other" category on Worksheet S-2, do not complete columns 2 through 5, 10, and 11.

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

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

Ratios

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

<u>For</u>	<u>To</u>
Hospital, subprovider, SNF, NF, swing bed-SNF, and swing bed-NF:	
1. Inpatient ancillary services for titles V, XVIII, Part A, and XIX	Wkst. D-4, column 1, for each cost center
Ancillary services furnished by the hospital-based HHA	Wkst. H-6, Part II, column 1, line as appropriate
Hospital-based CORF, CMHC, or OPT/OOT/OSP shared ancillary services for titles V, XVIII, Part B, and XIX	Wkst. J-2, Part II, column 3, line as appropriate

TEFRA Inpatient Ratio--Transfer the TEFRA inpatient ratio on lines 37 through 64 and 66 through 68 from column 10 for hospital or subprovider components for titles V, XVIII, Part A, and XIX inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) to Worksheet D-4, column 1 for each cost center.

PPS Inpatient Ratio--Transfer the PPS inpatient ratio on lines 37 through 64 and 66 through 68 from column 11 for hospital or subprovider components for titles V, XVIII, Part A, and XIX inpatient services subject to PPS (see 42 CFR 412.1(a) through 412.125) to Worksheet D-4, column 1 for each cost center.

3620.2 Part II - Calculation of Outpatient Services Cost to Charge Ratios Net of Reductions--This worksheet computes the outpatient cost to charge ratios reflecting the following:

o The reduction in hospital outpatient capital payments attributable to portions of cost reporting periods occurring from October 1, 1989 through September 30, 1998, as required by ' 1861(v)(1)(S)(ii) of the Act. The amount of capital reduction is 10 percent for payments for services rendered from October 1, 1991 through July 31, 2000.

o The reduction in reasonable costs of hospital outpatient services (other than the capital-related costs of such services) attributable to portions of cost reporting periods occurring from October 1, 1990 through September 30, 1998, as required by ' 1861(v)(1)(S)(ii) of the Act and enacted by ' 4151(b) of OBRA 1990. The amount of the reduction is 5.8 percent for payments for services rendered on or after October 1, 1990 through July 31, 2000.

The reductions do not apply to sole community hospitals (SCH), rural primary care hospitals (RPCH)/Critical Access Hospitals (CAH). However, if you have been granted SCH status or have ended SCH status during this cost reporting period, calculate the reductions for the periods during which time your hospital was not granted SCH status during your cost reporting year (i.e., compute the reduction percentage by dividing the number of days in your cost reporting period to which the

reductions applied (and during which you were not a SCH) by the total number of days in the cost reporting period. Multiply that ratio by the applicable percentage. The result is the applicable outpatient reduction percentage). Titles V and XIX follow their state plan in determining the applicable outpatient cost to charge ratios.

NOTE: If the RPCH/CAH is a complex which has subproviders, Worksheet C, Part II, must be completed to accommodate the RPCH/CAH subproviders.

Column Descriptions

Column 1--Enter the amounts for each cost center from Worksheet B, Part I, column 27, as appropriate. Transfer the amount on line 62 from Worksheet D-1, line 85 for the hospital and the subprovider if applicable and if you use inpatient routine beds as observation beds. (10/00) If you have a distinct observation bed area, add subscripted line 62.01 and transfer the appropriate amount from Worksheet B, Part I, column 27. Do not bring forward costs in any cost center with a credit balance from Worksheet B, Part I, column 27.

Column 2--Enter the sum of the amounts for each cost center from Worksheet B, Parts II and III, as appropriate. Do not bring forward costs in any cost center with a credit balance on Worksheet B, Part I, Worksheet B, Part II, or Worksheet B, Part III. For line 62, enter the amounts from Worksheet D-1, Part IV, column 5, sum of lines 86 and 87. Combine the hospital and subprovider amounts if applicable.

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

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

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

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

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

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

3620.3 Part III - Computation of Total Inpatient Ancillary Costs - Rural Primary Care Hospitals--This worksheet computes the total inpatient ancillary cost for rural primary care hospitals. This worksheet is not applicable for cost reporting periods beginning after October 1, 1997. CAHs replaced RPCHs and are reimbursed on reasonable cost based on a combined per diem of routine and ancillary costs.

Column Descriptions

Column 1--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 27. The amount reported on line 62 is transferred from Worksheet D-1, line 85. Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 27. However, report the charges applicable to such cost centers with a credit balance in columns 2 and 3 of the appropriate lines on Worksheet C, Part III.

Column 2--Enter on each cost center line the total gross patient charges, including charity care for that cost center, from Worksheet C, Part I, column 8. If the total charges in column 2 include charges for physician services, the charges in column 3 must also include physician charges.

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 anesthesiologist 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 anesthesiologist. 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.

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. 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)

For hospitals and subproviders transfer column 7, line 101 to Worksheet D-1, Part II, column 1, line 51. If you are a PPS hospital or subprovider, also transfer this amount to Worksheet E, Part A, line 15. For SNFs, NFs, and ICF/MRs for title XIX, for cost reporting periods beginning on or after July 1, 1998, transfer the amount on line 101 to Worksheet E-3, Part III, line 29.

3621.5 Part V - Apportionment of Medical and Other Health Services Costs.--This worksheet provides for the apportionment of costs applicable to hospital outpatient services reimbursable under titles V, XVIII, and XIX, as well as inpatient services reimbursable under title XVIII, Part B.

Title XVIII is reimbursed in accordance with 42 CFR 413.53. Do not complete this worksheet for an RPCH component that has elected the all-inclusive payment method for outpatient services. (See Worksheet S-2, lines 30 through 30.02.) Payment under the all-inclusive payment method for outpatient services is computed on Worksheet C, Part V. Critical access hospitals do not complete columns 2 through 4 and 6 through 8 of this worksheet .

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

For title XVIII, complete a separate Worksheet D, Part V, for each provider component as applicable. Enter the applicable component number in addition to the hospital provider number. Make no entries in columns 6 through 9 of this worksheet for any cost centers with a negative balance on Worksheet B, Part I, column 27. However, complete columns 2 through 5 for such cost centers.

For cost reporting periods that end on or after October 1, 1997 and before September 30, 1998, subscribe columns 2 through 4 and 6 through 8 and report the charges and cost during the period for services prior to October 1, 1997 in columns 2 through 4 and 6 through 8 and report the charges and costs for the periods on or after October 1, 1997 and before September 30, 1998 in columns 2.01 through 4.01 and 6.01 through 8.01. The subscribing is required as a result of the change in calculating the different payment methodologies on Worksheet E, Parts C, D, and E regarding the application of deductibles and coinsurance. Subscribing is not required for cost reporting periods ending on or after September 30, 1998. Revert back to reporting the charges and costs for these services in columns 2 through 4 and 6 through 8. **For services rendered on and after August 1, 2000, outpatient services are subject to prospective payment. For cost reporting periods that overlap the effective date, subscribe the columns to accommodate the proper reporting of cost reimbursement prior to August 1, 2000 and prospective payment on and after August 1, 2000. For critical access hospitals continue to use column 5 and column 9 for reporting charges and costs. No subscribing is required for critical access hospitals.**

Columns 1 and 1.01--Enter on each line in this column, for hospital and subprovider components, the ratio from the corresponding line on Worksheet C, Part II, column 8 for **services rendered prior to August 1, 2000**. For SCH (full cost reporting period), RPCH/CAH, SNF, NF, and swing bed services, enter on each line in this column the ratio from the corresponding line on Worksheet C, Part I, column 9. **Enter in column 1.01 the ratio from the corresponding line on Worksheet C, Part I, column 9 for services on and after August 1, 2000.**

Columns 2 and 2.01--Enter on the appropriate line the charges (per your records or the PS&R ASC segment) for outpatient ambulatory surgical services **through July 31, 2000**.

Columns 3 and 3.01--Enter on the appropriate line the outpatient radiology charges per your records or the PS&R outpatient radiology segment **through July 31, 2000**.

Columns 4 and 4.01--Enter on the appropriate line the other outpatient diagnostic procedure charges per your records or the PS&R other diagnostic segment **through July 31, 2000**.

Columns 5, 5.01 and 5.02--For title XVIII, enter the charges for inpatient Part B and outpatient services not included in any other column in Part V. For SNFs for services rendered which overlap the effective date of January 1, 1998 for physical, occupational and speech therapy (lines 50 through 52) subscript this column and report charges before January 1, 1998 in column 5 and on and after January 1, 1998 in column 5.01. Subscripting is not required for cost reporting periods beginning on or after January 1, 1998. **For hospitals claiming ambulance services for cost reporting periods which overlap October 1, 1997, subscript column 5. Enter on line 65, column 5 the charges relating to the period on or after October 1, 1997 and in column 5.01 the charges relating to prior to October 1, 1997.** For cost reporting periods beginning on or after October 1, 1997 do not complete column 5.01 for ambulance. Exclude charges for which costs were excluded on Worksheet A-8. For example, CRNA costs reimbursed on a fee schedule are excluded from total cost on Worksheet A-8. Therefore, do not report the charges associated with these costs on this worksheet. 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. 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 or begin on or after August 1, 2000, report all ambulance service charges 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.**

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. Multiply the charges in column 5.01 and 5.02 by the ratios in column 1.01, and enter the result in columns 9.01 and 9.02 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 on lines 50 through 52. These services are paid under a fee schedule.** 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).** For cost reporting periods beginning on or after October 1, 1997, costs for ambulance services are calculated from column 5 charges only. If this is the first year for claiming ambulance costs, the application of the limit does not apply. This year then becomes your base period for calculating future payment limits.

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. 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 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 $\frac{\text{Worksheet B, Part I, column 20, line 37}}{\text{Worksheet B, Part I, column 27, line 37}}$ = ratio (six decimal places)
- 2 $\frac{\text{Worksheet B, Part I, column 20, line 40}}{\text{Worksheet B, Part I, column 27, line 40}}$ = 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 the amount on line 101 plus or minus the amounts on lines 102 and 103.

Transfer Referencing: For title XVIII, transfer the amount in column 5, 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 amount in column 5, 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
Sum of columns 5 and 5.01 (SNF only) 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 Sum of columns 9 and 9.02	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, Hepatitis B, Influenza, and Osteoporosis. **These charges include, if applicable, vaccine services provided by hospital based RHC/FQHC which cannot be reported on Worksheet M-3. (1/98)**

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 August 1, 2000 subscript this line and report charges prior to August 1, 2000 on line 2 and on line 2.01 charges on or after August 1, 2000. For cost reporting periods beginning on or after August 1, 2000 no subscripting is required.**

Line 3--Multiply line 1 times line 2, for hospital services rendered prior to August 1, 2000, and enter the result on line 3. For services rendered on or after August 1, 2000 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 August 1, 2000 no subscripting is required. For hospitals for title XVIII, transfer the amount on line 3 to Worksheet E, Part B, line 1 for services rendered prior to August 1, 2000. 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 August 1, 2000. For all other providers transfer the amount from line 3 to Worksheet E-2, column 2, line 3, for swing bed SNF, and Worksheet E-3, Part III, line 2, for titles V and XIX.

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 HCFA 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,

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 HCFA 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.

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 AY@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 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), 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 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 fiscal 1996 use the amounts from fiscal year 1996.

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 1 percent of the target amount (line 56); 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, except cancer and children's hospitals, for services rendered on and after October 1, 1997 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, Parts III and IV, 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. (10/97)

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.

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.

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.

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 AY@). Treat all the days and costs as swing bed days and costs and include them with the hospital. (See HCFA 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.

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, respectively, line 25 or line 31.

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 III 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		Col. 2, line 62

Compute the average cost of organ acquisition by dividing the total cost of organ acquisition (including the inpatient routine service costs and the inpatient ancillary service costs applicable to organ acquisition) by the total number of organ transplanted into all patients and furnished to others. If the average cost cannot be determined in the manner described, then use the appropriate standard organ acquisition charge in lieu of the average cost.

Line 59--Enter line 53 minus line 58.

For All Organ Acquisitions

Line 60--Enter in all columns the total amount of organ acquisition charges billed to Medicare under Part B. This occurs when organs are transplanted into Medicare beneficiaries who, on the day of transplantation, are not entitled to Part A benefits. This computation reflects an adjustment between Medicare Part A and Part B costs and charges so that the amount added under Part B is the same amount subtracted under Part A.

Line 61--For columns 1 and 3 subtract line 60 from line 59. For columns 2 and 4 transfer that amount from line 60.

3625.4 Part IV - Statistics--

Lines 62 through 76--The data entered are data applicable to living donors (column 1) and cadaveric donors (column 2). Use column 1 for kidney transplants. If you complete this worksheet for hearts, livers, or partial livers do not complete column 1.

Line 66--Enter the sum of lines 62 through 65.

Lines 67 through 74--Enter in columns 1 and 2 the appropriate number of organs sold (or transplanted). Enter in column 3 the revenue applicable to organs furnished to other providers, organ procurement organizations and others, and for organs transplanted into non-Medicare patients. Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicare patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered on these lines must also include an amount representing the acquisition cost of the organs transplanted into such patients. Determine this amount by multiplying the average cost of organ acquisition by the number of organs transplanted into non-Medicare patients not liable for payment on a charge basis.

Compute the average cost of organ acquisition by dividing the total cost of organ acquisition (including the inpatient routine service costs and the inpatient ancillary service costs applicable to organ acquisitions) by the total number of organs transplanted into all patients and furnished to others. If the average cost cannot be determined in the manner described, then use the appropriate standard organ acquisition charge in lieu of the average cost.

Line 75--Enter in columns 1 and 2 the applicable number of unusable organs.

Line 76--Enter the sum of lines 67 through 75. These totals equal the totals on line 66, columns 1 and 2.

3626. WORKSHEET D-9 - APPORTIONMENT OF COST FOR SERVICES OF TEACHING PHYSICIANS

This worksheet provides for the computation of the RCE limit by medical specialty and for the apportionment of reimbursable adjusted cost to titles V, XVIII, and XIX for the direct medical and surgical services, including the supervision of interns and residents, rendered by physicians to patients in a teaching hospital which makes the election described in HCFA Pub. 15-I, ' 2148.

NOTE: Do not complete this worksheet for an **RPCH/CAH** component.

If such election is made, direct medical and surgical services to program patients, including supervision of interns and residents, rendered in a teaching hospital by physicians on the hospital staff are reimbursable as provider services on a reasonable cost basis. In addition, certain medical school costs may be reimbursed. Payments for services donated by volunteer physicians to program patients are made to a fund designated by the organized medical staff the teaching hospital or medical school.

Limits on the amount of physician compensation which may be recognized as a reasonable provider cost are imposed in accordance with 42 CFR 405.482.

Worksheet D-9 consists of two parts:

- Part I - Reasonable Compensation Equivalent Computation
- Part II - Apportionment of Cost for the Services of Teaching Physicians

3626.1 Part I - Reasonable Compensation Equivalent Computation--This part provides for the computation of the RCE limit by medical specialty of the physician on the hospital staff or physician on the medical school faculty. Complete separate parts for the hospital staff physicians and for physicians on the medical staff faculty. This part must be completed by applicable hospitals.

42 CFR 405.482(a)(2) provides that limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services paid for under the prospective payment system. (See 42 CFR Part 412.)

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

42 CFR 405.465 provides for the reimbursement of direct medical and surgical services to patients, including supervision of interns and residents, rendered in a teaching hospital by physicians on the faculty of a medical school where the hospital exercises the election as provided in 42 CFR 405.521.

Where several physicians work in the same specialty, see HCFA Pub. 15-I, ' 2182.6C for a discussion of applying the RCE limit in the aggregate for the specialty versus on an individual basis to each of the physicians in the specialty.

When RCE limits are applied on an individual basis to each physician in a medical specialty, prepare a supporting worksheet identical in columnar format to Worksheet D-9, Part I, for each medical specialty. Enter on the first line under columns 1 and 9 the line number applicable to the medical specialty (as displayed on Worksheet D-9, Part I). Enter the name of the medical specialty

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 HCFA 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 and MDH providers that have changed status during the cost reporting period, lines 1 through 6 (9/96) must be reported in subscripts of columns 1 and 1.01.

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. Enter on line 7, column 1, hospital-specific rate payments. (See instructions for line 7.) Enter on line 8, column 1, the greater of the amounts from column 1, line 6 or line 7, plus the amount in column 1.01, line 6.

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 September 30, 2000. 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 21.02 on Worksheet S-2, subscript column 1 and report the payments before the reclassification in column 1.01 and on or after the reclassification in column 1.**

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

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

The chart below provides guidance for reporting the payments for each of the lines identified above for each fiscal year including the potential for a 13 month cost report:

Cost reporting ending month	Line 1	Line 1.01	Line 1.02
October *	10/1-10/31	11/1-12/31	1/1-9/30
November*	10/1-11/30	12/1-12/31	1/1-9/30
December**	1/1-9/30	10/1-12/31	
January	2/1-9/30	10/1-12/31	1/1-1/31
February	3/1-9/30	10/1-12/31	1/1-2/28/29
March	4/1-9/30	10/1-12/31	1/1-3/31
April	5/1-9/30	10/1-12/31	1/1-4/30
May	6/1-9/30	10/1-12/31	1/1-5/31
June	7/1-9/30	10/1-12/31	1/1-6/30
July	8/1-9/30	10/1-12/31	1/1-7/31
August	9/1-9/30	10/1-12/31	1/1-8/31
September*		10/1-12/31	1/1-9/30

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

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

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

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

Line 1.03--Enter the total managed care "simulated payments" from the PS&R prior to October 1.

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

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

Line 1.06--If you answered "yes" to line 55 of Worksheet S-2, report the additional amount received or to be received in accordance with CFR 412.107 on line 1.06.

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(g) 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

Line 3.05--Enter the FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.86(g)(I).

| Line 3.06--Enter the **add-on** to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.86(g)(4).

Line 3.07--Enter the sum of lines 3.04 through 3.06.

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.

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 occurring prior to October 1.

Line 3.10--For cost reporting periods beginning before October 1, 1997 enter the percentage of discharges occurring on and after October 1.

| 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.

| 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.

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 3.11 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.

Line 3.16--Enter the total allowable FTE count for the penultimate year from line 3.01 if that year ended on or after September 30, 1997; otherwise enter zero.

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 zero is an actual count.** (See 42 CFR 413.86(g)(5).) Adjust the result by the number of FTE residents in the initial years of the program that **meet the exception in 42 CFR 413.86(g)(6).**

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 adjusted for the number of residents in the initial years of the program that meet the exception in 42CFR413.86(g)(6). If no intern to bed ratio was reported, calculate the ratio using the FTE count for residents in the initial years of the program. **For prior year cost reporting periods beginning prior to October 1, 1997, obtain this amount from the result of line 3.14 divided 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 - 1.54, and on or after October 1, 2001 - 1.35.**

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

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

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 $(\text{line } 1.02 + \text{line } 1.05 \text{ times the appropriate percentage identified in the paragraph prior to line 1.03})$

* For cost reporting periods beginning on or after October 1, 1997 replace $\{(\text{line } 3.14 \text{ divided by line } 3)\}$ **(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.

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.**

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.

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, and 1.02 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; and 4 percent for October 1, 2001.** Review the payment chart on page 137 for the proper splitting of payments before and on and after October 1 in order to properly calculate the reduction when the fiscal year overlaps October 1.

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, 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, and 5.06. **For cost reporting periods which overlap October 1, 1997,** if you answered yes to line 55 of Worksheet S-2 and the amount reported on Worksheet D-1, line 53 is greater than the sum of lines 1, 1.01, 1.02, 2, and 2.01 above, add to this sum the amount on line 1.06. If line 53 is less than the sum of lines 1 and 2 with subscripts, you do not qualify for the additional payment reported on line 1.06.

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. 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, 2000, in addition to the comparison of 1982 and 1987, hospitals can compare the hospital specific rate for cost reporting periods beginning in FY 1996. The transition into 1996 is actually a blend for FY 2001 of 75 percent of either 1982, 1987, or PPS and 25 percent of 1996. For FY 2002, the blend is 50/50 and for FY2003 the blend is 25/75. For discharges on and after FY2003 the comparison then becomes 1982, 1987, or 1996 compared to the Federal PPS rate.

Line 8--For SCHs and Medicare dependent/small rural hospitals only, enter the greater of line 6 column 1.01 or line 7 column 1.01 added to that amount on line 6 column 1. For hospitals subscribing column 1 due to a change in geographic location enter from line 6 the sum of the columns 1 and 1.01 For all other providers, enter the amount from line 6.

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.

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

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.

Line 15--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101.

Line 16--Enter the sum of lines 8 through 15.

Line 17--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, treat the services as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted by you in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 12. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

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

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

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

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

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

Line 21--Enter the program reimbursable bad debts, reduced by the bad debt recoveries

Line 21.01--Enter line 21 times 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; and 55 percent for October 1, 1999 and thereafter. **If line 21 is a negative (recoveries exceeded bad debts) enter that amount with no reduction.**

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

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

Line 24--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See HCFA Pub. 15-I, ' 2146.4.) Specify the adjustment in the space provided.

Line 25--If you are filing under the fully prospective payment methodology for capital costs or on the basis of 100 percent of the Federal rate under the hold harmless methodology, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. For providers paid under the hold harmless reasonable cost methodology, compute gains or losses on the disposal of old assets in accordance with HCFA Pub. 15-1, ' ' 132-134.4. For gains or losses on new capital, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment.

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

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

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

Line 28--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 28.01.

Line 29--Enter line 26 minus the sum of lines 27 and 28 or 27 and 28.01. Transfer to Worksheet S, Part II.

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

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. 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 you must subscript the column and make a separate transitional corridor payment for the appropriate periods.

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, column 9 and 9.02 for hospitals and column 9 plus column 9.01 for SNFs. For RPCH 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. To either transfer amount, add the amount reported on Worksheet D, Part VI, column 3, line 3.

Line 1.01--Enter the medical and other health services for services rendered on and after August 1, 2000 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 August 1, 2000.

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

Line 1.03--Enter the 1996 hospital specific payment to cost ratio provided by your intermediary.

Line 1.04--Line 1.01 times line 1.03 (Pre BBA amount)

Line 1.05--Line 1.02 divided by line 1.04. (PPS payments divided by the pre BBA amount)

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. If line 1.01 is > line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals), and Worksheet S-3, column 1, line 1 is =< 100, enter the difference of line 1.04 minus line 1.02; or

b. If line 1.01 is > line 1.04 and Worksheet S-2, line 19 response is 3 (cancer 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 the result of line 1.04 minus line 1.02.

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

a. If line 1.01 is > line 1.04, Worksheet S-2, line 21 response is 2 (rural hospital), and Worksheet S-3, column 1, line 1 is =< 100, enter the result of line 1.04 minus line 1.02; or

b. If line 1.01 is > line 1.04 and Worksheet S-2, line 19 response is 3 (cancer 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 the result of line 1.04 minus line 1.02.

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

a. If line 1.01 is > line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) and Worksheet S-3, column 1, line 1 is =< 100 enter the result of line 1.04 minus line 1.02; or

b. If line 1.01 is > line 1.04 and Worksheet S-2, line 19 response is 3 (cancer 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 the result of line 1.04 minus line 1.02.

Line 1.07--Enter the amount from worksheet D, Part IV, column 9, line 103.

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</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
Subprovider	Part I, col. 9, line 10; or Part II, col. 7, line 35, or Part III, col. 6, line 42
Skilled Nursing Facility	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 HCFA 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. For services rendered on and after August 1, 2000, enter the sum of lines 1, 1.01, 1.02, 1.06, 1.07, 2, 3, and 4 for columns 1 and 1.01 if applicable.

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 HCFA Pub. 15-I, ' 2104.3) and (2) charges to beneficiaries for excess costs. (See HCFA 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 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.

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.

NOTE: If these services are exempt from LCC, enter 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 the service or procedure, coinsurance entered on this line reflects coinsurance based on 20 percent of full charges, not discounted charges.

NOTE: If these services are exempt from LCC, enter the Part B deductibles billed to program beneficiaries only. Do not enter any Part B coinsurance.

Line 19--Subtract line 18 from line 17.

NOTE: If these services are exempt from LCC, subtract line 18 from line 17, and multiply the result by 80 percent.

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 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 the amount from Worksheet E-3, Part IV, line 25. Complete this line for the hospital component only.

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

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

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 all cost reporting periods beginning on or after October 1, 1999 (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 HCFA 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 HCFA 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 HCFA 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.

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

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

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

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

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

Line Descriptions

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

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

Line 3--Line 1 minus line 2.

Line 4--Enter 80 percent of line 3 in column 1. For column 1.01 do not complete this line.

Line 5--This amount is the ASC portion of the blended amount. The ASC portion of the blended amount is 58 percent of the amount on line 4 of column 1 and line 1 of column 1.01.

Line 6--Enter the amount of the outpatient ASC cost from Worksheet D, Part V, columns 6 and 6.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

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 for the same services for outpatient ambulatory surgical procedures only if that amount is lower than the blended ASC amount. 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).

If you bill an all-inclusive rate or bill gross departmental charges and reflect a discount on the bill, you must, when billing Medicare, show gross departmental charges for each service on the bill. Identify the difference between the sum of these gross charges and the net amount you wish to collect. Also maintain a memorandum record when you bill an all-inclusive charge to non-Medicare

patients. Always use the gross departmental charges for cost apportionment purposes. Show the discount amount in the customary charge computations, as appropriate.

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see ' 3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

Line 7--Enter the total charges which relate to reasonable cost on line 6 from Worksheet D, Part V, columns 2 and 2.01 (if applicable), line 104, in columns 1 (if applicable) and 1.01 respectively.

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 7. Submit a schedule showing these computations with the cost report.

Lines 8 through 11--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 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. 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 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of the customary charges over the reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 13--Enter the excess of reasonable cost over the customary charges. If line 6 exceeds line 11, enter the difference.

Line 14--Enter the lesser of the reasonable cost on line 6 or the customary charges on line 11.

NOTE: If these services are exempt from LCC, enter the reasonable cost from line 6.

Line 15--Enter in column 1 the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries for outpatient ambulatory surgical procedures. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for the service or procedure, coinsurance entered on this line reflects coinsurance based on 20 percent of full charges, not discounted charges. Make no entry for column 1.01.

NOTE: If these services are exempt from LCC, enter the Part B deductibles from line 2. Exclude Part B coinsurance.

Line 16--Subtract line 15 from line 14 for column 1 and enter the amount on line 14 for column 1.01.

NOTE: If these services are exempt from LCC, subtract the deductibles reported on line 15 from line 14, and multiply the result by 80 percent for column 1 only.

Line 17--Enter 42 percent of line 16.

Line 18--Enter the sum of lines 5 and 17.

Line 19--Enter the lesser of lines 16 or 18 in columns 1 and 1.01.

Line 20--Enter the Part B deductibles and coinsurance in column 1.01 only.

Line 21--In column 1, enter the amount reported on line 19. In column 1.01, subtract line 20 from line 19. If these services are exempt from LCC, subtract the deductibles reported on line 20 from line 19, and multiply the result by 80 percent. Transfer the sum of columns 1 and 1.01 for title XVIII to Worksheet E, Part B, line 20; titles V and XIX to Worksheet E-3, Part III, column 1, line 37.

3630.4 Part D - Outpatient Radiology Services--Use this worksheet to calculate reimbursement settlement for outpatient radiology services for the hospital and/or subprovider for titles V, XVIII, and XIX, **for services rendered prior to August 1, 2000; otherwise do not complete this form.**

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

As required by ' ' 1833(a)(2)(E) and 1833(n) of the Act, a payment methodology is imposed for radiology services performed on an outpatient basis by hospitals. Aggregate payment for radiology services performed in a hospital on an outpatient basis is based on the lower of (1) the hospital's reasonable cost or customary charges (in the aggregate) net of cost sharing, or (2) a blend of the hospital's outpatient radiology costs or its charges (whichever are less) net of (a) deductibles and coinsurance and (b) 62 percent of the physicians' fee schedule net of cost sharing as if the services were performed in a physician's office in the same locality. The blend consists of 42 percent hospital-specific cost and 58 percent fee schedule. For cost reporting periods that end on or after October 1, 1997 and on or before September 30, 1998 it is necessary to subscript the column to accommodate the change in payment methodology regarding the application of deductibles and coinsurance. For all cost reporting periods that end on or after September 30, 1998 continue to use the subscripted column and no longer complete column 1.

Line Descriptions

Line 1--Enter the fees from the PS&R or your records in columns 1 and 1.01 for services rendered before October 1 and on or after October 1, 1997, respectively.

Line 2--Enter 62 percent of the amount on line 1 and 1.01 Line 3--Enter the deductibles billed to program patients in column 1 only. Obtain this amount from the PS&R or from your records

Line 4--Enter 80 percent of the result of line 2 minus line 3 in column 1. Make no entry in column 1.01

Line 5--This amount is the blended charge proportion. Enter 58 percent of line 4 in column 1 and 58 percent of the amount on line 2, column 1.01.

Line 6--Enter the amount of the outpatient radiology cost from Worksheet D, Part V, columns 7 and 7.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or your customary charges for the same services for outpatient radiology services only if that amount is lower than the blended amount. 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: If the medical and other health services reported here qualify for exemption from the application of LCC (see ' 3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

Line 7--Enter the total charges that relate to reasonable cost on line 6 from Worksheet D, Part V, columns 3 and 3.01 (if applicable), line 104 in columns 1(if applicable) and 1.01 respectively.

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 7. Submit a schedule showing these computations with the cost report.

Lines 8 through 11--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 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. 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 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of customary charges over reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 13--Enter the excess of reasonable cost over the customary charges. If line 6 exceeds line 11, enter the difference.

Line 14--Enter the lesser of the reasonable cost on line 6 or the customary charges on line 11.

NOTE: If these services are exempt from LCC, enter the reasonable costs from line 6.

Line 15--Enter the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries in column 1 only. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for the service or procedure, coinsurance entered on this line reflects coinsurance based on 20 percent of full charges, not discounted charges

NOTE: If these services are exempt from LCC, enter the Part B deductibles from line 3. Exclude Part B coinsurance

Line 16--Subtract line 15 from line 14 for column 1. Enter the amount from line 14 for column 1.01

NOTE: If these services are exempt from LCC, subtract the deductibles included on line 15 from line 14, and multiply the result by 80 percent for column 1 only.

Line 17--Enter 42 percent of line 16 in column 1 and 1.01

Line 18--Enter the sum of lines 5 and 17 for columns 1 and 1.01.

Line 19--Enter the lesser of lines 16 or 18 in column 1 and 1.01.

Line 20--Enter the Part B deductibles and coinsurance in column 1.01 only.

Line 21--In column 1, enter the amount reported on line 19. In column 1.01, subtract line 20 from line 19. If these services are exempt from LCC, subtract the deductibles reported on line 20 from line 19, and multiply the result by 80 percent. Transfer the sum of columns 1 and 1.01 for title XVIII to Worksheet E, Part B, line 20; and for titles V and XIX to Worksheet E-3, Part III, column 1, line 37.

3630.5 Part E - Other Outpatient Diagnostic Procedures.--This worksheet calculates reimbursement settlement for other outpatient diagnostic procedures for both hospital and/or subprovider, **for services rendered prior to August 1, 2000; otherwise do not complete this worksheet.** As required by ' ' 1833(a)(2)(E) and 1833(n) of the Act, payment for other diagnostic procedures performed in a hospital on an outpatient basis is based on the lower of (1) the hospital's reasonable cost or customary charges (in the aggregate) net of cost sharing, or (2) a blend of the hospital's other outpatient diagnostic procedures costs or its charges, if less (hospital-specific), and 42 percent of the physician fee schedule, net of cost sharing for the same procedures as if the procedures were performed in a physician's office in the same locality. The blend consists of 50 percent hospital-specific cost and 50 percent fee schedule. For cost reporting periods that end on or after October 1, 1997 and on or before September 30, 1998, it is necessary to subscript the column to accommodate the change in payment methodology regarding the application of deductibles and coinsurance. For cost reporting periods that end on or after September 30, 1998 continue to use the subscripted column and no longer complete column 1.

NOTE: Rural primary care hospitals that have elected the all-inclusive method for payment of outpatient services and CAHs (see Worksheet S-2, lines 33 through 33.02) do not complete this worksheet.

Line Descriptions

Line 1--Enter the fee schedule amounts from the PS&R or from your records in columns 1 and 1.01 for services rendered before October 1 and on and after October 1, 1997 respectively.

Line 2--Enter 42 percent of the amount on line 1.

Line 3--Enter in column 1 the deductibles billed to program patients. Obtain this amount from the PS&R or from your records.

Line 4--Enter in column 1 80 percent of the result of line 2 minus line 3. No entry is required for column 1.01.

Line 5--This amount is the blended charge proportion. Enter 50 percent of line 4 in column 1 and 50 percent of line 2 in column 1.01.

Line 6--Enter the amount of the outpatient radiology cost from Worksheet D, Part V, columns 8 and 8.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

Computation of Lesser of Reasonable Cost or Customary Charges.--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or your customary charges for the same services for other outpatient diagnostic procedures only if the amount is lower than the blended amount. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b)(2) or customary charges as defined in 42 CFR 413.13(b)(1).

NOTE: If the medical and other health services reported here qualify for exemption from LCC (see ' 3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

Line 7--Enter the total charges that relate to the reasonable cost on line 6 from Worksheet D, Part V, columns 4 and 4.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

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 7. Submit a schedule showing these computations with the cost report

Lines 8 through 11--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 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. 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 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of customary charges over reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 13--Enter the excess of reasonable cost over the customary charges. If line 6 exceeds line 11, enter the difference.

Line 14--Enter the lesser of the reasonable cost on line 6 or the customary charges on line 11.

NOTE: If these services are exempt from LCC, enter the reasonable costs from line 6.

Line 15--Enter, in column 1, 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 the service or procedure, coinsurance entered on line 15 reflects coinsurance based on 20 percent of full charges, not discounted charges.

NOTE: If these services are exempt from LCC, enter the Part B deductibles from line 3. Exclude Part B coinsurance.

Line 16--Subtract line 15 from line 14 for column 1. Enter the amount on line 14 for column 1.01.

NOTE: If these services are exempt from LCC, subtract the deductible on line 15 from line 14, and multiply the result by 80 percent.

Line 17--Enter 50 percent of line 16 for columns 1 and 1.01.

Line 18--Enter the sum of lines 5 and 17.

Line 19--Enter the lesser of lines 16 or 18 in column 1 and 1.01.

Line 20--Enter the Part B deductibles and coinsurance in column 1.01 only.

Line 21--In column 1 enter the amount reported on line 19. In column 1.01 subtract line 20 from line 19. If these services are exempt from LCC, subtract the deductible on line 20 from line 19, and multiply the result by 80 percent. Transfer the sum of columns 1 and 1.01 for title XVIII, to Worksheet E, Part B, line 20; and for titles V and XIX to Worksheet E-3, Part III, column 1, line 37.

3631. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

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

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

- o Hospital-based HHAs use Worksheet **H-8**.
- o Hospital-based outpatient rehabilitation facilities use Worksheet J-4.

The column headings designate two categories of payments:

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

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

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

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

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to you (excluding payments made under the composite rate for ESRD services), including amounts paid under PPS. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must also include amounts withheld from your interim payments due to an offset against overpayments applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2--Enter the total Medicare interim payments (excluding payments made under the ESRD composite rate) payable on individual bills.

Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period but not paid as of the end of the cost reporting period.

Also, include in column 4 the total Medicare payments payable for servicing home program renal dialysis equipment when the provider elected 100 percent cost reimbursement.

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

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer as follows:

<u>Reimbursement Method</u>	<u>From Column</u>	<u>Transfer To</u>
Part B Payments	4	Wkst. E, Part B, line 34
<u>Part A Payments</u>		
PPS	2	Wkst. E, Part A, line 28
TEFRA	2	Wkst. E-3, Part I, line 19
Cost	2	Wkst. E-3, Part II, line 32

NOTE: For a swing bed-SNF, transfer the column 2, line 4, and column 4, line 4, amounts to Worksheet E-2, columns 1 and 2, line 20, respectively.

For SNFs reimbursed under PPS, transfer the amount in column 2, line 4, to Worksheet E-3, Part III, column 2, line 57.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.

Line 5--List separately each settlement payment after the cost report is received together with the date of payment. If the cost report is reopened after the NPR has been issued, continue to report all settlement payments after the cost report is received separately on this line.

Line 6--Enter the net settlement amount (balance due the provider or balance due the program). Obtain the amounts as follows:

<u>Worksheet E-1, Column as Indicated</u>	<u>From Settlement Worksheet</u>
2	Wkst. E, Part A, line 29
4	Wkst. E, Part B, line 35
2	Wkst. E-3, Part I, line 20
2	Wkst. E-3, Part II, line 33

For swing bed-SNF services, column 2 must equal Worksheet E-2, column 1, line 21. Column 4 must equal Worksheet E-2, column 2, line 21.

For SNFs paid under PPS, column 2 must equal Worksheet E-3, Part III, column 2, line 58.

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

Line 7--Enter in columns 2 and 4 the sum of lines 4 through 6. Enter amounts due the program as a negative number. This amount must agree with amount due provider reported on Worksheet E, Part A, line 26, Worksheet E, Part B, line 32, Worksheet E-2, line 18, Worksheet E-3, Part I, line 17, Worksheet E-3, Part II, line 30, and Worksheet E-3, Part III, line 55.

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
	Part II - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement
Titles	Part III - Calculation of Reimbursement Settlement - All Other Health Services for V or XIX Services - Part A Services for Title XVIII PPS SNFs
	Part IV - Direct Graduate Medical Education and ESRD Outpatient Direct Medical Education Costs
	Part V - Calculation of NHC MQ Demonstration Reimbursement Settlement for Medicare Part A Services

3633.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA.-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

Line 1--Enter (for TEFRA hospitals and subprovider) the amount from Worksheet D-1, Part II, line 59.

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 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 do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

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

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

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

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

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

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; 60percent for October 1, 1998 and 55 percent for October 1, 1999 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 HCFA 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 HCFA 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 HCFA Pub. 15-I, ' ' 132-132.4.)

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 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 HCFA 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 HCFA 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 HCFA 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.

Computation of Net Costs of Covered Services

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs.

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.

Line 25--Enter in column 1 the amount of outlier payments made for PPS discharges during the period. See HCFA 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.

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. If the hospital is receiving payment for graduate medical education, make no entry.

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. If the hospital is receiving payment for graduate medical education (Worksheet S-2, line 25.02 is yes.), make no entry.

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, 1998; 60 percent for October 1, 1998 and 55 percent for October 1, 1999 and all subsequent periods. If line 38 is negative, (recoveries exceed bad debts, enter that amount with no reduction.

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.

Line 40--Enter the sum of lines 35, 37, 38 or 38.01 and 39, minus line 36. (hospitals and subproviders only if title V or XIX follow Medicare principles.

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.

Line 3.03--Enter the adjustment for the unweighted resident FTE count for allopathic or osteopathic programs for affiliated programs in accordance with 42 CFR 413.86(b) and (g)(4).

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.

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 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.

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.

Line 3.09--Enter the sum of lines 3.07 and 3.08.

Line 3.10--If line 3.05 is less than line 3.04, enter the amount from line 3.09; otherwise multiply line 3.09 by (sum of line 3.01 and 3.03/line 3.05). (10/97)

Line 3.11--Enter the weighted Dental and Podiatric resident FTE count for the current year.

Line 3.12--Enter the sum of lines 3.10 and 3.11.

Line 3.13--Enter the total weighted resident FTE count for the prior cost reporting year (if subject to the cap in the prior year report the resident cap), other than those in the initial years of the program that meet the criteria for an exception to the averaging rules.

Line 3.14--For cost reporting periods beginning on or after October 1, 1998, enter the total weighted resident FTE count for the cost reporting year before last, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules.

Line 3.15--Enter the rolling average FTE count by adding lines 3.12 through 3.14 and divide by the number of these lines greater than zero, unless zero is an actual count. (See 42 CFR 413.86(g)(5).)

Line 3.16--Enter the weighted number of FTE residents in the initial years of a primary care and OB/GYN program that meets the exception.

Line 3.17--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).

Line 3.18--Enter the sum of lines 3.15 through 3.17.

Line 3.19--Enter the primary care and OB/GYN physician per resident amount.

Line 3.20--Enter the all other program per resident amount.

Line 3.21--Enter the primary care unadjusted approved amount by multiplying the sum of lines 3.07 and 3.16 by line 3.19.

NOTE: If you have reduced the current year FTE count to zero use the weighted count from the previous year in order to generate a weighted payment amount to apply against the rolling average.

Line 3.22--Enter the other unadjusted approved amount by multiplying line 3.20 by the sum of lines

3.08, 3.11, and 3.17. **If you have reduced the current year FTE count to zero use the weighted count from the previous year in order to generate a weighted payment amount to apply against the rolling average.**

Line 3.23--Enter the sum of lines 3.21 and 3.22.

Line 3.24--Divide line 3.23 by the sum of lines 3.07, 3.08, 3.11, 3.16, and 3.17.

Line 3.25--Enter the total approved amount for resident costs, line 3.24 times line 3.18.

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 and XIX, enter the amounts from columns 3 and 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.

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. 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 the payment of Graduate Medical Education per resident amount for these managed care days.

Line 6.02--Enter Medicare managed care days occurring on or after January 1 of this cost reporting period.

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 reduce the amount by the factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. Reduce in proportion to the number of days on and after January 1, 2000 to the end of the fiscal year to the total days in the period.**

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.**

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, reduce the amount by the factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. Reduce in proportion to the number of days on and after January 1, 2000 to the end of the fiscal year to the total days in the period.**

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.

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.

- PPS hospital and/or subproviders - Worksheet E, Part A, line 17;
- TEFRA hospital and/or subproviders - Worksheet E-3, Part I, line 5;
- 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;
- 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, line 5; 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, line 1; and Worksheet M-3, line 1.

Line 18--Enter the Part B primary payer amounts. Enter the sum of the amounts on each Worksheet E, Part B, line 24; Worksheet E-2, column 2, line 9; Worksheet H-7, Part I, sum of columns 2 and 3, line 9; and Worksheet J-3, line 2.

Line 19--Enter line 17 minus line 18.

Line 20--Enter the sum of lines 16 and 19.

Line 21--Divide line 16 by line 20, and enter the result.

Line 22--Divide line 19 by line 20, and enter the result.

Allocation of Medicare Direct GME Costs Between Part A and Part B--Use this section to compute the GME payments for title XVIII, Part A and Part B, and to compute the total GME payments applicable to titles V and XIX.

Line Descriptions

Line 23--For cost reporting periods ending prior to January 1, 1998, multiply line 3 by line 6, and enter the result. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, line 54. Do not compute lines 24 and 25.

Line 23.01--For cost reporting periods that end on or after January 1, 1998, enter the sum of lines 6.01, 6.05, and 6.08. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, line 54. Do not compute lines 24 and 25.

Line 24--Complete for title XVIII only. Multiply line 23 or 23.01 by line 21, and enter the result. If you are a hospital subject to PPS, transfer this amount to Worksheet E, Part A, line 11. If you are subject to TEFRA, transfer this amount to Worksheet E-3, Part I, line 13. If you are subject to cost reimbursement, transfer this amount to Worksheet E-3, Part II, line 18. Although this amount includes the Part A GME payments for subproviders, for ease of computation, transfer this amount to the hospital component worksheet only.

Line 25--Complete for title XVIII only. Multiply line 23 or 23.01 by line 22, and enter the result. Transfer this amount to Worksheet E, Part B, line 21. Although this amount includes the Part B GME payments for subproviders, for ease of computation, transfer this amount to the hospital component only.

3633.5 Part V - Calculation of NHCMQ Demonstration Reimbursement Settlement for Medicare Part A Services.--Use this part to calculate reimbursement if you are a part of the NHCMQ demonstration project for cost reporting periods beginning before July 1, 1998

Part A - Inpatient Services: Provider Computation of Reimbursement.--Use this part to calculate payment for title XVIII services furnished by NHCMQ Demonstration participants. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ Demonstration.

Line Descriptions

Line 1.--Enter the number of total title XVIII inpatient days. Obtain this figure from Worksheet S-3, Part I, column 4, line 15.

Line 2.--Enter the number of demonstration program days. Obtain this figure from Worksheet S-7, line 46, columns 3.01 and 4.01

Lines 3 through 5--Calculate the net non-NHCMQ Demonstration Part A inpatient ancillary services. These include radiology, laboratory, intravenous therapy, oxygen, electrocardiology, medical supplies charged to patients, and drugs charged to patients and others.

Line 3.--Enter the total Part A ancillary program costs. Obtain this figure from Worksheet D-4, column 3, line 101.

Line 4.--Enter the physical, occupational, and speech therapy ancillary program costs. To obtain this figure, add lines 50, 51, and 52 on Worksheet D-4, column 3.

Line 5.--Subtract line 4 from line 3, and enter the difference. This amount represents the net ancillary services not applicable to the NHCMQ Demonstration. Enter this amount on Worksheet E-3, Part III, column 2, line 2.

Line 6.--Enter the NHCMQ Demonstration inpatient routine/ancillary PPS amount paid. Obtain this figure from Worksheet S-7, column 5, line 46.

Lines 8 through 9--Calculate the program inpatient capital costs. The capital costs are not part of the PPS calculation. Instead the capital costs flow through the cost finding stepdown process on Worksheet B.

Line 7.--Do not use this line.

Line 8.--Enter the per diem capital-related cost from Worksheet D-1, line 72.

Line 9.-- Enter the program capital-related cost. Obtain this amount by multiplying line 8 by line 1.

Lines 10 through 24--Calculate the indirect cost component of the demonstration ancillary services. The indirect cost component of the demonstration ancillary services is not part of the PPS calculation. Instead the indirect costs are passed through from cost finding on the cost report. For participants in the demonstration, ancillary services are calculated as part of the PPS payment beginning in phase 3. Lines 10 through 24 are completed only for phase 3.

Line 10.--Enter the total general service cost allocation for physical therapy. Obtain this amount from Worksheet B, Part I, column 27, line 50

Line 11.--Enter the total general service cost allocation for occupational therapy. Obtain this amount from Worksheet B, Part I, column 27, line 51.

Line 12.--Enter the total general service cost allocation for speech therapy. Obtain this amount from Worksheet B, Part I, column 27, line 52.

Line 13.--Enter the direct cost for physical therapy. Obtain this amount from Worksheet B, Part I, column 0, line 50.

Line 14.--Enter the direct cost for occupational therapy. Obtain this amount from Worksheet B, Part I, column 0, line 51.

Line 15.--Enter the direct cost for speech therapy. Obtain this amount from Worksheet B, Part I, column 0, line 52.

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.

3640. FINANCIAL STATEMENTS - WORKSHEETS G, G-1, G-2, and G-3

Prepare these worksheets from your accounting books and records.

Complete all worksheets in the "G" series. Complete Worksheets G and G-1 if you maintain fund-type accounting records. If you do not maintain fund-type accounting records, complete the general fund columns only. Cost reports received with incomplete G worksheets are returned to you for completion. If you do not follow this procedure, you are considered as having failed to file a cost report.

If the lines on the worksheets are not sufficient, use lines 5, 9, 35, and 41, as appropriate, to report the sum of account balances and adjustments. Maintain supporting documentation or subscript the appropriate lines.

If you have more than one hospital-based HHA, and outpatient rehabilitation providers, subscript the appropriate lines on Worksheet G-2, Part I, to report the revenue for each multiple based facility separately.

Enter accumulated depreciation as a negative amount.

7) by the ratio (column 5) for each line. Enter the product in column 10.

Columns 8 and 11--To determine the Medicare Part B cost, multiply the Medicare charges (column 8) by the ratio (column 5) for each line. Enter the result in column 11.

Per Beneficiary Cost Limitation

Line 17--Enter the Medicare unduplicated census count from Worksheet S-4, column 2, line 2 for Medicare. Subscript the line for multiple MSAs as they were reported on Worksheet S-4 line 20.

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.

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 from January 1, 1998 through December 31, 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 services	Part I, col. 11, sum of lines 7, 15, and 16 and Part III, sum of columns 3.01 and 4, line 4 for rendered on and after January 1, 1998.

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 services	Part I, col. 11, sum of lines 14, 15, and 16 and Part III, sum of columns 3.01 and 4, line 4, for rendered on and after January 1, 1998

For cost reporting periods beginning on or after October 1, 1997:
36-190

This line provides for the computation of reasonable cost of program services. Enter the cost of services from Worksheet H-6, Parts I and III as follows:

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):

<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 III, sum of cols. 3.01 and 4, line 4, added to Part I, col. 11, lines 15 and 16

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 III, sum of cols. 3.01 and 4, line 4, added to Part I, col. 11, lines 15 and 16

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 HCFA Pub. 15-I, chapter 21) and (2) provider charges to beneficiaries for excess costs as described in HCFA 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.

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.

Line 11--Enter in column 2 the Part B deductibles billed to program patients. Include any amounts of deductibles satisfied by primary payer payments.

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.

3650. ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

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

3651. WORKSHEET I-1 - ANALYSIS OF RENAL COSTS

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

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

Column Descriptions

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

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

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

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

Line Descriptions

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

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

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

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

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

<u>Worksheet I-1, Part I, Column 1, Line Number</u>	<u>General Service Cost Centers</u>	<u>Worksheet B, Part I, Lines 57 or 64, Columns</u>
18	Old Capital-Related Costs- Buildings and Fixtures	1
19	Old Capital-Related Costs- Moveable Equipment	2
20	New Capital-Related Costs- Buildings and Fixtures	3
21	New Capital-Related Costs- Moveable Equipment	4
22	Employee Benefits	5
23	Administrative and General	6
24	Maintenance & Repairs, Operation of Plant and Housekeeping	Sum of 7, 8, and 10

3657. WORKSHEET J-2 - COMPUTATION OF OUTPATIENT REHABILITATION PROVIDER COSTS

Use this worksheet only if you operate a hospital-based outpatient rehabilitation provider. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility.

3657.1 Part I - Apportionment of Outpatient Rehabilitation Provider Cost Centers.--

Column 1--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, column 29. To facilitate the apportionment process, the line numbers are the same on both worksheets. Do not transfer lines 19 and 20 from Worksheet J-1.

Column 2--Enter the charges for each cost center. Obtain the charges from your records.

Column 3--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

Columns 4, 6, and 8--For each cost center, enter the charges from your records for the component's title V, title XVIII, and title XIX patients, respectively. Not all facilities are eligible to participate in all programs. For title XVIII, subscript column 6 to report services rendered prior to January 1, 1998 and services rendered on or after January 1, 1998 to allow for capital and operating reduction required by the BBA. For 1998 calendar year end cost reporting periods and after, no subscripting is required; simply report the charges for the whole year in column 6. No subscripting is required for CMHCs. However, for cost reporting periods which overlap August 1, 2000 you must subscript column 6 to report CMHC charges before August 1, 2000 in column 6 and on or after August 1, 2000 in column 6.01 to accommodate the implementation of prospective payment. For cost reporting periods beginning on or after August 1, 2000, no subscripting is required.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, by the ratio in column 3. Subscript column 7 to agree with column 6. Enter 90 percent of the result in the subscript of column 7. For proper subscripting and reporting of costs in column 7, see the discussion for columns 4, 6, and 8 above.

Line 20--Enter the totals of lines 1 through 19 in columns 1, 2, and 4 through 9.

3657.2 Part II - Apportionment of Cost of Outpatient Rehabilitation Provider Services Furnished by Shared Hospital Departments.--Use this part only when the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the hospital's outpatient rehabilitation provider.

Column 3--For each of the cost centers listed, enter the ratio of cost to charges that is shown on Worksheet C, Part I, column 9 from the appropriate line for each cost center.

Columns 4, 6, and 8--For each cost center, enter the charges from your records for title V, title XVIII, and title XIX CORF patients, respectively. For proper reporting of charges required to be subscripted see the discussion for columns 4, 6, and 8 in Part I above.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, respectively, by the ratio in column 3. Subscript column 7 to agree with column 6. Enter 90 percent of the result in the subscript of column 7. CMHCs are not subject to the 10 percent reduction. For proper subscripting and reporting of costs in column 7 and subscripts, see the discussion for columns 4, 6, and 8 in Part I above.

Line 27--Enter the totals for columns 4 through 9.

Line 28--Enter the total costs from Part I, columns 5, 7 and subscripts, and 9, line 20, plus columns 5, 7 and subscripts, and 9, line 27, respectively and transfer to Worksheet J-3, line 1, or 1.01.

3658. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT -
OUTPATIENT REHABILITATION PROVIDER SERVICES

Submit a separate Worksheet J-3 for each title (V, XVIII, or XIX) under which reimbursement is claimed. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility. For all outpatient rehabilitation providers, subscript column 1 to provide for the reporting of cost and charges before and on or after January 1, 1998 to agree with the subscripting occurring on Worksheet J-2, Parts I and II, columns 4 through 9. No subscripting is required for cost reporting periods beginning on or after January 1, 1998. For CMHCs, for title XVIII, subscript the column to report the services before and on or after August 1, 2000. No subscripting of the column is required for cost reporting periods beginning on or after August 1, 2000

Line 1--Enter the cost of the component's services from Worksheet J-2, Part II, line 28 from columns 5, 7 and subscripts (1/1/98), or 9, as applicable (column 5 for title V, column 7 for title XVIII, and column 9 for title XIX). Line 1 is not completed by CMHCs for cost reporting periods beginning on or after August 1, 2000.

Lines 1.01 through 1.06 are to be completed by CMHCs for title XVIII, for services on or after August 1, 2000.

Line 1.01--Enter the cost of the health services for services rendered on or after August 1, 2000, from worksheet J-2, Part II, column 7.01, line 28 (column 7 for cost reporting periods beginning after August 1, 2000).

Line 1.02--Enter the sum of gross PPS payments received, including outliers.

Line 1.03--Enter the 1996 hospital specific payment to cost ratio provided by your intermediary. If you did not file a cost report in 1996, you are not eligible for transitional corridor payments.

Line 1.04--Line 1.01 times line 1.03.

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 from August 1, 2000 through December 31, 2001:

a. If line 1.05 is ≥ 90 percent but < 100 percent, enter 80 percent of (line 1.04 minus line 1.02).

b. 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).

c. 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).

d. If line 1.05 is < 70 percent, enter 21 percent of the result of line 1.04 minus line 1.02.

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

a. If line 1.05 is ≥ 90 percent but < 100 percent, enter 70 percent of the result of line 1.04 minus line 1.02.

b. 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).

c. If line 1.05 is < 80 percent, enter 13 percent of the result of line 1.04 minus line 1.02.

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

a. If line 1.05 is = > 90 percent but < 100 percent, enter 60 percent of the result of line 1.04 minus line 1.02.

b. If line 1.05 is < 90 percent, enter 6 percent of the result of line 1.04 minus line 1.02.

If the cost reporting periods overlap any of these effective dates you must subscript the column and make a separate transitional corridor payment for the appropriate periods.

Line 2—Enter the amounts paid and payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer (from your records).

Line 3--Enter the amount obtained by subtracting line 2 from line 1 in column 1. For CMHCs subtract line 2 from the sum of lines 1 and 1.06 in column 1.01 or column 1 as applicable.

Line 4--Enter the charges for the applicable program services from Worksheet J-2, sum of Parts I and II, Columns 4, 6, 6.01, and 8 as appropriate, lines 20 and 27.

Lines 5 through 8--These lines provide for the reduction of program charges where 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 7 is greater than zero, enter on line 8 the product of multiplying the ratio on line 7 by line 4.

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

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 5, 6, and 7, but enter on line 8 the amount from line 4. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 8 exceed the actual charges on line 4.

Lines 9 and 10--Lines 9 and 10 provide for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in 42 CFR 413.13(e).

Enter on line 9 the excess of total customary charges (line 8) over the total reasonable cost (line 3). In situations when in any column the total charges on line 8 are less than the total cost on line 3, enter zero (0) on line 9.

Enter on line 10 the excess of total reasonable cost (line 3) over total customary charges (line 8). In situations when in any column the total cost on line 3 is less than the customary charges on line 8, enter zero (0) on line 10.

NOTE: Payment to CORFs is based on the reasonable cost of services prior to January 1, 1998. (See 42 CFR 413.13(c).) CORF providers do not complete lines 9 and 10 for services rendered prior January 1, 1998.

Line 12--Enter the Part B deductibles billed to program patients (from your records) excluding coinsurance amounts.

Line 14--If there is an excess of reasonable cost over customary charges, enter the excess on this line. CORF providers are to complete this line for services rendered on or after January 1, 1998.

Line 16--Enter in column 1, 80 percent of line 15 for title XVIII. Make no entry for titles V and XIX. Make no entry in column 1.01 for CMHC.

Line 17--Enter the actual coinsurance billed to program patients (from your records).

Line 19--Enter reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records).

Line 20--For title XVIII, in column 1, enter the lesser of line 16 plus line 19 or line 18 plus line 19. In column 1.01 enter the result of line 18 plus line 19. For titles V and XIX, enter the sum of lines 8 and 19.

Line 21--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 HCFA Pub. 15-1132ff.) Enter the amount of any excess depreciation taken as a negative number.

Line 22--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 HCFA Pub. 15-I, 1128ff.)

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 HCFA Pub. 15-I 2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 24--Enter the result of line 20 plus or minus lines 22 and 23, minus line 21. Add columns 1 and 1.01 if applicable.

Line 25--Enter the sequestration adjustment, if applicable.

Line 26--Enter the result of line 24 minus line 25.

Line 27--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4. For intermediary final settlement, report on line 27.01 the amount from line 5.99.

Line 28--Enter the balance due provider/program, and transfer this amount to Worksheet S, Part II, columns as appropriate, lines as appropriate.

Line 29--Enter the program reimbursement effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with 115.2. Attach a schedule showing the supporting details and computation.

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

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

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

Line Descriptions

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

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

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

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

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

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

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

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

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

3660. WORKSHEET L - CALCULATION OF CAPITAL PAYMENT

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

Worksheet L consists of the following four parts:

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

COMPLETE ONLY PART I, II, OR III.

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

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

Line Descriptions

Line 1--Enter the amount of the hospital-specific rate portion of capital payments for discharges during the period.

Line 2--Enter the amount of the Federal rate portion of the capital DRG payments for other than outlier during the period.

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

Enter the amount of the Federal rate portion of the additional capital payment amounts relating to the indirect medical education adjustment. (See 42 CFR 412.322.)

Line 4-- Enter the result of dividing total patient days (Worksheet S-3, Part I, column 6, 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 total patient days by nursery days (Worksheet S-3, Part I, column 6, line 11), and swing bed days (Worksheet S-3, Part I, column 6, lines 3 and 4).

Line 4.01--Enter the number of interns and residents from Worksheet S-3, Part I, column 9, line 12. For cost reporting periods beginning on or after October 1, 1997 obtain the intern and resident amount from Worksheet E, Part A, line 3.17

Line 4.02--Enter the result of the following calculation: $\{e^{.2822 \times \text{line 4.01}/\text{line 4}}\} - 1$ where $e = 2.71828$.
(See 42 CFR 412.322(a)(3) for limitation of the percentage of I&Rs to average daily census.)

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

Enter the amount of the Federal rate portion of the additional capital payment amounts relating to the disproportionate share adjustment. Complete these lines if you answered yes to line 36.01 on Worksheet S-2. (See 42 CFR 412.312(b)(3).) For hospitals qualifying for disproportionate share in accordance with 42 CFR 412.106(c)(2) (Pickle amendment hospitals), do not complete lines 5 through 5.02, and enter 35 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.

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

3663. **WORKSHEET M-2 - ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES** complex. If you have more than one provider-based RHC and/or FQHC, complete a separate

Use this worksheet only if you operate a certified provider-based RHC or FQHC as part of your worksheet for each RHC and FQHC facility.

Visits and Productivity--Worksheet M-2 summarizes the number of facility visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 list the types of practitioners (positions) for whom facility visits must be counted and reported.

Column descriptions

Column 1--Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility's practice. (See HCFA Pub. 27, ' 503 for a definition of FTEs).

Column 2--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2401(b) defining a visit.

Column 3--Productivity standards established by HCFA are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each nonphysician practitioner. You are not subject to the productivity standards if **you answered yes to question 13 of Worksheet S-8. If so, then enter the revised standards established by you and your fiscal intermediary.**

Column 4--For lines 1 through 3, enter the product of column 1 and column 3. This is the minimum number of facility visits the personnel in each staff position are expected to furnish.

Column 5--On line 4, enter the greater of the subtotal of the actual visits in column 2 or the minimum visits in column 4 .

Intermediaries have the authority to waive the productivity guideline in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the intermediary will substitute your actual visits if an exception is granted.

On lines 5 through 7 and 9, enter the actual number of visits for each type of position.

Line descriptions

Line 8--Enter the total of lines 4 through 7.

Line 9--Enter the number of visits furnished to facility patients by physicians under agreement with you. Physicians services under agreements with you are (1) all medical services performed at your site by a physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in RHC/FQHC services, physician services furnished in other locations by physicians who are not on your full time staff are paid to you only if your agreement with the physician provides for compensation for such services.

Determination of Total Allowable Cost Applicable To RHC/FQHC Services.--Lines 10 through 18 determine the amount of the overhead costs incurred by both the parent provider and the facility which apply to RHC or FQHC services.

Line 10--Enter the cost of health care services from Worksheet M-1, column 7, line 22.

Line 11--Enter the total nonreimbursable costs from Worksheet M-1, column 7, line 27.

Line 12--Enter the sum of lines 10 and 11 for the cost of all services (excluding overhead).

Line 13--Enter the percentage of RHC or FQHC services. This percentage is determined by dividing the amount on line 10 (the cost of health care services) by the amount on line 12 (the cost of all services, excluding overhead).

Line 14--Enter the total facility overhead costs incurred from Worksheet M-1, column 7, line 31.

Line 15--Enter the overhead costs incurred by the parent provider allocated to the RHC/FQHC. This amount is the difference between the total costs after cost allocation on Worksheet B, Part I, column 27 and Worksheet B, Part I, column 0. If GME costs are claimed on line 20 of Worksheet M-1, do not include the GME costs allocated to the RHC/FQHC in columns 22 and 23 of Worksheet B, Part I.

Line 16--Enter the sum of lines 14 and 15 to determine the total overhead costs related to the RHC/FQHC.

Line 17--If you are claiming allowable GME cost (line 20 of worksheet M-1 completed), divide the total visits reported on line 16 of Worksheet S-8 by the total visits for the facility, **sum of lines 8 and 9, column 2 above**, multiply the result by line 16 above, and enter that amount. If you are not claiming GME enter -0-.

Line 18--Subtract the amount on line 17 from line 16 and enter the result.

Line 19--Enter the overhead amount applicable to RHC/FQHC services. It is determined by multiplying the amount on line 13 (the ratio of RHC/FQHC services to total services) by the amount on line 18 (total overhead costs).

Line 20--Enter the total allowable cost of RHC/FQHC services. It is the sum of line 10 (cost of RHC/FQHC health care services) and line 19 (overhead costs applicable to RHC/FQHC services).

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 HCFA 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.

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. Complete columns 1 and 2 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 HCFA Pub. 27, '505 or from your intermediary.

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

NOTE: If you are based in a small rural hospital with less than 50 beds, Worksheet S-3, Part I, col. 1, line 12 minus line 11, do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2.

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 **2** 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 intern and resident visits reported on Worksheet S-8, column 2, line 16 by the total visits reported on Worksheet M-2, column 2, 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, 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.

Line 21--Enter the total reimbursable Medicare cost. This is equal to the 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 HCFA 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 cost finding process. (See ' 115.2.) A schedule showing the supporting details and computations must be attached.

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**.