
Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 35, Form HCFA-2540-96

Department of Health and
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HEALTH CARE FINANCING
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NEW/REVISED MATERIAL--EFFECTIVE DATE: See Below

Section 101 of the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) provides for a temporary, 20% increase in payment for 15 specified Resource Utilization Groups (RUGs). This increase becomes effective for services furnished beginning on April 1, 2000, and remains in effect until the date that HCFA implements a refined case-mix classification system. Section 101 of the BBRA also provides for an additional 4% increase in payment for ALL services furnished during fiscal years (FYs) 2001 and 2002.

Worksheet H-5, Part V adds column 5.01 (Medicare Program Visits for Services on or after January 1, 1999) for physical speech and occupational therapy services rendered to non-homebound beneficiaries. These services are reimbursed based on the physician fee schedule. Consequently, the visits associated with these services have no reimbursement impact, but are captioned for statistical purposes.

HHA's with cost reporting periods beginning in the Federal fiscal year 2000 only (10/1/1999 - 9/30/2000) will be reimbursed for costs associated with the Outcome and Assessment Information Set (OASIS) as required by Program Memorandum A-00-03. Worksheet H-6, line 20.01 "Other Adjustments" instructions are revised to reflect the reporting of these costs by multiplying the Medicare Unduplicated Census Count on Worksheet S-4, column 2, line 9, times \$10.00, minus the interim OASIS payment made to the provider on April 1, 2000. This procedure will be undertaken by fiscal intermediaries during final settlement.

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.

Columns 22 and 23.--The average number of employees (full-time equivalent) 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 payroll at the beginning of each quarter and divide the sum by four times the number of hours in the standard work period. When semiannual data are used, add the total number of hours worked by all employees on the first payroll of the first and seventh months of the period, and divide this sum by two times the number of hours in the standard work period. Enter the average number of paid employees in column 22 and the average number of non-paid worker's in column 23 for each component, an applicable.

3509.1 Part II - SNF Wage Index Information.--This part provides for the collection of skilled nursing facility and nursing facility data to develop an SNF wage index that is applied to the labor related portion of the SNF cost limits. The Social Security Act Amendments of 1994 (P.L. 103-432) requested the Secretary to begin collecting data on employee compensation and hours of employment specific to skilled nursing facilities for the purposes of constructing an SNF wage index. In order to collect the data necessary to develop an SNF wage index, HCFA has developed an SNF wage index form, as part of the cost report, to be completed by all SNFs.

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

Line 1.--Enter the wages and salaries paid to employees from Worksheet A, column 1, line 75.

Line 2.--Enter physician salaries paid to employees which are included on Worksheet A, column 1, line 75.

Line 3.--Enter the total physician and physician assistant salaries and wage related costs that are related to patient care and are included on line 1. Under Medicare, these services are billed separately under Part B.

Line 4.--Enter from Worksheet A the sum of salaries reported in column 1 of line 14 for interns and residents. Base the hours reported in column 4 on 2080 hours per each full time intern and resident employee.

Line 5.--If you are a member of a chain or other related organization, as defined in HCFA Pub 15-I, 2150, enter the allowable wages and salaries and wage related costs for home office personnel from your records that are included in line 1.

Line 6.--Enter the sum of lines 2 through 5.

Line 7.--Subtract line 6 from line 1 and enter the result.

Line 8.--Enter the total of Worksheet A, column 1, line 19. This amount represents other long term care.

Line 9.--Enter the total of Worksheet A, column 1, line 20. This amount represents other inpatient routine service. For cost reports ending on and after 11/30/1999, do not use this line.

Line 10.--Enter the amount from Worksheet A, column 1, line 49.

Line 11.--Enter the total of Worksheet A, column 1, lines 37 through 47. If these lines are subscripted to accommodate more than one HHA, also enter the total of the subscripted lines.

Line 12.--Enter the amount from Worksheet A, column 1, line 50.

Line 13.--Enter the amount from Worksheet A, column 1, line 55.

Line 14.--Enter the amount from Worksheet A, column 1, lines 58 through 63.

Line 15.--Enter the sum of lines 8 through 14.

Line 16.--Subtract line 15 from line 7 and enter the result.

Line 17.--Enter the amount paid (include only those costs attributable to services rendered in the SNF and/or NF), rounded to the nearest dollar, for contracted direct patient care services, i.e., nursing, therapeutic, rehabilitative, or diagnostic services furnished under contract rather than by employees and management contract services as defined below. Report only those personnel costs associated with these contracts. Eliminate all supplies and other miscellaneous items. Do not apply the guidelines for contracted therapy services under §1861(v)(5) of the Act and 42 CFR 413.106.

For example, you have a contract with a nursing service to supply nurses for the general routine service area on weekends. Contracted labor for purposes of this worksheet does NOT include the following services: consultant contracts, billing services, legal and accounting services, Part A CRNA services, clinical psychologists and clinical social worker services, housekeeping services, planning contracts, independent financial audits, or any other service not directly related to patient care.

Include the amount paid (rounded to the nearest dollar) for contract 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 facility in the capacity of chief executive, 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 labor does **NOT** include the following services: other management or administrative services, consultative services, unmet physician guarantees, physician services, clinical personnel, security personnel, housekeeping services, planning contracts, independent financial audits, or any other services not related to the overall management and operation of the facility.

Per instructions on Form HCFA-339, details, including the type of service, wages, and hours associated with each direct patient care related contract must be submitted to your intermediary as well as the aggregate total wages and hours for management contracts.

In addition, if you have no contracted labor as defined above or management contract services, 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.

Column 4.01.--Enter the number of demonstration inpatient days applicable to each group associated with the rate in effect January 1 through the end of your fiscal year. Enter the total on line 46.

Add the amounts on line 46, columns 3.01 and 4.01, and enter the result on Worksheet E, Part V, line 2.

Column 5.--Calculate the total for each revenue group by multiplying the rate by the days covered by that rate. Where you must report two rates and two sets of days for each group, multiply the rate in column 3 by the days in column 3.01. Multiply the second rate in column 4 by the days in column 4.01. For each line (group), add the product of column 3 multiplied by the 3.01 plus the product of columns 4 multiplied by 4.01, and enter the result in column 5 on the same line. Add lines 1 through 45, column 5, and enter the total on line 46. Transfer column 5, line 46, to Worksheet E, Part V, line 6.

3514.2 Part II- PPS Statistical Data. --Complete this part for cost reporting periods beginning on and after July 1, 1998. Use this part to report the Medicare days of the provider by RUG. The total on line 46 must agree with the amount on Worksheet S-3, column 4, line . This part has been revised with the issuance of Transmittal # 5. As of the issuance of Transmittal # 5, Part II has been replaced with Part III, and should not be completed.

3514.3 Part III - PPS Statistical Data.-- **Complete Part III for cost reporting periods beginning on or after July 1, 1998.** Use this part to report the Medicare days of the provider by RUG. The required information is for the provider's transition periods.

Transition Period.-- Indicate the applicable transition period. Your fiscal intermediary will provide you with this status. Example: If your cost report year begins on July 1, 1998, check the box for year number 1. For the next fiscal year beginning on July 1, 1999, check the box for year number 2. For the following fiscal year beginning on July 1, 2000, check the box for year number 3. For the last fiscal year in the transition period beginning on July 1, 2001, check the box for year number 4.

EXCEPTION: THE TRANSITION PERIOD PAYMENT METHOD DOES NOT APPLY TO A SNF THAT (1) ELECTED FOR IMMEDIATE TRANSITION TO FEDERAL RATE UNDER §102 OF THE BALANCED BUDGET REFINEMENT ACT OF 1999, OR (2) FIRST RECEIVED MEDICARE PAYMENTS (INTERIM OR OTHERWISE) ON OR AFTER OCTOBER 1, 1995 UNDER PRESENT OR PREVIOUS OWNERSHIP. THESE FACILITIES ARE PAID BASED ON ONE HUNDRED PERCENT (100%) OF THE FEDERAL RATE. Enter this rate in column 5.

For the first year of the provider's transition period, the PPS rate will be twenty-five percent (25%) of the Federal Case Mix Rate and seventy-five percent (75%) of the Facility Specific Rate. In the second year of the Provider's transition period, the PPS rate will be fifty percent (50%) of the Federal Case Mix Rate and fifty percent (50%) of the Facility Specific Rate. For the third year of the Provider's transition period, the PPS rate will be seventy-five percent (75%) of the Federal Case Mix Rate and twenty-five percent (25%) of the Facility Specific Rate. For the fourth and final year of the Provider's transition period, the PPS rate will be one hundred percent (100%) of the Federal Case Mix Rate. See columns 9 and 10 below.

Column 2-- Enter the Federal Specific Rate on each applicable RUG line.

Column 3-- Enter the Federal Case Mix rate applicable to each RUG for services from the beginning of the fiscal year through September 30.

Column 4--Enter the number of days applicable to each RUG for services from the beginning of the fiscal year through September 30.

NOTE: See special instructions below to subscript columns 3 and 4 for certain high-cost RUG's.

Column 5-- Enter the Federal Case Mix rate applicable to each RUG for services from October 1, through the end of the fiscal year. For services furnished on and after October 1, 2000, through the end of the provider's fiscal year, (1) enter the Federal Case Mix rate applicable to each of the fifteen High-Cost RUG'S listed below, (2) enter the Federal Case Mix rate times 104% for each NON-High-Cost RUG

Column 6--Enter the number of days applicable to each RUG for services from October 1 through the end of the fiscal year.

The total on line 75, columns 4, 4.01, 6, and 6.01 must agree with the amount on Worksheet S-3, Part I, column 4, line 1. Do not use columns 3 and 4 for a cost report period that begins on October 1. Report the applicable Federal Case Mix rates in column 5 and the Medicare days for each RUG in column 6.

Column 7--Multiply the rates in column 3 times the days in column 4. Round to zero places. Multiply the rates in column 3.01 times the days in column 4.01. Round to zero places. Multiply the rates in column 5 times the days in column 6. Round to zero places. Multiply the rates in column 5.01 times the days in column 6.01. Round to zero places. Add the results from column 4, 4.01, 6, and 6.01. Enter the combined total on each line. Round each line in column 7 to zero decimal places.

Column 8--Multiply the Facility Specific rate times the total program annual days (sum of columns 4, 4.01, 6 and 6.01) for each RUG, and enter the product in column 8.

Columns 9--Multiply the Federal amount in column 7 times your transition period percentage. I.E. year # 1 is 25%, year # 2 is 50%, year # 3 is 75%, an year # 4 and forward is 100%. Enter the results on the appropriate line for each RUG. Enter the sum of lines 1 through 45 on line 75.

Column 10--Multiply the facility specific amount times the reciprocal percentage applied to the Federal rate, I.E. 75%, 50%, 25%, or 0%. Enter the result on the appropriate line for each RUG. Enter the sum of lines 1 through 45 on line 75. Add the amount in column 9, line 75, plus the amount in column 10, line 75, together, and transfer this total to Worksheet E, Part III, line 7.

SPECIAL INSTRUCTIONS TO CALCULATE THE INCREASE FOR CERTAIN HIGH-COST PATIENTS, EFFECTIVE FOR SERVICES FURNISHED ON AND AFTER APRIL 1, 2000.

Section 101 of the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) provides for a temporary, 20% increase in payment for 15 specified RUGs (listed below). The BBRA provides that this 20% increase becomes effective for services furnished beginning on April 1, 2000, and remains in effect until the date that HCFA implements a refined case-mix classification system. The following is a list of the affected RUGs along with the corresponding line on Worksheet S-7, Part III.

<u>RUG</u>	<u>Line #</u>	<u>RUG</u>	<u>Line #</u>
RHC	7	RMC	10
RMB	11	SE3	15
SE2	16	SE1	17
SSC	18	SSB	19
SSA	20	CC2	21
CC1	22	CB2	23
CB1	24	CA2	25
CA1	26		

Subscript columns 3 and 4 of this worksheet to columns 3.01 and 4.01 respectively. Identify column 3.01 as "Federal Rate – High Cost Add-On", (for services between April 1, 2000 and September 30, 2000). Identify column 4.01 as "Add-On Days" (for services between April 1, 2000 and September 30, 2000). Enter in column 3.01 for each of the 15 lines identified above, 20% of the amount on the corresponding line in column 3. Enter in column 4.01 the days applicable to services, for the 15 lines listed above, from April 1, 2000 through September 30, 2000 or the end of the fiscal year. Where the fiscal year ends between April 2, 2000 and September 30, 2000, the provider should report in column 4.01 only the days applicable for April 1 through the end of the fiscal year. The days from the beginning of the next fiscal year through September 30, 2000 will be reported in column 4.01 of the subsequent cost report.

Section 101 of the BBRA also provides for an additional 4% increase in payment for ALL services furnished during fiscal years (FYs) 2001 and 2002. Therefore, for services furnished after September 30, 2000, and before October 1, 2002, columns 5 and 6 of this worksheet should be subscripted to columns 5.01 and 6.01, respectively. Identify column 5.01 as "Federal Rate – High Cost Add-On" (for services after September 30), and identify column 6.01 as "Add-On Days" (for services after September 30). Enter in column 5.01 for each line identified above, 24% of the Federal Case Mix Rate. Enter in column 6.01 the days applicable to services associated with the high cost RUGs (as listed above), from October 1, 2000 to the end of the provider's fiscal year.

All of the NON high cost RUG rates will be increased by 4%. Enter in column 5, the Federal Case Mix Rate times 104% for the following RIG's:

<u>RUG</u>	<u>Line #</u>	<u>RUG</u>	<u>Line #</u>
RUC	1	RUB	2
RUA	3	RVC	4
RVB	5	RVA	6
RHB	8	RHA	9
RMA	12	RLB	13
RLA	14	IB2	27
IB1	28	IA2	29
IA1	30	BB2	31
BB1	32	BA2	33
BA1	34	PE2	35
PE1	36	PD2	37
PD1	38	PC2	39
PC1	40	PB2	41
PB1	42	PA2	43
PA1	44	Default Rate	45

Line 14.--Enter the amount received from the sale of meals to employees. This income offsets the dietary expense.

Line 15.--Enter the cost of meals provided for non-employees. This amount offsets the allowable dietary costs.

Line 20.--Enter the cash received from imposition of interest, finance, or penalty charges on overdue receivables. This income must offset the allowable administrative and general costs. (See HCFA Pub. 15-I,§2110.2.)

Line 21.--Enter the interest expense imposed by the intermediary on Medicare overpayments to you. Also, enter the interest expense on borrowing made to repay Medicare overpayments to you. (See HCFA Pub 15-I, chapter 2.)

For therapy services provided on or after April 10, 1998, complete lines 22-25, as follows:

Line 22.--Enter the adjustment for speech therapy services in excess of the limitation for the SNF from Worksheet A-8-5, Part VII, line 77. Subscript this line to report the adjustment for speech therapy for each subprovider as follows:

Line 22.10 --Enter the adjustment for speech therapy in excess of the limitation for all SNF-based CORF services from Worksheet A-8-5, Part VII, sum of lines 78-78.90, if line 78 is subscripted; otherwise, enter the amount from line 78.

Line 22.20--Enter the adjustment for speech therapy in excess of the limitation for all SNF-based CMHC services from Worksheet A-8-5, Part VII, sum of lines 79-79.90, if line 79 is subscripted; otherwise, enter the amount from line 79.

Line 22.30--Enter the adjustment for speech therapy in excess of the limitation for all SNF-based OPT services from Worksheet A-8-5, Part VII, sum of lines 80-80.90, if line 80 is subscripted; otherwise, enter the amount from line 80.

Line 22.50--Enter the adjustment for speech therapy in excess of the limitation for all SNF-based HHA services from Worksheet A-8-5, Part VII, sum of lines 81-81.90, if line 81 is subscripted; otherwise, enter the amount from line 81.

Line 23--For services provided on or after April 10, 1998, add the adjustment for occupational therapy in excess of the limitation for the SNF from Worksheet A-8-5, Part VII, line 77. Subscript this line to report the adjustment for occupational therapy for each subprovider as follows:

Line 23.10 --Enter the adjustment for occupational therapy in excess of the limitation for all SNF-based CORF services from Worksheet A-8-5, Part VII, sum of lines 78-78.90, if line 78 is subscripted; otherwise, enter the amount from line 78.

Line 23.20--Enter the adjustment for occupational therapy in excess of the limitation for all SNF-based CMHC services from Worksheet A-8-5, Part VII, sum of lines 79-79.90, if line 79 is subscripted; otherwise, enter the amount from line 79.

Line 23.30--Enter the adjustment for occupational therapy in excess of the limitation for all SNF-based OPT services from Worksheet A-8-5, Part VII, sum of lines 80-80.90, if line 80 is subscripted; otherwise, enter the amount from line 80.

Line 23.50--Enter the adjustment for occupational therapy in excess of the limitation for all SNF-based HHA services from Worksheet A-8-5, Part VII, sum of lines 81-81.90, if line 81 is subscribed; otherwise, enter the amount from line 81. For HHA services provided prior to April 10, 1998, also add the amount from Worksheet A-8-3, Part VII, line 63 and enter on this line.

Line 24.--Enter the amount for an adjustment for respiratory therapy in excess of limitation for the SNF. Obtain the amount from Worksheet A-8-4, Part V, line 46, for services provided before April 10, 1998. Obtain the amount from Worksheet A-8-5, Part VII, line 77, for services provided on or after April 10, 1998. For providers with cost reporting periods which straddle the April 10, 1998 implementation date, line 24 should be a combination of the amounts from Worksheet A-8-4, Part V, line 46 and Worksheet A-8-5, Part VII, line 77. Subscript this line to report the adjustment for respiratory therapy services for each subprovider, as follows:

Line 24.10 --Enter the adjustment for respiratory therapy in excess of the limitation for all SNF-based CORF services from Worksheet A-8-5, Part VII, sum of lines 78-78.90, if line 78 is subscribed; otherwise, enter the amount from line 78.

Line 24.20--Enter the adjustment for respiratory therapy in excess of the limitation for all SNF-based CMHC services from Worksheet A-8-5, Part VII, sum of lines 79-79.90, if line 79 is subscribed; otherwise, enter the amount from line 79.

Line 24.30--Enter the adjustment for respiratory therapy in excess of the limitation for all SNF-based OPT services from Worksheet A-8-5, Part VII, sum of lines 80-80.90, if line 80 is subscribed; otherwise, enter the amount from line 80.

Line 25.--Enter the adjustment for physical therapy in excess of the limitation for all SNF services. Obtain the amount from Worksheet A-8-3, Part VI, line 57 for services provided prior to April 10, 1998. For services provided on or after April 10, 1998, also enter the amount of physical therapy in excess of the limitation for SNF services from Worksheet A-8-5, Part VII, line 77. The adjustment will be the sum of these amounts. Subscript this line to report the adjustment for respiratory therapy services for each subprovider, as follows:

Line 25.10 --Enter the adjustment for physical therapy in excess of the limitation for all SNF-based CORF services from Worksheet A-8-5, Part VII, sum of lines 78-78.90, if line 78 is subscribed; otherwise, enter the amount from line 78.

Line 25.20--Enter the adjustment for physical therapy in excess of the limitation for all SNF-based CMHC services from Worksheet A-8-5, Part VII, sum of lines 79-79.90, if line 79 is subscribed; otherwise, enter the amount from line 79.

Line 25.30--Enter the adjustment for physical therapy in excess of the limitation for all SNF-based OPT services from Worksheet A-8-5, Part VII, sum of lines 80-80.90, if line 80 is subscribed; otherwise, enter the amount from line 80.

Line 25.50--Enter the adjustment for physical therapy in excess of the limitation for all SNF-based HHA services from Worksheet A-8-5, Part VII, sum of lines 81-81.90, if line 81 is subscribed; otherwise, enter the amount from line 81. For HHA services provided prior to April 10, 1998, also add the amount from Worksheet A-8-3, Part VII, line 63 and enter on this line. The adjustment will be the sum of these amounts.

Line 19.--Add the amounts on lines 17 and 18 to determine the total program general inpatient routine service cost.

Line 20.--Enter the capital-related cost allocated to the general inpatient service cost center from Worksheet B, Part II, column 18, SNF from line 16, NF from line 18, or ICF/MR from line 18.1. See exception after line 5 above.

Line 21.--Determine the per diem capital-related cost by dividing line 20 by inpatient days on line 1.

Line 22.--Determine the program capital-related cost by multiplying line 20 by line 3.

Line 23.--Determine the inpatient routine service cost by subtracting the amount on line 21 from the amount on line 19.

Line 24.--Obtain the aggregate charges to beneficiaries for excess costs from your records.

Line 25.--Obtain the total program routine service cost for comparison to the cost limitation by subtracting the amount on lines 24 from the amount on line 23.

Line 26. --Enter the per diem limitation. This line will not be used for cost reporting periods beginning on and after July 1, 1998.

Line 27. --Obtain the inpatient routine service cost limitation by multiplying the number of inpatient days shown on line 3 by the cost limit for inpatient routine service cost applicable to you for the period for which the cost report is being filed. This amount is provided by your intermediary and is entered in the space provided in the line description. **Line 27 will not be calculated for PPS cost reports with fiscal years beginning on and after July 1, 1998**

Line 28.--Enter the amount of reimbursable inpatient routine service cost which is determined by adding line 22 to the lesser of lines 25 or 27. Transfer this amount to the appropriate Worksheet E, **Part I, line 4. For PPS cost reports with fiscal years beginning on and after July 1, 1998, enter the amount from line 19. No amount will be transferred for title XVIII to Worksheet E, Part I.**

3531.2 Part II - Calculation of Inpatient Intern and Resident Cost for PPS Passthrough.--This part is applicable for cost reporting periods beginning on and after July 1, 1998.

Line 1. --Enter the total inpatient days from Worksheet S-3, Part I, column 7, line 9, less the hospice days on line 8.

Line 2. --Enter the title XVIII inpatient days from Worksheet S-3, Part I, column 4, line 1.

Line 3. --Enter the program intern and resident cost from Worksheet B, Part I, column 14, line 14.

Line 4. --Calculate the ratio of program days to total days. Divide line 2 by line 1.

Line 5. --Calculate the intern and resident pass through cost. Multiply the amount on line 3 times the amount on line 4. Transfer this amount to Worksheet E, Part III, line 2.

3532. WORKSHEET D-2 - APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

3532.1 Part I - Not in Approved Teaching Program.--Use this part only if you have interns and residents who are not in an approved teaching program. (See HCFA Pub. 15-I, chapter 4.)

Column 1.--Enter the percentage of time that interns and residents are assigned to each of the indicated patient care areas on lines 2 through 11, 13, and 14 (from your records).

Column 2.--Enter on line 1 the total cost of services rendered in all patient care areas from Worksheet B, Part I, column 18, line 49. Multiply the percent in column 1 for each line by the total cost in column 2, line 1. Enter the resulting amounts on the appropriate line in column 2.

A. Inpatient.--

Column 3.--Enter the total inpatient days applicable to the various patient care areas of the complex:

<u>Description</u>	<u>Enter in Col. 3</u>	<u>Inpatient Days From</u>
SNF	line 2	Worksheet S-3, Part I, col. 4, line 1
SNF PPS	line 2	Worksheet S-3, Part I col. 7, line 1
NF	line 4	Worksheet S-3, Part I col. 3 or 5, line 3
ICF/MR	Line 4.1	Worksheet S-3, Part I col. 5, line 3.1

Column 4.--Divide the allocated expenses in column 2 by the inpatient days in column 3 to arrive at the average per diem cost for each cost center.

Columns 5, 6, and 7.--Enter in the appropriate column the health care program inpatient days for each patient care area.

Titles V and XIX

<u>Description</u>	<u>Enter in column 5 for title V or column 7 for title XIX</u>	<u>From</u>
SNF	line 2	Worksheet D-1, line 3
NF	line 4	Worksheet D-1, line 3
ICF/MR	Line 4.1	Worksheet D-1, line 3

Title XVIII.--Enter in column 6, line 2 the total number of days in which beneficiaries were inpatients of the provider and had Medicare Part B coverage. Determine such days without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days. The following reconciliation format is recommended.

3544.3 Part III - Supplies and Drugs Cost Computation.--Certain items covered by Medicare and furnished by an HHA are not included in the visit for apportionment purposes. Since an average cost per visit and the cost limit per visit do not apply to these items, the ratio of total cost to total charges is developed and applied to Medicare charges to arrive at the Medicare cost for these items. Enteral/parenteral nutrition therapy (EPNT) items which are considered prosthetic devices furnished by an HHA on or after March 14, 1986, are reimbursed on a reasonable charge basis through billings submitted to the DMERC. (As a prosthetic device, such services are reimbursable only under Part B.) Charges for these items must be included in the total charges, but excluded from title XVIII charge statistics in the apportionment of medical supply costs on Part IV, line 15.

NOTE: For services furnished on or after January 1, 1989, the HHA Part A reimbursement for DME, prosthetics, and orthotics was changed from cost reimbursement to a fee schedule reimbursement.

Additionally, certain items furnished by an HHA on or after January 1, 1990, are not considered as DME. This includes medical supplies such as catheters, catheter supplies, ostomy bags, and supplies relating to ostomy care.

NOTE: Injectable drugs are a Part B service only.

Lines 15 and 16--Enter in column 2 the applicable costs of each line item from Worksheet H-4, Part I, column 5, lines 10 and 11, respectively. Enter in column 3 the total charges applicable for each line. Enter in column 4 the ratio of HHA costs (column 2) to HHA charges (column 3) for each line.

Line 15--Enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule.

Line 16--Enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration. Enter in column 7 the charge for covered osteoporosis drugs furnished on or after January 1, 1991 and on or before December 31, 1995. (See §1861(s)(2)(O) of the Act.)

Column 8--To determine the Medicare Part A cost, multiply the Medicare charges (column 5) by the ratio (column 4) for each line item. Enter the product in column 8.

Column 9--To determine the Medicare Part B cost, multiply the Medicare charges (column 6) by the ratio (column 4) for each line item. Enter the product in column 9.

Column 10--To determine the Medicare Part B cost (subject to deductibles and coinsurance), multiply the Medicare charges (column 7) by the ratio (column 4). Enter the product in column 10.

3544.4 Part IV - Comparison of the Lesser of Aggregate Medicare Cost, the Aggregate of the Medicare Cost Per Visit Limitation and the Aggregate Per Beneficiary Cost Limitation.--This part provides for the comparison of the reasonable cost limitation, applied to each home health agency's total allowable cost attributable to Medicare patient care visits. This comparison is required by 42 CFR 413.53 and 42 CFR 413.30. For cost reporting periods beginning on or after October 1, 1997, §1861(v)(1)(L) of the Social Security Act is amended by §4601 of BBA 1997, requiring home health agency net cost of covered services to be based on the lesser of aggregate Medicare cost, the aggregate of the Medicare limitation, or the agency specific per beneficiary annual cost limit. The per beneficiary cost limitation is derived by totaling the application of each MSA/non-MSA's unduplicated census count (two decimal places) (see §3527) to the per beneficiary cost limitation for the corresponding MSA/non-MSA. To accomplish this, the sum of all worksheets H-5, Part II, amounts in column 11, line 7, plus the applicable cost of medical supplies is compared with the sum of all worksheet H-5, Part II amounts in column 11, line 14, plus the applicable cost of medical supplies and with the amount in column 6, line 24.

Line 18--Enter the sum of the amounts from each Part II, columns 8, 9, and 11, respectively, line 7. Enter the results in the corresponding column.

Line 19--Enter the sum the amounts from each Part II, columns 8, 9 and 11, respectively, line 14. Enter the results in the corresponding column.

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

Line 21--Enter the total cost per visit limitation for Medicare services which is the sum of the amounts from each Worksheet H-5, Part II, columns 8, 9, and 10 respectively, line 14.

Line 22--Enter the cost of medical supplies from Part III, columns 8 and 9, line 15.

Line 24--Enter the per beneficiary cost limitation for each MSA/non-MSA area serviced by the HHA. Line 24 will have to be subscribed for each area. For each MSA/non-MSA enter the following:

Column 2--Enter your HHA's blended agency-specific per beneficiary annual limit. Obtain this amount from your intermediary.

Columns 3 and 4--(Complete column 6 prior to the completion of columns 3 and 4.) Complete columns 3 and 4 only if column 6, line 25 is less than column 6, lines 18 and 21. Enter in column 3 the result of column 3, line 18 divided by column 6, line 18 multiplied by column 6, line 25. Enter on line 25 in column 4 the result of column 4, line 18 divided by column 6, line 18 multiplied by column 6, line 25.

Line 25--In column 1 (two decimal places) and 6, respectively, enter the sum of lines 24 (line 24 plus **all subscripted lines 24**). Enter in column 3, the result of column 3, line 20 divided by column 6, line 20, multiplied by column 6, line 25. Enter on line 25 in column 4, the result of column 4, line 20, divided by column 6, line 20, multiplied by column 6, line 25. (The sum of columns 3 and 4 must equal column 6.)

NOTE: The total Medicare (title XVIII) unduplicated census count (Worksheet S-4, column 3, line 9) must equal the sum of the unduplicated census count for all MSAs (Worksheet H-5, Part IV, column 6, line 25).

3544.5 Part V - Outpatient Therapy Reduction Computation.--This section computes the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology and outpatient occupational therapy) provided under arrangement for beneficiaries who are not homebound as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998. For outpatient therapy services rendered on or after January 1, 1999, §4541 of the BBA 1997 mandates a fee schedule payment basis for outpatient physical, outpatient occupational therapy, and outpatient speech pathology. Therefore, any outpatient therapy services furnished on or after January 1, 1999, must not be included in this section due to the application of a fee schedule for these services, but the corresponding visits must be recorded in column 5.01. These outpatient therapy services are reimbursed the lesser of the fee schedule amount or the statutory limitation which is applied on a beneficiary specific basis through the Medicare claims system. This requires no provider input on the cost report.

Column 2--Enter in column 2 the average cost per visit amount for each discipline from Part I, column 4, lines as indicated.

Columns 3 and 4--To determine the Medicare Part B cost of services subject to deductibles and coinsurance, multiply the total number of covered Part B visits made before January 1, 1998 by non-homebound program beneficiaries to rehabilitation facilities under arrangement (column 3) from your records by the average cost per visit amount in column 2 for each discipline. Enter the result in column 4.

Columns 5, 5.01 and 6--Enter in column 5 the number of Medicare covered Part B visits from your records made by non-homebound program beneficiaries to rehabilitation facilities under arrangement for services furnished January 1, 1998 through December 31, 1998 only. Enter in column 5.01 the number of Medicare covered Part B visits from your records made by non-homebound program beneficiaries to rehabilitation facilities under arrangement for services furnished on or after January 1, 1999. Outpatient therapy service visits rendered on or after January 1, 1999 are reimbursed based on a fee schedule as described above. Determine the Medicare cost of services subject to deductibles and coinsurance by multiplying the amount in column 5 by the average cost per visit amount in column 2 for each discipline. Enter the result in column 6. The non-homebound visits captured in column 5.01 are for statistical purposes only and do not impact the settlement.

Column 7--Compute the reasonable cost reduction by multiplying the cost of Medicare services in column 6 by 90% (.90). This is the application of the 10% reasonable cost reduction. Enter the result in column 7.

Column 8--Compute the reasonable costs net of the reduction by adding column 7 to column 4. Enter the result in column 8.

Line 29--For columns 3 through 8, enter the sum of lines 26 through 28.

3545 WORKSHEET H-6 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT
- PART A AND PART B SERVICES

Worksheet H-6 consists of the following two parts:

- Part I - Computation of the Lesser of Reasonable Cost or Customary Charges. This part provides for the reimbursement calculation of title XVIII, Part A and Part B, and title V and title XIX. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30. Use column 1 for Titles V and XIX.
- Part II - Computation of HHA Reimbursement Settlement. Complete this part for titles V, XVIII, and XIX, as applicable.

3545.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--Services not paid for 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 or customary charges. Use column 1 for titles V and XIX.

Line Descriptions

Line 1.--This line provides for the computation of reasonable cost of title XVIII, Part A and Part B services. Enter the cost of services from Worksheet H-5, Part III as follows.

If the amount in column 6, line 20 is less than the amount in column 6, line 23, and the amount in column 6, line 25, transfer (aggregate Medicare cost):

To Worksheet H-6, Line 1

From Worksheet H-5

Col. 1, Part A.

Part IV, Col. 3, line 20

Col. 2, Part B.

Part III, Sum of col. 9, line 16 and Part IV, col. 4, line 20

Col. 3, Part B.

Part III, Sum of col. 10, lines 15 and 16 and Part V, col. 8, line 29

If the amount in column 6, line 23 is less than the amount in column 6, line 20, and the amount in column 6, line 25, transfer (aggregate Medicare limitation):

To Worksheet H-6, Line 1

From Worksheet H-5

Col. 1, Part A.

Part IV, Col. 3, line 23

Col. 2, Part B

Part III, Sum of col. 9, line 16 and Part IV, col. 4, line 23

Col. 3, Part B.

Part III, Sum of col. 10, lines 15 and 16 and Part V, col. 8, line 29.

Line 17.-- Where your cost limit is raised as a result of your request for review, amounts which were erroneously collected on the basis of the initial cost limit are required to be refunded to the beneficiary. Enter any amounts which are not refunded, either because they are less than \$5 collected from a beneficiary or because you are unable to locate the beneficiary. (See HCFA Pub. 15-I, §2577.)

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

Line 19.--Enter the applicable sequestration adjustment. (See §120 for a detailed explanation.)

Line 20.01.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from a cash basis to an accrual basis. (See HCFA Pub. 15-1, §2146.4.) For purposes of reimbursing costs associated with the Outcome and Assessment Information Set (OASIS) as required by Program Memorandum A-00-03 for cost reporting periods beginning in the Federal fiscal year 2000 only (October 1, 1999 through September 30, 2000), report on this line, in column 1, the result of multiplying the Medicare unduplicated census count on Worksheet S-4, column 2, line 9, times \$10.00, minus the interim OASIS payment made to the provider on April 1, 2000. (For fiscal intermediary use only during final settlement.) Since other adjustments are normally subtracted from total costs, the OASIS amount must be input as a negative amount to effectuate the addition of this amount.

Line 22.--Enter the amount on line 20 plus the amount on line 20.01, minus the amount of line 21. The amounts on this line show the balance due to you or to the program and are transferred to Worksheet S, Part II, columns 2, 3, or 4, as appropriate, line 4. Indicate overpayments by parentheses ().

Line 23.--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of items as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the supporting details and computation for this line.

3551. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS

Use this worksheet if you operate a SNF-based CORF, a SNF-based CMHC, a SNF-based OPT, a SNF-based OOT, or a SNF-based OSP. Complete a separate worksheet for each provider.

3551.1 Part I - Allocation of General Service Costs to Outpatient Rehabilitation Provider Cost Centers.-- Worksheet J-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 22) from Worksheet A, column 7, line 50. Obtain the cost center allocation (column 0, lines 1 through 21) from your records.

3551.2 Part II - Computation of Unit Cost Multiplier for Allocation of Outpatient Rehabilitation Provider Administrative and General Costs.--

3551.3 Part III - Allocation of General Service Costs to Outpatient Rehabilitation Provider Cost Centers -Statistical Basis.--Worksheet J-1, Parts II and III provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet J-1, Part I.

To facilitate the allocation process, the general format of Worksheet J-1, Parts I and III, is identical.

The statistical basis shown at the top of each column on Worksheet J-1, Part III is the recommended basis of allocation of the cost center indicated.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year if received by the intermediary, in writing, within 90 days prior to the end of the fiscal year. The intermediary has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, is changed due to simplification of maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until an approval is made. If both sets of statistics are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used.

Lines 1 through 21.--On Worksheet J-1, Part III, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 22.--Enter the total of lines 1 through 21 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 50.

Line 23.--Enter the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B, Part I, line 50, from the same column used to enter the statistical base on Worksheet J-1, Part III (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 50).

Line 24.--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 23 by the total statistic entered in the same column on line 22. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet J-1, Part I in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 22, Part I) must equal the total cost on line 23, Part III.

Perform the preceding procedures for each general service cost center.

In column 16, Part I, enter the total of columns 3a through 15.

In Part II, compute the unit cost multiplier for allocation of the components' administrative and general costs as follows.

Line 1.--Enter the amount from Part I, column 18, line 22.

Line 2.--Enter the amount from Part I, column 18, line 1.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Divide the amount on line 2 by the amount on line 3 and enter the result rounded to six decimal places.

In column 19, Part I, for lines 2 through 21, multiply the amount in column 18 by the unit cost multiplier on line 4, Part II, and enter the result in this column. On line 22, enter the total of the amounts on lines 2 through 21. The total on line 22 equals the amount on column 18, line 1.

In column 20, Part I, enter on lines 2 through 21 the sum of the amounts in columns 18 and 19. The total in column 20, line 22 must equal the total in column 18, line 22.

3552. WORKSHEET J-2 - COMPUTATION OF COMPONENT COSTS

Use this worksheet if you operate a SNF-based CORF, a SNF-based CMHC, a SNF-based OPT, a SNF-based OOT, or a SNF-based OSP. Complete a separate worksheet for each provider.

3552.1 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 20. To facilitate the apportionment process, the line number designations are the same on both worksheets.

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

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

Columns 4, 6, and 8.--For each cost center, enter the charges from your records for title V, title XVIII, and title XIX patients, respectively.

Columns 5, 7, and 9.--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, respectively, by the ratio in column 3.

Line 22.--Enter the totals for columns 1, 2, and 4 through 9.

Column 10, lines 3, 4, 5, 24, 25 and 26. --For each cost center, enter the title XVIII charges (from your records) for services rendered on and after January 1, 1998.

Column 11, lines 3, 4, 5, 24, 25 and 26. --Determine the title XVIII cost for services rendered on or after January 1, 1998 by multiplying the charges in column 10 by the ratio in column 3, and enter the result.

Column 12, lines 3, 4, 5, 24, 25 and 26. --Determine the reduction amount by multiplying the cost in column 11 by the ten percent cost reduction, and enter the result.

Column 13, lines 3, 4, 5, 24, 25 and 26. --Determine the title XVIII cost net of applicable cost reduction by subtracting the amount in column 12 from the amount in column 9. For lines 2, 6 through 21, 23, and 27 through 29, enter the cost from column 9.

3552.2 Part II - Apportionment of Cost of Outpatient Rehabilitation Services Furnished by Shared Skilled Nursing Facility Departments.--Use this part only when the SNF complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the skilled nursing facility's outpatient rehabilitation facility.

Column 3.--For each of the cost centers listed, enter the ratio of cost to charges that is shown on Worksheet C, column 3, 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 patients, respectively.

Columns 5, 7, and 9.--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8 respectively by the ratio in column 3.

Line 30.--Enter the totals for columns 4 through 7, 9 and 13.

3552.3 Part III - Total Rehabilitation Costs-- Use this section to determine the applicable facilities rehabilitation costs.

Line 31. --Enter the amounts from Part I, column 13, line 22 and the amount from Part II, column 13, line 30. Add the amount from Part I, line 22 and Part II, line 30 for columns 8 through 11.

3553. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT OF REHABILITATION SERVICES

3553.1 Part I - Calculation of Reimbursement Settlement for SNF-based providers not subject to the computation of the lesser of reasonable costs or customary charges.

This worksheet is to be completed if you operate a SNF-based CMHC, a SNF-based OPT, SNF-based OSP, and/or SNF-based OOT.

Line 1.--Enter the cost of rehabilitation services from Worksheet J-2, Part II, line 31 from columns 5, 7, or 13, as applicable (column 5 for title V, column 7 for title XIX, and column 13 for title XVIII).

Line 2.--Enter the amounts paid and payable by workmen's compensation and other primary payers (from your records).

Line 3.--Enter the amount obtained by subtracting line 1 from line 2.

Line 6.--Enter 80 percent of line 5 for title XVIII. Make no entry for title V or title XIX.

Line 7.--Enter the actual coinsurance billed to program patients (from your records).

Line 9.--Enter reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records).

Line 10.--Enter the lesser of line 6 or line 8; plus line 9.

Line 11.--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, §§132ff.) Enter the amount of any excess depreciation taken in parentheses ().

Note: Section 1861 (v) (1) (O) 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.

Line 12.--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, §§136ff.)

Line 13.--Enter the amount on line 10, plus or minus the amount on line 11, minus the amount on line 12.

Line 14.--Using the methodology explained in §120, enter the sequestration adjustment on this line.

NOTE: Public Law 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman), provides for an automatic deficit reduction procedure to be established for Federal fiscal years (FYs) 1986 through 1991, unless the deficit would reach zero.

For title XVIII, reduce each payment amount by a specified percentage which could not exceed 1 percent for FY 1986 and 2 percent for each subsequent year in which sequestration (reduction of otherwise payable program payment amount pursuant to a Presidential Order under PL. 99-177) takes place. Section 120 outlines the methodology by which the sequestration adjustment is computed.

Line 15--Enter the amount on line 13 minus the amount on line 14.

Line 16--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4.

Line 17--Enter the balance due provider/program and transfer this amount to Worksheet S, Part II, columns as appropriate, line 5.

Line 18--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 worksheet showing the details and computations for this line.

3553.2 Part II - Computation of Customary Charges for Rehab Services.

Pursuant to §4541 of BBA 1997, §1834(k) of the Social Security Act is amended to require that title XVIII services rendered in Calendar Year 1998 for CORF be subject to the lesser of charges imposed for those services or the adjusted reasonable costs.

If you have more than one SNF-based facility, a separate worksheet must be completed for each facility.

Line 1--Enter the total cost of outpatient rehabilitation services from Worksheet J-2, Part II, column 13, line 31.

Line 1.1--Enter the total reasonable cost of rehabilitation services prior to 1/1/98, from Worksheet J-2, Part II, column 9, line 31 minus the amount from column 11, line 31.

Line 1.2--Enter the total reasonable cost of rehabilitation services rendered on or after 1/1/98 by multiplying the amount from Worksheet J-2, Part II, column 11, line 31 by 90 percent.

NOTE: Line 1 must equal the sum of lines 1.1 and 1.2

Line 2--Enter (from your records) the amounts paid and payable by Workmen's Compensation and other primary payers.

Line 3--Enter the amount obtained by subtracting line 2 from line 1

Line 4--Enter the total charges from Worksheet J-2, Part III, column 8, line 31.

Lines 5, 6, 7, and 8--These lines provide for the reduction of Medicare 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. Enter on line 8 the product of multiplying the ratio on line 7 by line 4. In no instance may the customary charges on line 8 exceed the actual charges on line 4.

Line 8.1--Enter the customary charges for rehabilitation services rendered prior to 1/1/98 from Worksheet J-2, Part II, column 8, line 31, minus the amount from column 10, line 31.

Line 8.2--Enter the customary charges for rehabilitation services rendered on or after 1/1/98 by multiplying the amount from Worksheet J-2, Part II, column 10 by 90 percent.

Line 8.3--Enter on line 8.3 the excess of total customary charges (8.2) over the total reasonable cost (line 1.2). When the total charges on line 8.2 are less than the total cost on line 1.2, enter zero (0) on line 8.3.

Line 8.4--Enter on line 8.4 the excess of total reasonable cost (line 1.2) over total customary charges (line 8.2). When the total cost on line 1.2 is less than the customary charges on line 8.2, enter zero (0) on line 8.4.

3553.3 Part III - Computation of Reimbursement Settlement of Outpatient Rehabilitation Services

Line 9--Enter the cost of rehabilitation services from Part II, line 3.

Line 10--Enter the Part B deductibles billed to program patients (from your records) excluding any coinsurance amounts.

Line 11--Enter the amount obtained by subtracting line 10 from line 9.

Line 11.1--Enter the amount from Part II, line 8.4.

Line 12--Enter 80 percent of line 11.2.

Line 13--Enter the actual coinsurance billed to program patients (from your records).

Line 14--Enter the amount obtained by subtracting line 13 from line 11.2.

Line 15--Enter (from your records) reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance.

Line 16--Enter the lesser of the amounts on line 12 or 14 plus the amount on line 15.

Line 17--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. 15-1, §132ff.) Enter the amount of any excess depreciation taken in parentheses. ().

NOTE: Effective for changes in ownership that occur on or after December 1, 1997, §4404 of BBA 1997 amends §1861(v)(1)(O) of the Act which states, in part, that "...a provider of services which has undergone a change of ownership, such regulations provide that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record...". That is, no gain or loss is recognized for such transactions on or after December 1, 1997.

Line 18--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, §136ff.)

3558. WORKSHEET I-2 - ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

For services beginning on or after January 1, 1998, use this worksheet only if you operate a certified SNF-based RHC or FQHC as part of your complex. If you have more than one SNF-based RHC and/or FQHC, complete a separate worksheet for each facility.

3558.1 Part I - Visits and Productivity.--Worksheet I-2, Part I, 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 of Part I 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. Enter a level of 4200 visits for each physician (line 1) and a level of 2100 visits for each nonphysical practitioner (lines 2 and 3), unless you received an exception to these levels. If you were granted an exception to the productivity standards, enter the number of productivity visits approved by the intermediary in lines 1 through 3.

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 could set any number of visits as reasonable (not just your actual visits) if an exception is granted. For example, if the guideline number is 4200 visits and you have only furnished 1000 visits, the intermediary need not accept the 1000 visits but could permit 2500 visits to be used in the calculation.

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.

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.

3558.2 Part II - Determination of Total Allowable Cost Applicable To RHC/FQHC Services.--Worksheet I-2, Part II, determines the amount of the overhead costs incurred by both the parent provider and the facility which apply to RHC/FQHC services.

Line 10.--Enter the cost of health care services from Worksheet I-1, column 7, line 21, less the total allowable GME costs, on line 20. The allowable GME costs are not subject to the per visit limits.

Line 11.--Enter the total nonreimbursable costs from Worksheet I-1, column 7, line 26.

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/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 I-1, column 7, line 29.

Line 15.--Enter the amount of GME overhead costs. To determine the amount of GME overhead multiply the amount of facility overhead by the ratio of Intern and Resident visits over total visits. This amount will be deducted from the total facility overhead costs on line 14.

Line 16.--Enter the net facility overhead costs. This is determined by subtracting the amount on line 15 from the amount on line 14.

Line 17.--Enter the overhead cost incurred by the parent provider allocated to the RHC/FQHC. This amount is the difference between the total costs allocated to the corresponding RHC/FQHC cost center on Worksheets B, Part I column 18, line 35, minus column 14, line 35, minus column 0, line 35.

Line 18.--Enter the sum of lines 16 and 17 to determine the total overhead costs related to the RHC/FQHC.

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).

3560. WORKSHEET I-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet provides for the reimbursement calculation of Rural Health Clinics and Federal Qualified Health Clinics. Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due you for the reporting period.

3560.1 Part I - Determination of Rate For RHC/FQHC Services.-- Part I 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 I-2, Part II, line 20.

Line 2.--Enter zero on this line. Worksheet I-4 has been eliminated. Do not enter any amount cost of pneumococcal and influenza vaccine.

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 I-2, Part I, column 5, line 8.

Line 5.--Enter the visits made by physicians under agreement from Worksheet I-2, Part I, 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.--Complete columns 1 and 2 of lines 8 and 9 to identify costs and visits affected by different payment limits during a cost reporting period. If only one payment limit is applicable during the cost reporting period, complete column 2 only.

Line 8.--Enter the maximum rate per visit that can be received by you. 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. For periods with cost reporting periods beginning on or after January 1, complete column 2 only. For cost reporting periods beginning prior to January 1, amounts will be entered in columns 1 and 2.

3560.2 Part II - Calculation of Settlement.--Use Part II to determine the total payment based on specific title due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period.

Complete columns 1 and/or 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period. If the provider's cost reporting period begins on or after January 1, then only column 2 is completed. For all other cost reporting periods beginning prior to January 1, both columns 1 and 2 must be completed.

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 Medicare 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 1/2 percent. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15. --Enter the total allowable GME pass-through costs. To determine the direct GME cost, divide the **program** visits performed by Interns and Residents from Worksheet S-5, line 16, column 2, by the total visits from Worksheet I-3, line 6. Multiply the result by the total allowable GME costs from Worksheet I-1, column 7, line 20. Add the applicable overhead costs associated with GME, from Worksheet I-2, line 15. Add the provider facility overhead applicable to GME, from Worksheet B, Part I, column 14, line 35. Enter the result on this line. (If there are no allowable GME pass-through costs, this line is zero.)

Line 16.--Enter the total **program** cost. This is equal to the sum of the amounts on lines 11 and 14, columns 1 and 2, plus the GME pass through costs on line 15.

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. RHC's 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 amount on line 17 from the amount on line 16.

Line 19.--Enter 80 percent of the amount on line 18.

Line 20.--Enter zero on this line. Worksheet I-4 has been eliminated.

Line 21.--Enter the total reimbursable **program** cost. This is equal to the sum of the amounts on line 19 and 20.

Line 22.--Enter the 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 15-1, § 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 made to you for covered services furnished to program beneficiaries during the reporting period (from intermediary records). Transfer amount from Worksheet I-5, line 4.

| Line 26--Enter the total amount due to/from the program (line 24 minus line 25). Transfer this amount to Worksheet S, Part II, columns 1, 3, or 4 as applicable, line 6.

Line 27--Enter the program reimbursement effect of protested items. The reimbursement effect of 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 PRM-15-1 §115.2).

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM HCFA 2540-96
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
Worksheet S-7, Part III				
Transition Period	0	1-4	1	X
Facility Specific Rate	1-45	2	6	9(8).99
Federal Case Mix Rate	1-45	3 & 5	6	9(8).99
Federal Rate – High Cost Add On	7,10,11, 15-26	3.01& 5.01	6	9(8).99
Days (Prior to 10/01/XXXX)	1-45	4	6	9
Add On Days (Services on and after 04/01/2000, but prior to 10/01/2000)	7,10,11, 15-26	4.01	6	9
Days (After 09/30/XXXX)	1-45	6	6	9
Add On Days (Services on and after 10/01/2000)	7,10,11, 15-26	6.01	6	9
Federal Case Mix	1-45	7	9	9
Facility Specific	1-45	8	9	9
Blend Amounts	1-45	9 & 10	9	9

WORKSHEET A

Direct salaries by department	3-16,18-19,21- 51,54-56,58-63	1	9	-9
Total direct salaries	75	1	9	9
Other direct costs by department	1-16,18-19,21- 51,52-56,58-63	2	9	-9
Total other direct costs	75	2	9	9
Net expenses for cost allocation by department	1-16,18-19,21- 51,55-56,58-63	7	9	-9
Total net expenses for cost allocation	75	7	9	9

WORKSHEET A-6

For each expense reclassification:

Explanation	1-35	0	36	X
Reclassification code	1-35	1	2	X

