Medicare

Department of Health and Human Services (DHHS)

Provider Reimbursement Manual

Centers for Medicare and Medicaid Services (CMS)

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

Transmittal 4 **Date: September 2013**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4000 - 4000 (Cont.)	40-7 - 40-8 (2pp.)	40-7 - 40-8 (2pp.)
4004.1 (Cont.) - 4004.1 (Cont.)	40-31 - 40-38.2 (12pp.)	40-31 - 40-38.2 (10 pp.)
4004.2 (Cont.) - 4004.2 (Cont.)	40-41 - 40-42 (2pp.)	40-41 - 40-42 (2pp.)
4005 - 4005.4 (Cont.)	40-55 - 40-65.1 (16 pp.)	40-55 - 40-65.1 (10 pp.)
4007 - 4007 (Cont.)	40-69 - 40-70.2 (4 pp.)	40-69 - 40-70 (2 pp.)
4012 (Cont.) - 4013 (Cont.)	40-79 - 40-82 (4 pp.)	40-79 - 40-82 (4 pp.)
4013 (Cont.) - 4013 (Cont.)	40-87 - 40-88 (2 pp.)	40-87 - 40-88 (2 pp.)
4013 (Cont.) - 4013 (Cont.)	40-91 - 40-94 (4 pp.)	40-91 - 40-94 (4 pp.)
4014 - 4014 (Cont.)	40-99 - 40-100 (2 pp.)	40-99 - 40-100 (2 pp.)
4016 (Cont.) - 4016 (Cont.)	40-105 - 40-106 (2 pp.)	40-105- 40-106 (2 pp.)
4021 (Cont.) - 4022	40-125 - 40-126 (2 pp.)	40-125 - 40-126 (2 pp.)
4024.4 - 4024.5 (Cont.)	40-135 - 40-136 (2 pp.)	40-135 - 40-136 (2 pp.)
4025.1 (Cont.) - 4025.1 (Cont.)	40-143 - 40-146 (4 pp.)	40-143 - 40-146 (4 pp.)
4030.1 - 4030.1 (Cont.)	40-169 - 40-176.8 (18 pp.)	40-169 - 40-176.8 (17 pp.)
4030.2 (Cont.) - 4031.1	40-178.1 - 40-182 (6 pp.)	40-178.1 - 40-182 (6 pp.)
4031.2 (Cont.) - 4033.4 (Cont.)	40-185 - 40-202 (18 pp.)	40-185 - 40-202 (18 pp.)
4033.5 (Cont.) - 4033.7	40-205 - 40-208 (4 pp.)	40-205 - 40-208 (4 pp.)
4033.7 (Cont.) - 4034 (Cont.)	40-211 - 40-216.2 (8 pp.)	40-211 - 40-216.2 (8 pp.)
4045.2 - 4045.2 (Cont.)	40-241 - 40-242 (2 pp.)	40-241 - 40-242 (2 pp.)
4050 - 4052 (Cont.)	40-249 - 40-252 (8 pp.)	40-249 - 40-252 (4 pp.)
4055 (Cont.) - 4056	40-257 - 40-258 (2 pp.)	40-257 - 40-258 (2 pp.)
4066 (Cont.) - 4069	40-281 - 40-286 (8 pp.)	40-283 - 40-286 (7 pp.)
4090	40-503 - 40-508 (6 pp.)	40-503 - 40-508 (6 pp.)
	40-511 - 40-514 (4 pp.)	40-511 - 40-514 (4 pp.)
	40-517 - 40-518 (2 pp.)	40-517 - 40-518 (2 pp.)
	40-521 - 40-524 (4 pp.)	40-521 - 40-524 (4 pp.)
	40-529 - 40-530 (2 pp.)	40-529 - 40-530 (2 pp.)
	40-535 - 40-538 (4 pp.)	40-535 - 40-538 (4 pp.)
	40-541 - 40-550 (10 pp.)	40-541 - 40-550 (10 pp.)
	40-553 - 40-556 (4 pp.)	40-553 - 40-556 (4 pp.)
	40-559 - 40-562 (4 pp.)	40-559 - 40-562 (4 pp.)
	40-569 - 40-570 (2 pp.)	40-569 - 40-570 (2 pp.)
	40-581 - 40-586 (6 pp.)	40-581 - 40-586 (6 pp.)
	40-589 - 40-598 (10 pp.)	40-589 - 40-598 (10 pp.)
	40-607 - 40-612 (6 pp.)	40-607 - 40-612 (6 pp.)
	40-615 - 40-622 (8 pp.)	40-615 - 40-622 (8 pp.)
	40-625 - 40-626 (2 pp.)	40-625 - 40-626 (2 pp.)
	40-629 - 40-630 (2 pp.)	40-629 - 40-630 (2 pp.)
	40-635 - 40-638 (4 pp.)	40-635 - 40-638 (4 pp.)
	40-641 - 40-642 (2pp.)	40-641 - 40-642 (2pp.)
	40-647 - 40-650 (4 pp.)	40-647 - 40-650 (4 pp.)
	40-653 - 40-654 (2 pp.)	40-653 - 40-654 (2 pp.)
	40-661 - 40-663 (3 pp.)	40-661 - 40-663 (3 pp.)

4095	40-701 - 40-710 (10 pp.)	40-701 - 40-710 (10 pp.)
	40-717 - 40-720 (4 pp.)	40-717 - 40-720 (4 pp.)
	40-725 - 40-732 (10 pp.)	40-725 - 40-732 (8 pp.)
	40-735 - 40-742 (8 pp.)	40-735 - 40-742 (8 pp.)
	40-745 - 40-750 (6 pp.)	40-745 - 40-750 (6 pp.)
	40-753 - 40-760 (6 pp.)	40-753 - 40-760 (6 pp.)
	40-763 - 40-766 (4pp.)	40-763 - 40-766 (4pp.)
	40-769 - 40-770 (2 pp.)	40-769 - 40-770 (2 pp.)
	40-773 - 40-776 (4 pp.)	40-773 - 40-776 (4 pp.)
	40-779 - 40-782 (4 pp.)	40-779 - 40-782 (4 pp.)
	40-785 - 40-802 (20 pp.)	40-785 - 40-802 (20 pp.)
	40-809 - 40-810 (2 pp.)	40-809 - 40-810 (2 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Beginning on or After October 1, 2012.

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

Revisions:

- Worksheet S-2, Part I:
  - Added line 39 for low volume eligibility.
  - Added lines 61.01 through 61.06, and 61.10 and 61.20 to collect indirect medical education (IME) and direct graduate medical education (GME) full-time equivalents (FTE) counts in approved teaching programs to ensure compliance with section 5503 of the Patient Protection and Affordable Care Act of 2010 (ACA).
- Worksheet S-3, Part I:
  - Added lines 24.10 (Hospice (non-distinct part)) and 32.01 (Outpatient ancillary labor and delivery days), and revised line 32 (Labor and delivery) to adjust the bed days available to calculate the total number of inpatient beds.
- Worksheet S-3, Part II:
  - Clarified line 1, line 26, and column 2 for reporting direct salaries and wages.
  - Clarified line 17 instructions for health insurance and health-related wage related costs.
- Worksheet S-5:
  - Added lines 10.01 through 10.03 to identify a provider approved for a low volume payment adjustment, ESRD PPS payment election and transition period.
  - Added line 22 and revised lines 13 through 20 to properly report erythropoiesis-stimulating agents (ESA's) for cost reporting periods ending on or after December 31, 2012. (Also impacts Worksheet B-2)
- Worksheet S-10:
  - Clarified lines 26 and 27, total facility bad debt expenses and total facility Medicare reimbursable bad debts, respectively.
- Worksheet A:
  - Clarified line 4 as employee benefit department costs.
- Worksheet A-6:
  - Clarified instructions regarding reclassification of salary amounts paid in addition to direct salaries or wages (such as paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay) to the same cost center where the direct salaries and wages are reported.
- Worksheet A-8:
  - Added line 30.99 to adjust for amounts received under contractual agreements with hospices.

- Worksheet D, Part IV:

- Reinstated the use of column 1 for certified registered nurse anesthetists (CRNA) services.

- Worksheets E, Part A; E, Part B; E-1, Part II; E-2; E-3, Parts I - VI; H-4, Part II; J-3; and M-3:
  - Added a line for the sequestration adjustment amount reducing payments by 2 percent in accordance with the Executive Order effective for portions of cost reporting periods that overlap or begin on or after April 1, 2013 pursuant to Section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended by the Budget Control Act of 2011.
- Worksheets E, Part A; E, Part B; E-2; E-3, Parts I - VI; H-4, Part II; I-5; J-3; and M-3:
  - Revised the bad debt instructions in accordance with section 3201 of the Middle Class Tax Relief and Job Creation Act of 2012.
- Worksheet E, Part A:
  - Revised line 4 to adjust for non-distinct part hospice days, outpatient ancillary labor and delivery days, and total labor and delivery room days.
  - Revised lines 40 and 41 for the calculation of the ESRD add-on payment in accordance with FR 160, Vol. 76, dated August 18, 2011, page 51693.
  - Revised lines 48 and 49 to reflect the extension of the Medicare-dependent hospital program through September 30, 2013 in accordance with section 606 of the American Taxpayer Relief Act of 2012.
  - Added line 70.92 to reflect the Model 1 bundled payment initiative in accordance with ACA 2010, section 3023 effective for discharges occurring on or after October 1, 2013.
  - Added line 70.93 to reflect the payment adjustment amount for the Hospital Value-Based Purchasing (HVBP) program in accordance with ACA 2010, section 3001 effective for discharges occurring on or after October 1, 2012.
  - Added line 70.94 to reflect the payment adjustment amount for the Hospital Readmissions Reduction program in accordance with ACA 2010, section 3025 effective for discharges occurring on or after October 1, 2012.
  - Revised the instructions for lines 70.96 through 70.98 to reflect the extension of the low volume adjustment through federal fiscal year 2013 in accordance with section 605 of the American Taxpayer Relief Act of 2012.
- Worksheet E, Part B:
  - Clarified line 27 to appropriately calculate costs for cost reimbursed providers exempt from the lower of reasonable costs or customary charges.
- Worksheet E-1, Part II:
  - Added lines 9 and 10 and revised line 32 for the sequestration adjustment impacting the electronic health record incentive payment.
- Worksheet I-4 and I-5:
  - Revised the instruction for services furnished on or after January 1, 2011, to calculate reimbursable bad debts and a facility-specific composite cost percentage under ERSD PPS.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods beginning on or after October 1, 2012.

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

This page is intentional blank to maintain proper odd-even pagination.

4000. GENERAL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 23--Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" *if* days are based on the date of discharge. Is the method of identifying the days in

the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.

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

Line 24--If *line 23 is "3" and* this is an IPPS provider, enter the in-state Medicaid paid days in column 1 *(report on S-3, Part I, lines 1 and 8 through 12, respectively, column 7)*, the in-state Medicaid eligible but unpaid days in column 2 *(report on S-3, Part I, line 2, column 7),* the out-of-state Medicaid paid days in column 3 *(report on S-3, Part I, line 2, column 7)*, the out-of-state Medicaid eligible but unpaid days in column 4 *(report on S-3, Part I, line 2, column 7)*, Medicaid HMO paid and eligible but unpaid days in column 5 *(report on S-3, Part I, line 2, column 7). Enter only labor and delivery days (reported on S-3, Part 1, line 32, column 7) as "Other Medicaid days" in column 6. If line 23 is "1" or "2", enter the Medicaid days based on each column description; however, these days may not equal the Medicaid days reported by discharge on Worksheet S-3, Part I.* Do not include swing-bed, observation or hospice days in any columns on this line. *See 42 CFR 412.106(a)(1)(ii) and 412.106(b)(4).*

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

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

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

Lines 28 - 34--Reserved for future use.

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

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

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

Line 38--Enter the beginning and ending dates of MDH status *during this cost reporting period.* Subscript line 38 if more than 1 period is identified for this cost reporting period and enter multiple dates.

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

status in writing to their contractor and provide documentation that they meet the mileage criteria.

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

NOTE: *42 CFR §412.101(c)(2) provides for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2011 through 2013 as follows:*

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

To qualify as a low-volume hospital, the hospital must meet both of the following criteria:
•Be more than 15 road miles from the nearest subsection (d) hospital; and
•Have fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data as determined by CMS.

Lines *40* - 44--Reserved for future use.

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

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

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

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

Lines 49 - 55--Reserved for future use.

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

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

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

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

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

Line 60--Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 42 CFR 413.85? Enter “Y” for yes or “N” for no. If yes, you

must identify such costs in the applicable column(s) of Worksheet D, Parts III and IV to separately identify nursing and allied health (paramedical education) from all other medical education costs.

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

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

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

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

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

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

Enter the average unweighted number of primary care FTE residents for direct GME in column 3. This primary care average is based on the hospital's total unweighted primary care FTE count that would otherwise be allowable if not for the FTE resident cap for each year in the 3-year period. If the hospital did not train any OB/GYN residents in its three most recent cost reports ending and submitted prior to March 23, 2010, convert the weighted primary care FTE counts from line 3.19 of Worksheet E-3, Part IV of Form CMS-2552-96, to unweighted FTE counts, compute a 3-year average, and report the average in column 3. If the hospital did train OB/GYN FTE residents in its three most recent cost reports ending and submitted prior to March 23, 2010, subtract the OB/GYN FTE counts from line 3.19 of Worksheet E-3, Part IV of Form CMS-2552-96, convert the remaining primary care FTE counts to unweighted FTE counts, compute a three year average, and report the average in column 3. Exclude general surgery FTE residents. If any of the three cost reports is not a 12-month cost report, enter the 12-month equivalent FTE count.

Line 61.02--Enter the current cost reporting period total unweighted primary care FTE count (excluding obstetrics and gynecology and general surgery), which is used to determine compliance with the 3-year primary care average requirement. In accordance with section 5503 of the ACA, which states that the 3-year primary care average requirement must be met by "excluding any additional positions" added as a result of the section 5503 FTE cap increase, also exclude from this unweighted primary care FTE count any primary care FTEs added in the current cost reporting period specific to new or expanded programs under section 5503 (see 75 FR 72198-9 dated November 24, 2010). Enter the unweighted IME FTE count in column 2 and the direct GME FTE count in column 3. If the current cost report is not a 12-month cost report, enter the 12-month equivalent FTE count. These current cost reporting period unweighted primary care FTE counts are compared to the 3-year primary care average amounts in line 61.01.

Line 61.03--Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75 percent requirement. These primary care and/or general surgery FTEs would be a part of the unweighted allopathic and osteopathic FTE count from the hospital's 12-month (or prorated equivalent) cost report that immediately precedes the cost report that includes July 1, 2011. Report the IME primary care and/or general surgery baseline FTE count in column 2 and the direct GME baseline primary care and/or general surgery FTE count in column 3. (For example, the baseline cost report for June 30 providers would be July 1, 2010 through June 30, 2011; for December 31 providers, this would be January 1, 2010 through December 31, 2010; for September 30 providers, this would be October 1, 2009 through September 30, 2010). (On the Form CMS-2552-96, the baseline FTE primary care and/or general surgery count is included and commingled in the allopathic and osteopathic FTEs reported on line 3.08 of Worksheet E, Part A, and on line 3.05 of Worksheet E-3, Part IV. On the Form CMS-2552-10, the baseline primary care and/or general surgery FTE count is included and commingled in the allopathic and osteopathic FTEs reported on line 10 of Worksheet E, Part A, and on line 6 of Worksheet E-4). Use the rotation schedules from the hospital's 12-month (or prorated equivalent) cost report that immediately precedes the cost report that includes July 1, 2011, as the source for the primary care and/or general surgery FTEs.

Line 61.04--Enter the total number of unweighted primary care and/or general surgery allopathic and/or osteopathic FTEs in the current cost reporting period. If the cost report is not a 12-month cost report, enter the 12-month equivalent FTE count. Exclude OB/GYN FTEs. (These FTEs are part of the current year FTE count, and are included on Form CMS-2552-10, line 10 of Worksheet E, Part A, and line 6 of Worksheet E-4). Report the unweighted IME FTE count in column 2 and the direct GME FTE count in column 3.

Line 61.05--Determination of Compliance with 75 Percent Requirement--Enter the difference between the baseline primary care and/or general surgery FTE counts and the current year primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). Report the IME FTE count difference in column 2 and the direct GME FTE count difference in column 3. (If the difference is less than or equal to zero, enter a zero).

The section 5503 FTE cap slots reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (direct GME) are dependent upon this difference on line 61.05, because of the requirement that 75 percent of the section 5503 FTE cap award be ***used*** *for primary care and/or general surgery FTEs in new or expanded programs. If the difference on line 61.05 is greater than zero, then it must be at least 75 percent of the section 5503 FTE cap award to be reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME). For example, if a hospital was awarded a total of 10 slots, but the difference reported on line 61.05 is 5, then the section 5503 FTE slots reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME)* ***cannot be more than*** *6.67 (that is, 5 divided by 75 percent). Therefore, determine that the difference on line 61.05 is at least 75 percent of the section 5503 award amount that is reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME).*

Line 61.06--Enter the amount of the ACA section 5503 award FTEs that are being used for cap relief, if any, and/or that are nonprimary care or non-general surgery FTEs. Report the IME amount in column 2 and the direct GME amount in column 3. The amount reported on this line can be no more than 25 percent of the section 5503 FTE cap slots reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME). If the amount on line 61.05, column 2 and 3 is greater than or equal to the section 5503 cap award reported on line 61, columns 4 and 5, respectively, report zero on this line.

If the amount on line 61.05 is less than the section 5503 cap award, and the hospital either is training FTE residents over its existing FTE cap or has added nonprimary care and non-general surgery FTEs in the current cost reporting period, report on this line the difference of the section 5503 cap slots on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME) and the amount reported on line 61.05. For example, if a hospital was awarded a total of 10 slots, and 5 is reported on line 61.05, and the section 5503 FTE slots reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME) is 6.67 FTEs, then the amount reported on line 61.06 cannot exceed 1.67 FTEs which is the difference between the amount on line 61.05 and the amount reported on Worksheet E, Part A, line 8.01 (for IME) and Worksheet E-4, line 4.01 (for direct GME). If 10 is reported on line 61.05, then report 0 (zero) on line 61.06. If 8 is reported on line 61.05 and the hospital added 2 or more nonprimary care FTEs in the current cost reporting period, then report 2 on this line.

Lines 61.07 - 61.09--Reserved for future use.

Line 61.10--Of the FTEs in line 61.05, specify each new primary care or general surgery program specialty, if any, and the number of FTE residents for each new program. Use subscripted lines 61.11 through 61.19 for each additional new program. Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 the direct GME FTE unweighted count.

Line 61.20--Of the additional FTEs in line 61.05, specify each expanded primary care or general surgery program specialty, if any, and the number of FTE residents for each program expansion. Use subscripted lines 61.21 through 61.29 for each additional program expansion. Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 the direct GME FTE unweighted count.

Lines 62 - 62.01--Affordable Care Act Provisions Affecting the Health Resources and Services Administration (HRSA)--These provisions are effective for a five year period for the Health Resources and Services Administration (HRSA) Primary Care Residency Expansion (PCRE) program and the Teaching Health Center (THC) program.

Line 62--Effective for services rendered during September 30, 2010 through September 29, 2015, of the HRSA PCRE program, enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding. (Sections 4002 and 5301 of the ACA.)

Line 62.01--Effective for services rendered during October 1, 2010, through September 30, 2015, enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during this cost reporting period under the HRSA THC program. (Section 5508 of the ACA.)

Line 63--Has your facility trained residents in a non-provider setting during this cost reporting period? Enter “Y” for yes or “N” for no in column 1. See Federal Register, Vol. 75, number 226, dated November 24, 2010, page 72139-40. If column 1 is “Y” for yes, complete lines 64 through 67 and applicable subscripts. If “N” for no, but your facility trained residents in a non-provider setting during the base year period (cost reporting period that begins on or after July 1, 2009 and before June 30, 2010), complete lines 64 and 65 and applicable subscripts effective for cost reporting periods beginning on or after July 1, 2010.

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

Line 64--If line 63 is yes or your facility trained residents in the base year period, enter in column 1, for cost reporting periods that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that

occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimarycare FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.

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

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

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

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

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

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

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

Lines 68 - 69--Reserved for future use.

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

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

Lines 72 - 74--Reserved for future use.

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

Line 76--If this facility is an IRF or contains an IRF subprovider (response to line 75, column 1 is "Y" for yes), did the facility train residents in teaching programs **in the most recent cost reporting period ending on or before November 15, 2004?** Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in new teaching programs in accordance with FR, Vol. 70, No. 156, page 47929 dated August 15, 2005? Enter in column 2 "Y" for yes or "N" for no. (Note: questions 1 and 2 must have opposite answers, i.e., if column 1 is "Y", then column 2 must be "N" and vice versa; columns 1 and 2 cannot be "Y" simultaneously, columns 1 and 2 can be "N" simultaneously.) If yes, enter a "1", "2", or "3", respectively, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that begins during the current cost reporting period. If the current cost reporting period covers the beginning of the fourth academic year of the first new teaching program's existence, enter the number "4" in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program's existence, enter the number "5" in column 3.

Lines 77 - 79--Reserved for future use.

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

Lines 81 - 84--Reserved for future use.

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

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

Line 87 - 89--Reserved for future use.

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

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

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

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

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

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

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

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

Lines 98 - 104--Reserved for future use.

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

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

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

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

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

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

Lines 110 - 114--Reserved for future use.

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

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

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

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

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

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

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

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

Line 120--If this is an SCH (or EACH), that qualifies for the outpatient hold harmless provision in accordance with ACA section 3121, enter "Y" for yes or "N" for no in column 1. If this is a rural hospital with 100 or fewer beds, that qualifies for the outpatient hold harmless provision in accordance with ACA section 3121, enter "Y" for yes or "N" for no in column 2. ACA section

3121, was amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002. Note that for SCHs and EACHs the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012, regardless of bed size and from March 1, 2012 through December 31, 2012, for SCHs and EACHs with 100 or fewer beds. Rural hospitals with 100 or fewer beds are also extended through December 31, 2012. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.

Line 121--Did this facility incur and report costs in the "Implantable Devices Charged to Patients" (line 72) cost center as indicated in the Federal Register, Vol. 73, number 161, dated August 19, 2008, page 48462 under the following revenue codes: code 0275 - pacemaker, code 0276 - intraocular lens, code 0278 - other implants and code 0624 - Food and Drug Administration (FDA) investigational devices. Enter "Y" for yes or "N" for no in column 1.

Lines 122 - 124--Reserved for future use.

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

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

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

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

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

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

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

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

Line 133--Use this line if your facility contains a Medicare certified transplant center not specifically identified on lines 126 through 132. Enter the certification date in column 1 and termination date in column 2. Subscript this line as applicable and complete a separate Worksheet D-4 for each Medicare certified transplant center type.

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

Lines 135 - 139--Reserved for future use.

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

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

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

Line 143--Enter the city, State and *ZIP* code of the Home Office.

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

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

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

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

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

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

Lines 150 - 154--Reserved for future use.

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

Lines 162 - 164--Reserved for future use.

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

Line 166--If you responded "Y" for yes to question 165, enter information for each campus (including the main campus) as follows: name in column 0, county in column 1, State in column 2, *ZIP* code in column 3, *geographic* CBSA in column 4, and the FTE count for this campus in column 5. If additional campuses exist, subscript this line as necessary. *Enter the information in columns 0 through 5 for the main campus first, and then enter the information in each column for the subordinate campuses, in any order. For example, for the main campus, enter on line 166 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus. For the first subordinate campus, enter on line 166.01 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus.*

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

Line 168--If this provider is a CAH (line 105 is "Y" for yes) and is also a meaningful EHR technology user (line 167 is "Y" for yes) enter, if applicable, the reasonable acquisition cost incurred for EHR assets either purchased or initially rented under a virtual purchase lease (see PRM-1, §110.B.1.b) in the current cost reporting period. If applicable, also enter the un-depreciated cost (i.e., net book value), as of the beginning of the current cost reporting period, for assets purchased or initially rented under a virtual purchase lease in prior cost reporting period(s) which were used for EHR purposes in the current cost reporting period. Do not enter on this line any cost for EHR assets which was already claimed for the same assets in previous cost reporting period(s). The reasonable acquisition cost incurred is for depreciable assets such as computers and associated hardware and software necessary to administer certified EHR technology. (See Federal Register, Vol. 75, number 144, dated July 28, 2010, pages 44461 and 42 CFR 495.106(a) and (c)(2).)

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

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

See Federal Register, Vol. 75, number 144, dated July 28, 2010, pages 44458-60. The transition factor equals:

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

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

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

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

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

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

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

This page is reserved for future use.

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

Exhibit 2 requires the following documentation:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This worksheet consists of five parts:

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

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

Column Descriptions

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

Column 2--Refer to 42 CFR 412.105(b) and Vol. 69*, No. 154* of the FR dated August 11, 2004, pages 49093 *through 49098* to determine the facility bed count. Indicate the number of beds available for use by patients at the end of the cost reporting period.

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

For cost reporting periods beginning prior to October 1, 2012, beds in distinct ancillary labor and delivery rooms and the proportion of LDP room (birthing room) beds used for labor and delivery services are not a bed for these purposes. (See Vol. 68, No. 148 of the FR dated August 1, 2003, page 45420.)

For cost reporting periods beginning on or after October 1, 2012, in accordance with Vol. 77, No. 170 of the FR dated August 31, 2012, pages 53411 through 53413, beds in distinct labor and delivery rooms, when occupied by an inpatient receiving IPPS-level acute care hospital services or when unoccupied, are considered to be part of a hospital's inpatient available bed count in accordance with 42 CFR 412.105(b) and are to be reported on line 32. Furthermore, the proportion of the inpatient LDP room (birthing room) beds used for ancillary labor and delivery services is considered part of the hospital's available bed count.

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

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

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

days are reported in columns 7 (title XIX) and 8 (total), line 28. For LTCH, enter in column 6 on the applicable line the number of covered Medicare days (from the PS&R) and enter in column 6, line 33 the number of noncovered days (from provider's books and records) for Medicare patients.

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

NOTE: 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 lines 2*, 3 or 4* in accordance with 42 CFR 412.106(b)(4)(ii). Therefore, Medicaid patient days reported on line 1, column 7 do not include days for Medicaid patients who are also members of an HMO, *out of State Medicaid days, Medicaid secondary payer patient days, Medicaid eligible days for which no payment was received, and baby days after mother's discharge.*

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

Column 9--Enter the number of intern and resident full time equivalents (FTEs) in an approved program determined in accordance with 42 CFR 412.105(f) for the indirect medical education adjustment. The FTE residents reported by an IPF PPS facility or an IRF PPS facility (whether freestanding or a unit reported on line 16 or 17, respectively, of an IPPS hospital's cost report) shall be determined in accordance with 42 CFR 412.424(d)(1)(iii) for IPFs and in accordance with the Federal Register, Vol. 70, number 156, dated August 15, 2005, pages 47929-30 for IRFs.

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

Columns 12 through 14--Enter the number of discharges including deaths (excluding newborn and DOAs) for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.) Enter the *title* XVIII *Medicare Advantage (MA)* discharges in column 13, line 2.

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

Line Descriptions

Line 1--*For cost reporting periods beginning before October 1, 2012, exclude from column 2 the portion of LDP room (birthing room) beds used for ancillary labor and delivery services, but include on this line beds used for routine adult and pediatric services (postpartum). In accordance with the instructions in Vol. 68, No. 148 of the FR dated August 1, 2003, page 45420, compute this proportion (off-the-cost report) by multiplying the total number of occupied*

and unoccupied available beds in the LDP room by the percentage of time these beds were used for ancillary labor and delivery services. An example of how to calculate the "percentage of time" would be for a hospital to determine the number of hours for the cost reporting period during which each LDP room maternity patient received labor and delivery services and divide the sum of those hours for all such patients by the sum of the total hours (for both, ancillary labor and delivery services and for routine postpartum services) that all maternity patients spent in the LDP room during that cost reporting period. Alternatively, a hospital could calculate an average percentage of time maternity patients received ancillary labor and delivery services in an LDP room during a typical month.

For cost reporting periods beginning on or after October 1, 2012, include all the available LDP room (birthing room) beds in the available bed count in column 2. (See Vol. 77, No. 170 of the FR dated August 31, 2012, pages 53411 through 53413.) The proportion of available LDP room beds related to the ancillary labor and delivery services must not be excluded from column 2 for those cost reporting periods.

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

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

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

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

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

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

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

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

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

Line 14--Enter the sum of lines 7 - 13 for columns 2 - 8, and for columns 12 - 15, enter the amount from line 1. For columns 9 - 11, enter the total for each from your records.

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

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

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

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

Line 18--Enter the applicable data for other than IPF or IRF subproviders. If you have more than one subprovider, subscript this line.

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

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

Line 21--Enter data for an other long term care facility.

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

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

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

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

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

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

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

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

Line 30--Enter in column 8 the employee discount days if applicable. These days are used on Worksheet E, Part A, line 31 in the calculation of the DSH adjustment and Worksheet E-3, Part III, line 3 in the calculation of the LIP adjustment.

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

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

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

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

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

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

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

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

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

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

Column 2

General instructions for completing column 2:

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

NOTE: Methodology for including vacation/holiday/sick/other PTO accruals in the wage index:

PTO salary cost--The required source for costs on Worksheet A is the General Ledger (see §4013 and 42 CFR 413.24(e)). Worksheet S-3, Part II (wage index) data are derived from Worksheet A; therefore, the proper source for costs for the wage index is also the General Ledger. A hospital's current year General Ledger includes both costs that are paid during the current year and costs that are expensed in the current year but paid in the subsequent year (current year accruals). Hospitals and contractors are to include on Worksheet S-3, Part II the current year PTO cost incurred as reflected on the General Ledger; that is, both the current year PTO cost paid and the current year PTO accrual. (Costs that are expensed in the prior year but paid in the current year (prior year accruals) are not included on a hospital's current year General Ledger and should not be included on the hospital's current year Worksheet S-3, Part II.)

PTO hours--The source for PTO paid hours on Worksheet S-3, Part II is the Payroll Report. Hours are included on the Payroll Report in the period in which the associated PTO expense is paid. Hospitals and contractors are to include on Worksheet S-3, Part II the PTO hours that are reflected on the current year Payroll Report, which includes hours associated with PTO cost that was expensed in the prior year but paid in the current year. The time period must cover the weeks that best matches the provider's cost reporting period. (Hours associated with PTO cost expensed in the current year but not paid until the subsequent year (current year PTO accrual) are not included on the current year Payroll Report and should not be included on the hospital's current year Worksheet S-3, Part II.)

Although this methodology does not provide a perfect match between paid PTO cost and paid PTO hours for a given year, it should approximate an actual match between cost and hours. Over time, any variances should be minimal.

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

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

Line 2--Enter the salaries for directly-employed Part A non-physician anesthetist 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 9 and 10. Additionally, contract CRNA cost must be included on line 11. Report in column 5 the hours that are associated with the costs in column 4 for directly employed and contract Part A CRNAs.

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

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

This page is reserved for future use.

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

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

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

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

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

Line 11--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, and top level management services as defined below. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs). Do not include costs applicable to excluded areas reported on line 9 and 10. Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and 7.01 respectively). Include on this line contract pharmacy and laboratory wage costs as defined below.

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

Direct patient care services include nursing, diagnostic, therapeutic, and rehabilitative services. Report only personnel costs associated with these contracts. DO NOT apply the guidelines for contracted therapy services under §1861(v)(5) of the Act and 42 CFR 413.106. Eliminate all supplies, travel expenses, and other miscellaneous items. Direct patient care contracted labor, for purposes of this worksheet, DOES NOT include the following: services paid under Part B: (e.g., physician clinical services, physician assistant services), management and consultant

contracts, billing services, legal and accounting services, clinical psychologist and clinical social worker services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care.

Include the amount paid for **top level 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 top level management services DO NOT include the following: other management or administrative services (to be included on lines 12 or 28; see instructions), physician Part A services, consultative services, clerical and billing services, legal and accounting services, unmet physician guarantees, physician services, planning contracts, independent financial audits, or any services other than the top level management contracts listed above. Per instructions on Worksheet S-2, Part II, for direct patient care, pharmacy and laboratory contracts, submit to your Medicare contractor the types of services, wages, and associated hours; for top level management contracts, submit the aggregate wages and hours.

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

Contract pharmacy services are furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. Per instructions on Worksheet S-2, Part II, submit to your contractor the following for direct patient care pharmacy contracts: the types of services, wages, and associated hours.

Contract laboratory services are furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. Per instructions on Worksheet S-2, Part II, submit to your contractor the following for direct patient care laboratory contracts: the types of services, wages, and associated hours.

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

Examples of contract management and administrative services that would be reported on line 12 include department directors, administrators, managers, ward clerks, and medical secretaries. Report only those personnel costs associated with the contract. DO NOT include on line 12 any contract labor costs associated with lines 26 through 43 and subscripts for these lines. DO NOT include the costs for contract top level management: chief executive officer, chief operating officer, chief financial officer and nurse administrator; these services are included on line 11. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items.

Line 13--Enter from your records the amount paid under contract (as defined on line 11) for Part A physician services - administrative, excluding teaching physician services. DO NOT include contract I & R services (to be included on line 7). DO NOT include the costs for Part A physician services from the home office allocation and/or from related organizations (to be reported on line 15). Also, DO NOT include Part A physician contracts for any of the management positions reported on line 11.

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

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

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

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

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

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

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

hospital does not complete Worksheet S-3, Part IV, or, the hospital is unable, when requested, to provide a copy of the standard used in developing the wage-related costs, the contractor may remove the cost from the hospital's Worksheet S-3 due to insufficient documentation to substantiate the wage-related cost relevant to GAAP.

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

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

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

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

Health Insurance and Health-Related Wage Related Costs:

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

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

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

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

Health-Related Services: inpatient and outpatient health services that are not covered under the hospital's health insurance plan, but are provided to employees at no cost or at a discount; for example, employee physicals and flu shots. Health-related services are to be included on Worksheet S-3, Parts II and IV as Core Wage-Related costs:

- *Costs the hospital incurs in providing services to its employees. (Domestic claim charges must be reduced to cost. Costs must also exclude any copayments and deductibles paid by employees.)*

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

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

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

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

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

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

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

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

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

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

These lines provide for the collection of hospital wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded

units. These lines are completed by all hospitals if the ratio of Part II, column 5, sum of lines 9 and 10 divided by the result of column 5, line 1 minus the sum of lines 2, 3, 4.01, 5, 6, 7, 7.01 and 8 equals or exceeds a threshold of 15 percent. However, all hospitals with a ratio greater than 5 percent must complete line 7 of Part III for all columns. Calculate the percent to two decimal places for purposes of rounding.

Line 26--Salaries and hours reported on this line correlate to the salaries reported in line 4, column 1 of worksheet A, for the Employee Benefit Department, or Human Resources Department.

Lines 28, 33, and 35--Enter the amount paid for services performed **under contract**, rather than by employees, for administrative and general, housekeeping, and dietary services, respectively. DO NOT include costs for equipment, supplies, travel expenses, and other miscellaneous or overhead items. Report only personnel costs associated with these contracts. Continue to report on the standard lines (line 27, 32, and 34), the amounts paid for services rendered by employees not under contract.

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

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

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

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

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

NOTE: For workers who are contracted solely for the purpose of providing services on-call, the wages and associated hours must be included on the appropriate contract labor line on Worksheet S-3.

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

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

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

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

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

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

Line 4--From Part II, enter the sum of lines 11, 12, 13, 14, and 15. (Line 16 is omitted from Part III, line 4 because physicians' teaching services are excluded from the wage index.)

Line 5--From Part II, enter the sum of lines 17, 18, and 22. Enter on this line in column 6 the wage-related cost percentage computed by dividing Part III, column 4, line 5, by Part III, column 4, line 3. Round the result to 2 decimal places.

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

Line 7--Enter from Part II above, the sum of lines 26 through 43. 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 26 through 43 for calculating the percentage.)

4005.4 Part IV - Wage Related Costs.--The hospital must provide the contractor with a complete list of all core wage related costs included in Part II (section 4005.2), lines 17 and 19 through 25. This worksheet provides for the identification of such costs.

The hospital must determine whether each wage related cost "other than core", reported on line 25, exceeds one (1) percent of the total adjusted salaries net of excludable salaries and meets all of the following criteria:

- The costs are not listed on lines 1 through 23, "Wage Related Costs Core"
- If any of the additional wage related cost applies to the excluded areas of the hospital, the cost associated with the excluded areas has been removed prior to making the 1 percent threshold test.
- The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS.
- The individual wage related cost is not included in salaries reported on Worksheet S-3, Part II, Column 3, Line 17.
- The wage related cost is not being furnished for the convenience of the employer.

For wage related costs not covered by Medicare reasonable cost principles (excluding the reporting of certain defined benefit pension costs; see instructions below), a hospital shall use GAAP in reporting wage related costs. In addition, some costs such as payroll taxes, which are reported as a wage related cost(s) on Worksheet S-3, Part IV, are not considered fringe benefits for Medicare cost finding.

Enter on each line as applicable the corresponding amount from your accounting books and/or records.

Line 3--Report pension cost for defined benefit pension plans than do not meet the applicable requirements for a qualified pension plan under section 401(a) of the Internal Revenue Code.

The policy adopted in the federal fiscal year (FFY) 2012 IPPS final rule (CMS-1518-F; 76 FR 51586 - 51590, August 18, 2011) does not change the reporting basis for these costs.

NOTE: These plans generally are not funded by a funding vehicle that is for exclusive benefit of employees or their beneficiaries and *do not qualify* for special tax benefits, such as tax deferral of employer contributions. For such unfunded defined benefit plans, the costs of these plans are reported on a cash basis which recognizes benefit payments made during the current period. Typically these plans supplement the basic qualified defined benefit plan or provide benefits to a select class of employees, such as executives.

Line 4--Commencing with cost reporting periods used for the FFY 2013 wage index, report pension cost for defined benefit pension plans which meet the applicable requirements for a qualified pension plan under section 401(a) of the Internal Revenue Code for the wage index. The allowable pension costs to be reported for these defined benefit pension plans shall be determined in accordance with the policy adopted in the FY 2012 IPPS final rule (CMS-1518-F; 76 FR 51586 - 51590, August 18, 2011) and as discussed below. Enter the pension costs from your records or from the Wage Index Pension Cost Schedule (Exhibit 3) below.

NOTE: The policy adopted in the FFY 2012 IPPS final rule replaces and supersedes the provisions of PRM-1, section 2142.

Policy

Defined Benefit Pension Plan: A defined benefit pension plan is a type of deferred compensation plan, which is established and maintained by the employer primarily to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Pension plan benefits are generally measured by, and based on, such factors as age of employees, years of service, and compensation received by employees. This section applies only to defined benefit pension plans which meet the applicable requirements for a qualified pension plan under section 401(a) of the Internal Revenue Code. A qualified pension plan is for the exclusive benefit of employees or their beneficiaries and qualifies for special tax benefits, such as tax deferral of employer contributions.

Pension Contributions: Pension costs for a defined benefit pension plan are allowable only to the extent that costs are actually incurred by the provider Such costs are found to have been incurred only if paid directly to participants or beneficiaries under the terms of the plan or paid to a pension fund which meets the applicable tax qualification requirements under section 401(a) of the Internal Revenue Code. For purposes of the wage index, provider pension payments shall be measured on a cash-basis without regard to §2305 of PRM-1. Payment must be made by check or other negotiable instrument, cash, or legal transfer of assets such as stocks, bonds, real property, and etcetera. A contribution payment shall be deemed to occur on the date it is credited to the fund established for the pension plan, or for provider payments made directly to a plan participant or beneficiary, on the date the provider's account is debited. Contributions made under a pension plan that covers multiple providers or employers shall be allocated on a basis consistent with plan records. If the plan records do not show a separate accounting of the actuarially determined cost estimates, contribution deposits, and/or assets attributable to each participating provider or employer, the allocation basis must represent a reasonable approximation of the funding attributable to each employer.

Source of Documentation for Pension Contributions: Providers are required to obtain contribution data from the pension trustee, insurance carrier, Schedule B or SB of IRS Form 5500, and if applicable, from accounting records showing the allocation of total plan contributions to each participating provider. These records must be maintained as needed for subsequent periods.

Reasonable Compensation: In order for pension costs to be allowable, the benefits payable under the plan (attributable to employer contributions) together with all other compensation paid to the employee must be reasonable in amount.

4007. WORKSHEET S-5 - HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to the renal dialysis department. The data maintained, depending on the services provided by the hospital, includes patient data, the number of treatments, number of stations, and home program data.

If you have more than one renal dialysis department, submit one Worksheet S-5 combining all of the renal dialysis departments' data. You must also have on file (as supporting documentation), a Worksheet S-5 for each renal dialysis department and the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-1, *chapter 27,* §2720. Also enter on the combined Worksheet S-5 the applicable data for each renal dialysis satellite for which you are separately certified (that is, a satellite for which you were issued a satellite CCN).

Section 153(b) of MIPPA amended section 1881(b) of the Act to require the implementation of an ESRD bundled payments system effective January 1, 2011. This new payment system is effectuated on Worksheets I-4 and I-5 (sections 4051 and 4052).

Column Descriptions

Columns 1 and 2--Include in these columns information regarding outpatient hemodialysis patients. **Do not include information regarding intermittent peritoneal dialysis.** In column 2, report information if you are using high flux dialyzers.

Columns 3 through 6--Report information concerning the provider's training and home programs. **Do not include intermittent peritoneal dialysis information in columns 3 and 5**.

Line Descriptions

Line 1--Enter the number of patients receiving dialysis at the end of the cost reporting period.

Line 2--Enter the average number of times patients receive dialysis per week. For CAPD and CCPD patients, enter the number of exchanges per day.

Line 3--Enter the average time for furnishing a dialysis treatment.

Line 4--Enter the average number of exchanges for CAPD.

Line 5--Enter the number of days dialysis is furnished during the cost reporting period.

Line 6--Enter the number of stations used to furnish dialysis treatments at the end of the cost reporting period.

Line 7--Enter the number of treatments furnished per day per station. This number represents the number of treatments that the facility can furnish not the number of treatments actually furnished.

Line 8--Enter your utilization. Compute this number by dividing the number of treatments furnished by the product of lines 5, 6, and 7. This percentage cannot exceed 100 percent.

Line 9--Enter the number of times your facility reuses dialyzers. This number is the average number of times patients reuse a dialyzer. If none, enter zero.

Line 10--Enter the percentage of patients that reuse dialyzers.

Line 10.01.--Indicate whether your facility qualified and was approved as a low-volume facility for this cost reporting period. CMS adjusts the base rate for low-volume ESRD facilities. In order to receive this low-volume adjustment, a facility must attest in accordance with 42 CFR §413.232(f).

Line 10.02.--Indicate if your facility elected 100 percent PPS effective January 1, 2011. Enter "Y" for yes or "N" for no. This election must have been received by the ESRD facility's contractor by November 1, 2010. Requests received after this date will not be accepted regardless of postmark or delivery date.

New providers: ESRD facilities certified for Medicare participation on or after January 1, 2011, are paid based on 100 percent of the ESRD PPS payment. ESRD facilities certified for Medicare participation on or after January 1, 2011, enter "Y" for yes.

Line 10.03.--If your facility did not elect to be paid based on 100 percent of the ESRD PPS payment and your cost reporting period is a December 31 fiscal year end, enter the transition period in column 2 as follows: For the fiscal year ending December 31, 2011, enter 1; for the fiscal year ending December 31, 2012, enter 2; for the fiscal year ending December 31, 2013, enter 3; and, for the fiscal year ending December 31, 2014, enter 4 for 100 percent ESRD PPS payment. Column 1 will be blank.

If your cost reporting period ends on a date other than December 31, indicate in column 1 the transition period effective for the portion of the cost reporting period prior to January 1. Indicate in column 2 the transition period effective for the portion of the cost reporting period on and after January 1. For example, a cost reporting period with a fiscal year ending October 31 would indicate the applicable transition periods as follows:

> *Fiscal year ending October 31, 2011: Leave column 1 blank as this would be pre-bundled ESRD PPS, and enter 1 in column 2 for the period of January 1, 2011, through October 31, 2011.*
> *Fiscal year ending October 31, 2012: Enter 1 in column 1 for the period of November 1, 2011 through December 31, 2011, and enter 2 in column 2 for the period of January 1, 2012 through October 31, 2012.*
> *Fiscal year ending October 31, 2013: Enter 2 in column 1 for the period of November 1, 2012 through December 31, 2012 and enter 3 in column 2 for the period of January 1, 2013 through October 31, 2013.*
> *Fiscal year ending October 31, 2014: Enter 3 in column 1 for the period of November 1, 2013 through December 31, 2013 and enter 4 in column 2 for the period of January 1, 2014 through October 31, 2014.*

For all cost reporting periods beginning on or after January 1, 2014, enter 4 in column 2 for 100 percent ESRD PPS payment.

Payments during the transition period 1 are a blend of 25 percent case-mix adjusted ESRD PPS and 75 percent basic case-mix adjusted composite rate (25/75). Payments during the transition period 2 are a blend of 50 percent case-mix adjusted ESRD PPS and 50 percent basic case-mix adjusted composite rate (50/50). Payments during the transition period 3 are a blend of 75 percent case-mix adjusted ESRD PPS and 25 percent basic case-mix adjusted composite rate (75/25). Payments for services rendered on and after January 1, 2014 are 100 percent ESRD PPS.

Line 11--Enter the number of patients who are awaiting a transplant at the end of the cost reporting period.

Line 12--Enter the number of patients who received a transplant during the fiscal year.

Line 13--Enter the direct product cost net of discount and rebates for Epoetin (EPO). Include all EPO cost for patients receiving outpatient, home (*M*ethod I or II *(claims that would have been processed as Method II are processed as Method I for services rendered on or after January 1, 2011)*), or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Report on this line the amount of EPO cost included in line 74 of Worksheet A. *Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 2.*

Line 14--Based on the instructions contained on line 13, enter the amount of *EPO* included on line 94 (home dialysis program) from Worksheet A. *Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 3.*

Erythropoiesis-Stimulating Agents (ESA) Statistics--Effective January 1, 2005 and prior to January 1, 2011, Medicare paid for ESAs based on the Average Sales Price Drug Pricing File. Effective January 1, 2011, payment for ESAs is included in the ESRD PPS payment.

Line 15--Enter the number of EPO units furnished relating to the renal dialysis department. *Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22 (and subscripts), column 4.*

Line 16--Enter the number of EPO units furnished relating to the home dialysis program. *Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22, (and subscripts), column 5.*

Line 17--Enter the direct product cost net of discount and rebates for *d*arbepoetin *a*lfa (Aranesp) Include all Aranesp cost for patients receiving outpatient, home (*M*ethod I or II *(claims that would have been processed as Method II are processed as Method I for services rendered on or after January 1, 2011)*), or training dialysis treatments. This amount includes Aranesp cost furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Report on this line the amount of Aranesp cost included in line 74 of Worksheet A. *Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 2.*

Line 18--Based on the instructions contained on line 17, enter the dollar amount of Aranesp included on line 94 (home dialysis program) from Worksheet A. *Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 3.*

Line 19--Enter the number of micrograms (mcgrs) of Aranesp furnished relating to the renal dialysis department. *Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22 (and subscripts), column 4.*

Line 20--Enter the number of micrograms of Aranesp furnished relating to the home dialysis program. *Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22 (and subscripts), column 5.*

Line 21--Identify how physicians are paid for medical services provided to Medicare beneficiaries. Under the monthly capitation payment (MCP) methodology, contractors pay physicians for their Part B medical services. Under the initial method, the renal facility pays for physicians' Part B medical services. The facility's payment rate is increased in accordance with 42 CFR 414.313. There are a limited number of facilities electing this method.

Line 22--Identify each ESA separately on line 22 and subscripts. Complete this line effective for cost reporting periods ending after December 31, 2012. Enter in column 1, the name of the ESA

Administered to renal dialysis patients. Enter in column 2, the direct product cost net of discounts and rebates for ESAs administered to renal dialysis patients. These costs are included in line 74 of Worksheet A. Include all ESA costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes ESA costs furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Enter in column 3 the direct product cost net of discounts and rebates for ESAs administered to home dialysis patients. These costs are included in line 94 of Worksheet A.

Include all ESA costs for patients receiving self-care home dialysis treatments. This amount includes ESA costs furnished in the home dialysis program for an end stage renal disease dialysis patient. Enter in column 4, the total ESA units furnished to renal dialysis department patients during the cost reporting period. Enter in column 5, the total ESA units furnished to home program dialysis patients during the cost reporting period.

Line 15--Calculate the costs for patients covered by a state or local government program by multiplying line 1 times line 14.

Line 16--Calculate the difference between net revenue and costs for patients covered by a state or local government program by subtracting line 13 from line 15. If line 15 is less than line 13, then enter zero.

Uncompensated care:

Line 17--Enter the value of all non-government grants, gifts and investment income received during this cost reporting period that were restricted to funding uncompensated or indigent care. Include interest or other income earned from any endowment fund for which the income is restricted to funding uncompensated or indigent care.

Line 18--Enter all grants, appropriations or transfers received or expected from government entities for this cost reporting period for purposes related to operation of the hospital, including funds for general operating support as well as for special purposes (including but not limited to funding uncompensated care). Include funds from the Federal Section 1011 program, if applicable, which helps hospitals finance emergency health services for undocumented aliens. While Federal Section 1011 funds were allotted for federal fiscal years 2005 through 2008, any unexpended funds will remain available after that time period until fully expended even after federal fiscal year 2008. If applicable, report amounts received from charity care pools net of related provider taxes or assessments. Do not include funds from government entities designated for non-operating purposes, such as research or capital projects.

Line 19--Calculate the total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs by entering the sum of lines 8, 12 and 16.

Line 20--Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria (measured at full charges), for care delivered during this cost reporting period for the entire facility. For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider (column 1), this is the patient's total charges. For patients covered by a public program or private insurer with which the provider has a contractual relationship (column 2), these are the deductible and coinsurance payments required by the payer. Include charity care for all services except physician and other professional services. Do not include charges for either uninsured patients given discounts without meeting the hospital's charity care criteria or patients given courtesy discounts. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.

Line 21--Calculate the cost of initial obligation of patients approved for charity care by multiplying line 1 times line 20. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 22--Enter payments received or expected from patients who have been approved for partial charity care for services delivered during this cost reporting period. Include such payments for all services except physician or other professional services. Payments from payers should not be included on this line. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 23--Calculate the cost of charity care by subtracting line 22 from line 21. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 24--Enter "Y" for yes if any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported in line 20, column 2, and complete line 25. Otherwise enter "N" for no.

Line 25--If you answered yes to question 24, enter charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program for services delivered during this cost reporting period. The amount must match the amount of such charges included in line 20, column 2.

Line 26--Enter the total facility (entire hospital complex) *amount of* bad debts written off *on balances owed by patients* during this cost reporting period. Include such *bad debts* for all services except physician and other professional services. *The amount reported must also include the amounts reported on* Worksheets: E, Part A, line 64; E, Part B, line 34; E-2, line 17, *columns 1 and 2*; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; *E-3,* Part VII, line 34; *I-5, line 5 (line 5.05, column 2 for cost reporting periods that overlap or begin on or after or January 1, 2011)*; J-3, line 21; and M-3, line 23. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.

Line 27--Enter the total facility (entire hospital complex) Medicare reimbursable (also referred to adjusted) bad debts as the sum of Worksheet E, Part A, line 65; E, Part B, line 35; E-2, line 17, columns 1 and 2 *(line 17.01, columns 1 and 2 for cost reporting periods that begin on or after October 1, 2012)*; E-3, Part I, line 12; E-3, Part II, line 24; E-3, Part III, line 25; E-3, Part IV, line 15; E-3, Part V, line 26; E-3, Part VI, line 10; I-5, line *11*; J-3, line 21 *(line 22 for cost reporting periods that begin on or after October 1, 2012)*; and M-3, line 23 *(line 23.01 for cost reporting periods that begin on or after October 1, 2012)*.

Line 28--Calculate the non-Medicare and non-reimbursable Medicare bad debt expense by subtracting line 27 from line 26.

Line 29--Calculate the cost of non-Medicare and non-reimbursable Medicare bad debt expense by multiplying line 1 times line 28.

Line 30--Calculate the cost *of* uncompensated care by entering the sum of lines 23, column 3 and line 29.

Line 31--Calculate the cost of unreimbursed and uncompensated care and by entering the sum of lines 19 and 30.

4013. 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). While providers are expected to maintain their accounting books and general ledger in a manner consistent with the standard cost centers/departments identified on this worksheet, not all of the cost centers listed apply to all providers using these forms. For example, IPPS providers may contain a Burn Intensive Care Unit, where CAHs may not furnish this type of service.

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 75; Worksheet E, Part B, line 44; Worksheet E-2, line 23; and Worksheet E-3, Parts I, II, III, IV, V, VI, and VII lines 22, 35, 36, 26, 34, 19, and 43, respectively). For provider based-facilities enter the protested amounts on line 35 of Worksheet H-4, Part II for home health agencies; line 30 of Worksheet J-3 for CMHCs; and line 30 of Worksheet M-3 for RHC/FQHC providers.

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 contractor.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If you need to use additional or different cost center descriptions, add (subscript) 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 24 through 29, 47 through 49, 77 through 87, 102 through 104, 119 through 189, and 195 through 199.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. Form CMS-2552-10 provides for preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. Additionally, 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 five digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. You are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §4095, table 5**.**

Columns 1, 2, and 3--**The expenses listed in these columns must be the same as listed in your accounting books and records and/or trial balance.**

List on the appropriate lines in columns 1, 2, and 3 the total expenses incurred during the cost reporting period. These expenses are detailed between salaries (column 1) and other than salaries (column 2).

Include in column 1 *only direct salaries and wages plus related* salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay. *Refer to the instructions at Worksheet S-3, Part II, column 2, line 1, for the definition of bonus pay and PTO salary cost.*

NOTE: *Paid vacation, holiday, sick, other PTO, severance, and bonus pay must be reported with related direct salaries or wages in column 1. Do not report wage-related costs in column 1, as defined in §4005.4.*

The sum of columns 1 and 2 equals the sum of column 3. Record any needed reclassifications and/or adjustments in columns 4 and 6, as appropriate.

Column 4--With the exception of the reclassification of capital related costs which are reclassified via Worksheet A-7, all reclassifications in this column are made via Worksheet A-6. Worksheet A-6 need not be completed by all providers and is completed only to the extent that the reclassifications are needed and appropriate in the particular circumstance. Show reductions to expenses as negative numbers.

The net total of the entries in column 4 must equal zero on line 200.

Column 5--Adjust the amounts entered in column 3 by the amounts in column 4 (increase or decrease) and extend the net balances to column 5. Column 5, line 200 must equal column 3, line 200.

Column 6--Enter on the appropriate lines in column 6 the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The total on Worksheet A, column 6, line 200, equals Worksheet A-8, column 2, line 50.

Column 7--Adjust the amounts in column 5 by the amounts in column 6 (increase or decrease), and extend the net balances to column 7.

Transfer the amounts in column 7 to the appropriate lines on Worksheet B, Part I, column 0.

Line 4--Enter on this line incurred employee benefit *department* costs, including human resources *department* costs, *that* cannot be placed in the various cost centers along with the associated salaries.

Line 5--Enter administrative and general (A & G) costs on this line. A&G includes a wide variety of provider administrative costs such as but not limited to cost of executive staff, legal and accounting services, facility administrative services (not already included in other general services cost centers), etcetera. If this line is componentized into more than one cost center, eliminate line 5. Componentized A & G lines must begin with subscripted line 5.01 and continue in sequential and consecutive order except where this manual specifies otherwise.

Line 6--Maintenance and repairs are any activity to maintain the facility and grounds such as, but not limited to, costs of routine painting, plumbing and electrical repairs, mowing and snow removal.

Line 7--Operation of plant includes the cost such as, but not limited to, the internal hospital environment including air conditioning (both heating and cooling systems and ventilation) and other mechanical systems.

Line 8--Laundry and linen services includes the cost of routine laundry and line*n* services whether performed in-house or by outside contractors.

Line 9--Housekeeping includes the cost of routine housekeeping activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 10--Dietary includes the cost of preparing meals for patients.

Line 11--Cafeteria includes the cost of preparing food for provider personnel, physicians working at the provider, visitors to the provider.

Line 12--Maintenance of personnel includes the cost of room and board furnished to employees. (See Pub. 15-1, *chapter 7,* §704.3.)

Line 13--Nursing administration normally includes only the cost of nursing administration. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks.

However, if your accounting system fails to specifically identify all direct nursing services to the applicable patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 14--Central services and supply includes the costs of supplies and services which are requested by departments throughout the provider, including medical supplies charged to patients.

Line 15--Pharmacy includes the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients.

Line 16--Medical records and medical records library includes the direct costs of the medical records cost center including the medical records library. The general library and the medical library are not included in this cost center but are reported in the A & G cost center.

Line 17--Social service includes the cost of explaining health care resources and policies to patients, family and professional staff; assistance in planning for post-hospital patient needs; assisting patients and families receive needed follow-up care by referral to health care resources and providing advocacy through appropriate organizations.

Line 19--The services of a nonphysician anesthetist generally are paid for by the Part B contractor based on a fee schedule rather than on reasonable cost basis through the cost report. As such, the salary and fringe benefit costs included on line 19 generally are not reimbursed through the cost report.

NOTE: Any costs are included on this line are limited to salary and employee benefit costs.

However, payment for the nonphysician anesthetists on a fee basis may not apply to a qualified rural hospital or CAH if the facility employed or contracted with not more than one FTE (2080 hours) nonphysician anesthetist and, if (1) the hospital had 800 or fewer surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services and (2) each nonphysician employed by or under contract with the hospital has agreed not to bill under Part B of title XVIII for professional services furnished. 42 CFR 412.113(c)(2)(i)

Payment under the fee schedule applies to qualified hospitals and CAHs unless the hospital establishes, before the beginning of each calendar year, that it did not exceed 800 surgical procedures requiring anesthesia in the previous year. 42 CFR 412.113(c)(2)(ii)

Hospitals which do not qualify for the exception and are therefore subject to the fee schedule payment method must remove the salary and fringe benefit costs from line 19. The total amount is reported on Worksheet A-8, line 28 and in column 6, line 19 of this worksheet. This removes these costs from the cost reported in column 7.

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

Lines 47-49--Reserved for future use.

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

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

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

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

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

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

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

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

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

Line 71--The cost of medical supplies charged to patients is for low cost medical supplies generally not traceable to individual patients. Do not include high cost implantable devices on this line. The cost of this cost center generally is not the direct cost of the cost center, but rather allocated to this cost center on Worksheet B from cost center 14 (central service and supply) based on the recommended statistic of costed requisitions. Where providers directly assign costs to this cost center, such amounts must be reported in this cost center on Worksheet A. (See *CMS* Pub. 15-1, *chapter 23,* §2307.)

Line 72--Include the expense of implantable devices charged to patients. All providers who responded "Y" to question 121 on Worksheet S-2, Part I must complete this line. The types of items includable on this line are high cost implantable devices that remain in the patient upon discharge and are chargeable and traceable to individual patients. Do not include low cost medical supplies on this line. When determining what costs are reported in this cost center, providers should use costs associated with implantable devices bearing revenue codes identified in the FR, Vol. 73, No. 161, page 48462, dated August 19, 2008. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 14 (central service and supply) based on the recommended statistic of costed requisitions. Where providers directly assign costs to this cost center, such amounts must be reported in this cost center on Worksheet A. (See *CMS* Pub. 15-1, *chapter 23,* §2307.) Identify this line with the appropriate cost center code according to Table 5 in §4095 of the electronic reporting specifications.

NOTE: Hospitals maintain the option to directly assign costs to a specific cost center (*CMS* Pub. 15-1, §2307) or, if such costs are overhead costs, they can be placed in the appropriate overhead cost center and allocated to the applicable cost centers. This applies generally to all cost centers, but is re-emphasized for medical supplies charged to patients (line 71) and implantable devices charged to patients (line 72).

Line 74--If you furnish renal dialysis treatments, account for such costs by establishing this separate ancillary service cost center. In accumulating costs applicable to the cost center, include no other ancillary services even though they are routinely administered during the course of the dialysis treatment. However, if you physically perform a few minor routine laboratory services associated with dialysis in the renal dialysis department, such costs remain in the renal dialysis cost center. Outpatient maintenance dialysis services are reimbursed under the composite rate reimbursement system. For purposes of determining overhead attributable to *ESAs*, include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

Effective for services rendered on or after January 1, 2011, ESRD services are paid under the ESRD PPS.

NOTE: ESRD physician supervisory services are not included as your costs under the composite rate reimbursement system or *ESRD PPS*. Supervisory services are included in the physician's monthly capitation rate.

Line 75--Enter the cost of ASCs that are not separately certified as a distinct part but which have a separate surgical suite. Do not include the costs of the ancillary services provided to ASC patients. Include only the surgical suite costs (i.e., those used in lieu of operating or recovery rooms).

Lines 77 - 87--Reserved for future use.

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

NOTE: For lines 88 through 90 and 93 any ancillary service billed as clinic, RHC, and FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, laboratory.

Line 88--Use this line to report the costs of provider-based RHCs. If more than one is maintained, subscript the line. See Table 5 in §4095 for the proper cost center code for RHCs.

In accordance with CMS Pub. 100-02 *(Medicare Benefit Policy Manual)*, chapter 13, §30.4A, 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 contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Line 89--Use this line to report the costs of provider-based FQHCs. If more than one is maintained, subscript the line. See Table 5 in §4095 for the proper cost center code for FQHCs.

In accordance with CMS Pub. 100-02, chapter 13, §30.4A, compensation paid to a physician for FQHC services rendered in a hospital-based FQHC is cost-reimbursed. Where the physician agreement compensates for FQHC services as well as non-FQHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Line 90--Enter the cost applicable to the clinic not included on lines 88 and 89. If you have two or more clinics which are separately costed, separately report each such clinic. Subscript this line to report each clinic. If you do not separately cost each clinic, you may combine the cost of all clinics on the clinic line.

Line 91--Enter the costs of the emergency room cost center.

Line 92--Do not use this line on this worksheet. If you have a distinct part area specifically designated for observation (e.g., where observation patients are not placed in a general acute care area bed), report this on a subscripted line 92.01.

NOTE: It is possible to have both a distinct observation bed area and a non-distinct area (for example, where your distinct part observation bed area is only staffed from 7:00 a.m. - 10:00 p.m. Patients entering your hospital needing observation bed care after 10:00 p.m. and before 7:00 a.m. 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 93--Use this line to report the costs of other outpatient services not previously identified on lines 88 through 90. If more than one other service is offered, subscript the line. See Table 5 in §4095 for the proper cost center code for this line.

Lines 94 - 98 and 100--Use these lines for other reimbursable cost centers (other than HHA and CMHC).

Line 94--Use this line to accumulate the direct costs incurred for self-care home dialysis. For purposes of determining overhead attributable *ESA's*, include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

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 directly 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 93 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).

Effective for services rendered on or after January 1, 2011, ESRD services are paid under the ESRD PPS.

4014. WORKSHEET A-6 - RECLASSIFICATIONS

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

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

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

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

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

Examples of reclassifications that may be needed are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 21--Enter the cash received from the imposition of interest, finance, or penalty charges on overdue receivables. Use this income to offset the allowable administration and general costs. (See CMS Pub. 15-1, *chapter 22,* §2110.2.)

Line 22--Enter the interest expense imposed by the contractor on Medicare overpayments. Also, enter interest expense on borrowing made to repay Medicare overpayments.

Line 23--Enter, if applicable, the amount from Worksheet A-8-3, line 65.

Line 24--Enter, if applicable, the amount from Worksheet A-8-3, line 65.

Line 25--This line pertains to the hospital-based SNF only. When the utilization review covers only Medicare patients or Medicare and title XIX patients, allocate 100 percent of the reasonable compensation paid to the physicians for their services on utilization review committees to the health care programs. Apportion all other allowable costs applicable to utilization review which cover only health care program patients among all users of the hospital-based SNF. Reclassify such other costs on Worksheet A-6. Enter the physicians' compensation for service on utilization review committees which cover only health care program patients in the hospital-based SNF. The amount entered equals the amount shown on Worksheet A, column 6, line 114. (See CMS Pub. 15-1, *chapter 22,* §2126.2.) If the utilization review costs pertain to more than one program, the amount entered on Worksheet E-2, column 1, line 7 must equal the amount adjusted on Worksheet A-8.

Lines 26 and 27--When depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on lines 26 and 27, as applicable. Use line 26 capital related buildings and fixtures costs and line 27 for new capital related movable equipment costs. Personal use of assets requires adjustment to depreciation expense, e.g., automotive used 50% for business and 50% personal.

Line 28--This adjustment is required for salaries and fringe benefits paid to nonphysician anesthetists reimbursed on a fee schedule. (See the instructions for Worksheet A, line 19.)

Line 29--Sections 1861(s)(2)(K), 1842(b)(6)(C), and 1842(b)(12) of the Act provide for coverage of and separate payment for services performed by a physician assistant. The physician assistant is an employee of the hospital and payment is made to the employer of the physician assistant. Make an adjustment on Worksheet A-8 for any payments made directly to the physician assistant for services rendered. This avoids any duplication of payments.

Line 30--Enter, if applicable, the amount from Worksheet A-8-3, line 65 for occupational therapy services rendered.

Line 31--Enter, if applicable, the amount from Worksheet A-8-3, line 65 for speech pathology services rendered.

Line 32--For CAHs, where applicable in accordance with ARRA of 2009, section 4102, remove the current year depreciation expense associated with purchased assets for which the total cost or remaining un-depreciated cost was reimbursed either in the current or prior cost reporting period as EHR incentive payment if such depreciation was included on Worksheet A, line 2 (capital-related movable equipment) or any other line. This includes the depreciation expense for EHR assets purchased in the current cost reporting period, as well as depreciation expense related to the remaining net book value (i.e., un-depreciated basis) of EHR assets purchased in prior cost reporting periods which were not fully depreciated at the beginning of the current cost reporting period.

Also, use this line to remove that portion of the annual rent/lease expense applicable to EHR assets leased under a virtual purchase lease which equals the depreciation expense for this asset since the total cost of the asset (or the un-depreciated cost if the lease was initiated in a prior cost reporting period), was claimed as EHR incentive payment. Also remove any portion of the total

rental charge which exceeds the actual cost of ownership of the EHR asset. (See *CMS Pub. 15-1*, *chapter 1, §*110.B.2.) In accordance with *CMS Pub. 15-1*, *chapter 1, §*110.B.2, the actual cost of ownership of an asset leased under a virtual purchase lease includes not only the depreciation expense, but insurance and interest as well. For example, if the depreciation for the asset is $50,000 per year, the insurance is $3,000 per year, the interest is $10,000 per year, and the rental charge is $70,000 per year, the rental expense must be limited to the cost of ownership which in this example is $63,000. Since the adjustment to limit the rent expense to the cost of ownership is $7,000, the actual adjustment on this line will be to reduce the allowable rent expense for this EHR asset by $57,000 (i.e., $50,000 depreciation portion and $7,000 excess rental charge over the cost of ownership).

Lines 33 - 49--Enter any additional adjustments which are required under the Medicare principles of reimbursement. Label the lines appropriately to indicate the nature of the required adjustments. If the number of blank lines is not sufficient, subscript lines 33 through 49. The grossing up of costs in accordance with provisions of CMS Pub. 15-1, *chapter 23,* §2314 is an example of an adjustment entered on these lines and is explained below.

If you furnish ancillary services to health care program patients under arrangements with others 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 costs of the health care program portion. Therefore, allocation of indirect costs to a cost center which includes only the cost of the health care program portion results in excessive assignment of indirect costs to the health care programs. Since services were also arranged for the non-health care program patients, allocate part of the overhead costs to those groups.

In the foregoing situation, do not allocate indirect costs to the cost center unless your contractor determines that you are able to gross up both the costs and the charges for services to non-health care program patients so that both costs and charges for services to non-health care program patients are recorded as if you had provided such services directly. See the instructions for Worksheet C, Part I for grossing up of your charges.

Meals furnished by you to an outpatient receiving dialysis treatment also require an adjustment. These costs are nonallowable for title XVIII reimbursement. Therefore, the cost of these meals must be adjusted.

In accordance with CMS Pub. *100-04, chapter 9, §40*, 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 contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

If the hospital performs ESRD services and costs are reported on either line 74, 94, or both, these costs should include the cost of *all ESAs*. Do not report the cost of these drugs claimed in any other cost center. These costs will be removed later on Worksheet B-2.

If the hospital pays membership dues to an organization that performs lobbying and political activities, the portion of the dues associated with these non-allowable activities must be removed from costs.

Line 30.99 (hardcoded)--When the hospital enters into a contractual arrangement with a hospice for the use of general inpatient routine beds, enter the amount received under contract from the hospice. This amount must be used to offset general inpatient routine care costs on Worksheet A, line 30.

Line 50--Enter the sum of lines 1 through 49. Transfer the amounts in column 2 to *the appropriate lines on* Worksheet A, column 6.

Since capital-related cost, non-physician anesthetists, and approved education programs are not included in the operating cost per discharge, columns 19 through 23, lines 30 through 194 are shaded on Worksheet B, Part II, for all lines except 19 through 23, 200, 201, and 202. These are the only lines and columns where an approved educational cost center can be shown. For purposes of this paragraph only, the statistic for line 200 is the sum of the statistics on lines 30 through 117 and 190 through 194 on Worksheet B-1 for the same column. Enter these amounts on line 200 for cross footing purposes. Use line 200 of Worksheet B-1, columns 19 through 23, for this purpose in the allocation of capital-related cost on Worksheet B, Part II. Use the statistic on line 200 together with the statistics on lines 19 through 23 of Worksheet B-1 to allocate columns 19 through 23 of Worksheet B, Part II. If column 20 is subscripted for additional education cost centers qualifying as educational pass through costs (see the instructions for Worksheet A, lines 20 through 23), the subscripted column(s) must be shaded similarly to columns 20 through 23

The total for each column includes lines 200 and 201 for cross footing purposes.

Transfer:

From Worksheet B, Part II, Column 26	To Worksheet D, Part I
Line 30 - Adults and Pediatrics	Column l, line 30 for the hospital
Lines 31-35 - Intensive Care Type Inpatient Hospital Units	Column 1, lines 31 through 35
Line 40 - IPF Subprovider	Column l, line 40
Line 41 - IRF Subprovider	Column l, line 41
Line 42 - Subprovider	Column l, line 42
Line 43 - Nursery	Column 1, line 43 for titles V and XIX
From Worksheet B, Part II, Column 26	**To Worksheet D-l, Part III**
Line 44 - SNF	Line 75 for the SNF
Sum of lines 44 and 45	Line 75 for the NF
From Worksheet B, Part II, Column 26	**To Worksheet D, Part II**
Lines 50-76 - Ancillary Services	Column l, lines 50-76
Lines 90, 91, subscripts of 92, and 93 - Outpatient Service Cost	Column l, lines 90, 91, subscripts of 92, and 93
Lines 94, 95, and 98 - Other Reimbursable Cost Centers	Column l, lines 94, 95, and 98
	To Worksheet C, Part II, Column 2
Lines 50-98	Lines 50-98

4022. WORKSHEET B-2 - POST STEP-DOWN ADJUSTMENTS

This worksheet provides an explanation of the post step down adjustments reported in column 25 of Worksheets B, Parts I and II, and L-1, Part I.

Column Descriptions

Column 1--Enter a brief description of the post step down adjustment.

Column 2--Make post step down adjustments on Worksheets B, Parts I and II, and L-1, Part I. Enter the worksheet part to which the post step down adjustment applies. For lines 74 and/or 94 remove the amount for *ESAs (i.e.,* Epoetin and Aranesp*)* reported on Worksheet S-5 lines 13, 14, 17, 18, *and subscripts of line 22, columns 2 and 3*.

Use the codes below to identify the worksheet in which the adjustment applies:

Code	Worksheet
1	B, Part I
2	B, Part II
3	L-1, Part I

Column 3--Enter the worksheet line number to which the adjustment applies.

Column 4--Enter the amount of the adjustment. Transfer these amounts to the appropriate lines on Worksheets B, Parts I, and II, or L-1, Part I, column 25.

Line Descriptions

Line 1--Enter the amount of the EPO adjustment for the renal dialysis inpatient department from Worksheet S-5, line 13. *Do not use this line effective for cost reporting periods ending after December 31, 2012.*

Line 2--Enter the amount of the EPO adjustment for the home dialysis program from Worksheet S-5, line 14. *Do not use this line effective for cost reporting periods ending after December 31, 2012.*

Line 3--Enter the amount of the Aranesp adjustment for the renal dialysis inpatient department from Worksheet S-5, line 17. *Do not use this line effective for cost reporting periods ending after December 31, 2012.*

Line 4--Enter the amount of the Aranesp adjustment for the home dialysis program from Worksheet S-5, line 18. *Do not use this line effective for cost reporting periods ending after December 31, 2012.*

Line 5--Enter the amount of the ESA adjustment for the renal dialysis inpatient department from Worksheet S-5, sum of the subscripts of line 22, column 2. Complete this line effective for cost reporting periods ending after December 31, 2012.

Line 6--Enter the amount of the ESA adjustment for the home dialysis program from Worksheet S-5, sum of the subscripts of line 22, column 3. Complete this line effective for cost reporting periods ending after December 31, 2012.

Lines *7* - 59--Enter any additional adjustments that are required under the Medicare principles of reimbursement. Label the lines appropriately to indicate the nature of the required adjustments. If the number of blank lines is not sufficient, use additional Worksheets B-2.

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

4024.4 Part IV - Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs--The TEFRA rate of increase limitation applies to inpatient operating costs. In order to determine inpatient operating costs, it is necessary to exclude capital-related and medical education costs as these costs are reimbursed separately. Hospitals and subprovider components subject to IPPS must also direct medical education costs as these costs are reimbursed separately. Determine capital-related inpatient ancillary costs on Worksheet D, Part II. SNFs are required to report medical education costs as a pass through cost. Prepare a separate Worksheet D, Part IV for the SNF and NF or ICF/MR (if applicable). Hospital payment for outpatient services are 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 26.

Column 1--Transfer from Worksheet B, Part I, column 19 *for each applicable line (*plus or minus any adjustments reported on Worksheet B, Part I, column 25*, if applicable)* the nonphysician anesthetist's *costs which qualify for a reasonable cost payment in accordance with 42 CFR 412.113(c).* (See *also* §4013, line 19 description for more information.)

Column 2--Transfer from Worksheet B, Part I, column 20, for each applicable line, (plus or minus post step down adjustments made on Worksheet B, Part I, column 25, if applicable), the applicable medical education costs for nursing school when Worksheet S-2, Part I, line 60 is yes. Do not transfer the costs if the response is no. For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 91.

Column 3--Transfer from Worksheet B, Part I, column 23, for each applicable line, (plus or minus post step down adjustments made on Worksheet B, Part I, column 25, if applicable), the applicable medical education costs for paramedical education (allied health) when Worksheet S-2, Part I, line 60 is yes. Do not transfer the costs if the response is no. For the hospital component only, enter on line 92 the observation bed amount from Worksheet D-1, Part IV, column 5, line 92.

Column 4--Transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, (plus or minus post step down adjustments made on Worksheet B, Part I, column 25), the applicable medical education costs for interns and residents when Worksheet S-2, Part I, line 57, column 1 is yes and column 2 is no, otherwise do not transfer the costs. For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 93.

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

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

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

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

Column 8--Divide the cost of each cost center in column 5 by the charges in column 7 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to .032151. Enter the resultant departmental ratio in column 8.

Column 9--This column computes the outpatient ratio of cost to charges. Divide the cost of each cost center in column 6 by the charges in column 7 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to .032151. Enter the resultant departmental ratio in column 9.

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

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

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

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

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

For hospitals, IPPS hospitals, CAHs and subproviders transfer column 13, line 200 to Worksheet E, Part B, line 9.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CAHs are also required to complete this worksheet.

Line Descriptions

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

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

4030. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

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

Worksheet E consists of the following two parts:

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

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

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

4030.1 Part A - Inpatient Hospital Services Under IPPS--

For SCH/MDH status change and/or geographical reclassification (see 42 CFR 412.102/103) subscript column 1 for lines 1-3, 22, 28, 29, 33, 34, 41, 45 47, and 48. If you responded “1” and “2” or “2” and “1”, respectively to Worksheet S-2, Part I, questions 26 and 27, which indicated your facility experienced a change in geographic classification status during the year, subscript column 1 and report the payments before the reclassification in column 1 and on or after the reclassification in column 1.01.

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

Line Descriptions

Line 1--The amount entered on this line is computed as the sum of the Federal operating portion (DRG payment) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period.

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

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

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

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

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

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

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

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

Line 6--Enter the FTE count for allopathic and osteopathic programs which meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1) *or (e)(3)*, the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995*, but before October 1, 2012. For hospitals that began training residents in a new program for the first time on or after October 1, 2012, the cap is effective beginning with the sixth program year (see 77 FR August 31, 2012, 53417).* For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited *or begun on or after January 1, 1995, and before August 6, 1997, is reported on this line and* is effective in the fourth program year of each of those new programs (see 66 FR, August 1, 2001, page 39881). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 5. *Do not report new program FTEs during the time frame prior to the effective date of the hospital's FTE cap adjustment on this line. New program FTEs during the time frame prior to the effective date of the hospital's FTE cap adjustment are reported on line 16. For urban hospitals that already have an FTE cap adjustment on line 5 but start a rural track program in accordance with 42 CFR 413.79(k),* enter here the allopathic or osteopathic FTE count for residents in all years of a rural track program that meet the criteria for an add-on to the cap under 42 CFR 412.105(f)(1)(x). (If the rural track program is a new program under 42 CFR 413.79 and *the urban hospital* qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (3), do not report FTE residents in the rural track program on this line *during the time frame prior to the effective date of the hospital's FTE cap.*

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

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

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

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

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

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

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

Calculation of the allowable current year FTEs:

Line 10--Enter the FTE count for allopathic and osteopathic programs in the current year from your records. Do not include residents in the initial years of the new program, which means that the program has not yet completed one cycle of the program (i.e., "period of years," or the minimum accredited length of the program). (42 CFR 412.105(f)(1)(iv) and/or (f)(1)(v).) Contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. Exclude FTE residents displaced by hospital or program closure that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 412.105(f)(1)(v)).

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

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

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

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

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

Line 16--Enter the number of FTE residents in the initial years of the program that meet the rolling average exception. (See 42 CFR 412.105(f)(1)(v))

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

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

Line 19--Enter the current year resident to bed ratio. Line 18 divided by line 4.

Line 20--In general, enter from the prior year cost report the intern and resident to bed ratio by dividing line 12 by line 4 (divide line 3.14 by line 3 if the prior year cost report was the 2552-96). However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e), add to the numerator of the prior year intern and resident to bed ratio the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program (i.e., the period of years is the minimum accredited length of the program). If the provider is participating in a Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap and current year FTE count due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator and the prior year numerator, and b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior year's numerator (see FR Vol. 66, No. 148 dated August 1, 2001, page 39880). Effective for cost reporting periods beginning on or after 10/1/02, if the hospital is training FTE residents in the current year that were displaced by the closure of another hospital or program, also adjust the numerator of the prior year ratio for the number of current year FTE residents that were displaced by hospital or program closure (42 CFR 412.105(a)(1)(iii)). The amount added to the prior year's numerator is the displaced resident FTE amount that you would not be able to count without a temporary cap adjustment. This is the same amount of displaced resident FTEs entered on line 17.

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

Line 22--Calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 21) to the .405 power) - 1} times {the sum of line 1 + line 3}.

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

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

Line 24--IME FTE Resident Count Over the Cap--Subtract line 9 from line 10 and enter the result here. If the result is zero or negative, the hospital does not need to use the 422 IME cap. Therefore, do not complete lines 23 through 28.

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

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

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

Line 28--IME Add On Adjustment--Enter the sum of lines 1 and 3, multiplied by the factor on line 27.

Line 29--Total IME Payment--Enter the sum of lines 22 and 28.

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

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

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

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

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

Line 34--Multiply line 33 by line 1.

Lines 35 - 39--Reserved for future use.

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

Line 40--Enter total Medicare discharges excluding discharges for MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48447 and 48520).). *Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see FR 160, Vol. 76, dated August 18, 2011, page 51693) for all Medicare beneficiaries entitled to Medicare Part A. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under section 1876 of the Act (HMOs), and competitive medical plans (CMPs). These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the denominator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals.*

Line 41--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see Vol. 69, FR 154, dated August 11, 2004, page 49087) excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48520 and 48447). *Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see FR 160, Vol. 76, dated August 18, 2011, page 51693) for all ESRD Medicare beneficiaries entitled to Medicare Part A who receive inpatient dialysis. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under section 1876 of the Act (HMOs), and CMPs. These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the numerator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals.*

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

Line 43--Enter the total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684, and 685, as applicable.

Line 44--Enter the average length of stay expressed as a ratio to 7 days. Divide line 43 by line 41, sum of columns 1 and 1.01, and divide that result by 7 days.

Line 45--Enter the average weekly cost per dialysis treatment of $405.45 ($135.15 times the average weekly number of treatments (3)). See CR 6679, Transmittal 113, dated October 30, 2009. This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.

Line 46--Enter the ESRD payment adjustment (line 44, column 1 times line 45, column 1 times line 41, column 1 plus, if applicable, line 44, column 1 times line 45, column 1.01 times line 41, column 1.01).

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

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

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

Additionally, for sole community hospitals only (effective for cost reporting periods beginning on or after January 1, 2009), use the *highest of the determined* hospital specific rate based on *federal fiscal year* 1982, 1987, 1996, or 2006.

For MDH discharges occurring on or after October 1, 2006, and before *October 1, 2013*, an MDH can use a FY 2002 hospital specific rate. *The MDH program ends on September 30, 2013.*

Line 49--For SCHs, enter the greater of line 47 or 48. For MDH discharges occurring on or after October 1, 2006, and *before October 1, 2013*, if line 47 is greater than line 48, enter the amount on line 47. Where line 48 is greater than line 47, enter the amount on line 47, plus 75 percent of the amount that line 48 exceeds line 47. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 47.

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

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

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

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

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

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

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

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

Line 56--Enter the cost of teaching physicians from Worksheet D-5, Part II, column 3, line 20.

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

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

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

Line 60--Enter the amounts paid or payable by 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:

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

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

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

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

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

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

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

Line 62--Enter from the PS&R or your records the deductibles billed to program patients.

Line 63--Enter from the PS&R or your records the coinsurance billed to program patients.

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

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

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

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

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

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

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

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

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

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

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

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

Line 70.96 through 70.98 (lines 70.96 and 70.97 are hardcoded)--Effective for discharges occurring during *f*ederal fiscal years 2011 and 2012 (October 1, 2010, through September 30, 2011, and October 1, 2011, through September 30, 2012, respectively), temporary improved/changed payments are mandated by §§3125 and 10314 ACA of 2010, as addressed in 42 CFR 412.101. *Section 605 of the American Taxpayer Relief Act of 2012 extends these provisions through federal fiscal year 2013 (October 1, 2012 through September 30, 2013). For cost reporting periods that are concurrent with the federal fiscal year (10/1 through 9/30), use line 70.97 only.* For cost reporting periods *that* overlap October 1 for years 2010, 2011, 2012, *and 2013*, enter on lines 70.96 (Low Volume Adjustment *(enter the corresponding federal year for the period prior to 10/1)*) and line 70.97 (Low Volume Adjustment *(enter the corresponding federal year for the period ending on or after 10/1)*), and if necessary *line 70.98 (low volume adjustments for additional portions of the cost reporting period, if necessary),* the Medicare inpatient payment adjustment for low volume hospitals as applicable in accordance with Exhibit 4 (low volume adjustment calculation schedule and corresponding instructions).

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

Line 71.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 71].

Line 72--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For contractor final settlements, enter the amount reported on Worksheet E-1, column 2, line 5.99 on line 73. Include in interim payment the amount received as the estimated nursing and allied health managed care payments.

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

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

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

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

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

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

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

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

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

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

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

NOTE: If a cost report is reopened more than one time, subscript lines 90 through 96, respectively, one time for each time the cost report is reopened.

Instructions For Completing Exhibit 4--

Low Volume Adjustment Calculation Schedule:

Sections 3125 and 10314 of ACA 2010 and *§605 of the American Taxpayer Relief Act of 2012* amended the low-volume hospital adjustment in section 1886(d)(12) of the Social Security Act by revising, for *F*FYs 2011, 2012 *and 2013* the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. CMS implemented these changes to the low-volume payment adjustment in the regulations at section *42 CFR* 412.101 in the FY 2011 IPPS final rule (75 FR 50238 through 50275).

The legislative amendments referenced in the preceding paragraph provide for a temporary change in the low-volume adjustment for qualifying hospitals for *F*FYs 2011, *2012 and 2013* as follows:

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

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

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

CMS provided a table listing the IPPS hospitals with fewer than 1,600 Medicare discharges and their low-volume percentage add-on if applicable, for FYs 2011, 2012 *and 2013*. However, this list is not a list of all hospitals that qualify for the low-volume adjustment since it does not reflect whether or not the hospital meets the mileage criteria. Hospitals were required to request low-volume status in writing to their *contractor* and provide documentation that they met the mileage criteria.

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

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

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

- Operating Federal IPPS payments;
- Operating HSR payments;
- Operating Outlier payments including any Operating Outlier Reconciliation amounts;
- Operating IME payments;
- Operating IME payments for Medicare Advantage patients;
- Operating DSH payments;
- ESRD Adjustment payments;
- Total Capital IPPS payment
- New Technology payments; and
- Capital Outlier Reconciliation amounts (if applicable, see instructions)

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

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

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

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

In addition, if there are discharges occurring during FFY 2011, 2012 *or 2013* and the provider was not eligible for the low-volume adjustment for the entire eligibility period, report the information relative to those discharges in this column, for example, where a provider has a cost reporting period ending June 30, 2011*, which began prior to the October 1, 2010 effective date of the provision. Or where t*he low-volume adjustment for discharges occurring in this cost reporting period is effective for discharges on or after October, 1, 2010; however, the provider did not request the low-volume adjustment until November 15, 2010 and the low-volume adjustment was implemented within 30 days of the request. The period of time from October 1, 2010 until the *contractor* notified the provider of eligibility, which should be no later than December 15, 2010, is considered a period of ineligibility.

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

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

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

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

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

Line Descriptions

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

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

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

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

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

Line 6 (Corresponds to Worksheet E, Part A, Line 22)--Calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times {the sum of line 1 + line 4}. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 22.

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

Line 8 (Corresponds to Worksheet E, Part A, Line 28)--IME Add On Adjustment--Enter the sum of lines 1 and 4, multiplied by the factor on line 7.

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

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

Line 11 (Corresponds to Worksheet E, Part A, Line 34)--Multiply line 10 by line 1. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 34.

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

Line 13 (Corresponds to Worksheet E, Part A, Line 47)--Enter the sum of lines 1, 2, 3, 9, 11 and 12.

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

Line 15 (Corresponds to Worksheet E, Part A, Line 49)--Enter in column 1, the amount from Worksheet E, Part A, line 49. For SCHs, if line 13, column 1 is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, for each applicable column. If line 14, column 1 is greater than line 13, column 1, enter in columns 2 through 4, the amount reported on line 14, for each applicable column. For MDH discharges occurring on or after October 1, 2006, and before October 1, *2013*, if line 13, column 1 is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 through 4, the amount on line 13, for each applicable column, plus or minus 75 percent of the difference between line 14 minus line 13 for each applicable column. Hospitals not qualifying as SCH or MDH providers will enter in columns 2 through 4, the amount from line 13, for each applicable column. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 49.

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

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

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

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

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

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

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

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

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

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

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

Low-volume *payment* adjustment--Effective for discharges occurring during FFYs 2011, *2012 and 2013*, compute the amount of the low-volume adjustment as follows:

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

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

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

EXHIBIT 4

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE

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

		W/S E, Part A line	(Amounts from E pt A)	Pre/Post Entitlement	*Prior to 10/1*	*On or after 10/1*	(col. 2 through 4) Total	
		(0)	(1)	(2)	(3)	(4)	(5)	
1	DRG Amounts Other than Outlier Payments	1						1
2	Outlier payments for discharges. (see instructions)	2						2
3	Operating outlier reconciliation	2.01						3
4	Managed Care Simulated Payments	3						4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E, Part A, line 21 (see instructions)	21						5
6	IME payment adjustment (see instructions)	22						6
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	Amount from Worksheet E Part A, line 27 (see instructions)	27						7
8	IME Adjustment (see instructions)	28						8
9	Total IME payment (sum of lines 6 and 8)	29						9
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage (see instructions)	33						10
11	Disproportionate share adjustment (see instructions)	34						11
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment (see instructions)	46						12
13	Subtotal (see instructions)	47						13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48						14
15	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49						15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50						16
17	Special add-on payments for new technologies	54						17
18	Capital outlier reconciliation adjustment amount (see instructions)	93						18
19	**SUBTOTAL**							19
		W/S L, line	(Amounts from L)					
		(0)	(1)	(2)	(3)	(4)	(5)	
20	Capital DRG other than outlier	1						20
21	Capital DRG outlier payments	2						21
22	Indirect medical education percentage (see instructions)	5						22
23	Indirect medical education adjustment (line 1 times line 5)	6						23
24	Allowable disproportionate share percentage (see instructions)	10						24
25	Disproportionate share adjustment (line 10 times line 1)	11						25
26	Total prospective capital payments (sum of lines 1-2, 6 and 11)	12						26
		W/S E, Part A line	(Amounts to E pt A)					
		(0)	(1)	(2)	(3)	(4)	(5)	
27	Low volume adjustment factor							27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, *line 70.96*) *(prior to 10/1)*							28
29	Low volume adjustment (transfer amount to Worksheet E, Part A, *line 70.97*) *(on or after 10/1)*							29

This page is reserved for future use.

Line Descriptions

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see 42 CFR 413.13(c)), also enter the total reasonable cost from line 11 directly on line 21. Still complete lines 6 through 16 to insure that you meet one of the criteria for this exemption.

Lines 12 - 20--These lines provide for the accumulation of charges which relate to the reasonable cost on line 11.

Do not include on these lines: (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, *chapter 21,* §2104.3) and (2) charges to beneficiaries for excess costs. (See CMS Pub. 15-1, *chapter 25,* §§2570-2577.)

Line 12--For total charges for medical and other services, enter the sum of Worksheet D, Part V, columns 3 and 4, line 202.

Line 13--If you are an approved CTC, enter the organ acquisition charges from Worksheet D-4, Part III, column 4, line 69 for the hospital or the hospital component of a health care complex.

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

Lines 15 - 18--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or fail to make reasonable efforts to collect such charges from those patients. If line 17 is greater than zero, multiply line 14 by line 17, and enter the result on line 18. 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 15 through 17. Enter on line 18 the amount from line 14. In no instance may the customary charges on line 18 exceed the actual charges on line 14. (See 42 CFR 413.13(e).)

Line 19--Enter the excess of the customary charges over the reasonable cost. If line 18 exceeds line 11, enter the difference.

Line 20--Enter the excess of reasonable cost over the customary charges. If line 11, exceeds line 18, enter the difference.

Line 21--Enter the amount from line 11, less any amount reported on line 20 for hospital/services subject to LCC.

For hospital/services that are not subject to LCC in accordance with 42 CFR 413.13 (e.g., CAHs or nominal charge public or private hospitals identified on Worksheet S-2, Part I, lines 155-161), enter the reasonable costs from line 11.

For CAHs enter on this line 101 percent of line 11.

Line 22--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

Provider/Component	Title XVIII Hospital	Title XVIII Subprovider	Title XVIII Skilled Nursing Facility
Hospital	Part I, col. 9, line 9 plus line 27; or Part II, col. 7, line 37; or Part III, col. 6, line 45	Part I, col. 9, lines 10, 11 or 12; or Part II, col. 7,col. lines 38, 39 or 40 or Part III, col. 6, line 46, 47 or 48	Part I, col. 9, line 13; or Part II, 7, line 41; or Part III, col. 6, line 49

Line 23--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost (see 42 CFR 415.160 and CMS Pub. 15-1, *chapter 21,* §2148), enter the amount from Worksheet D-5, Part II, column 3, line 21.

Line 24--Enter the sum of lines 3, 4, 8, and 9, all columns.

Computation of reimbursement Settlement

Line 25--Enter the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for coinsurance, enter on this line the full coinsurance amount not the discounted amount.

Line 26--Enter the deductible and coinsurance relating to the amounts reported on line 24.

NOTE: If these services are exempt from LCC as a result of charges being equal to or less than 60 percent of cost (refer to Worksheet S-2, Part I, lines 155-161 columns 1-5, as applicable), enter the Part B deductibles billed to program beneficiaries only. Do not enter any Part B coinsurance. For CAHs enter the deductibles on line 25 and the coinsurance on line 26.

Line 27--Subtract lines 25 and 26 from lines 21 and 24 respectively. Add to that result the sum of lines 22 and 23.

NOTE: If these services are exempt from LCC, *(*line 21 minus line 25 *minus Worksheet D, Part V, line 202, column 7)* times 80 percent*, then add back Worksheet D, Part V, line 202, column 7,* plus lines 22 and 23. Add to that result line 24 minus line 26.

For critical access hospitals (CAHs), enter the lesser of (line 21 minus the sum of lines 25 and 26) or 80 percent times the result of (line 21 minus line 25 minus 101% of lab cost (Worksheet D, Part V, column 6, lines 60, 61, and subscripts) minus 101% of costs not subject to deductible and coinsurance (Worksheet D, Part V, column 7, line 20*2*). Add back the aforementioned 101% of lab cost and 101% of cost not subject to deductibles and coinsurance. Add to that result the sum of lines 22 and 23.

Line 28--Enter in column 1 the amount from Worksheet E-4, line 50. Complete this line for the hospital component only.

Line 29--Enter in column 1 the amount from Worksheet E-4, line 36. Complete this line for the hospital component only.

Line 30--Enter in column 1 the sum of columns 1 and 1.01, lines 27 through 29.

Line 31--Enter the amounts paid or payable by 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:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, the services are treated as if they were non-program services for cost reporting purposes only. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient charges in total charges but not in program charges. In this situation, enter no primary payer payment on line 31. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

When the primary payment does not satisfy the beneficiary's liability, include the covered charges in program charges, and include the charges in charges for cost apportionment purposes. Enter the primary payer payment on line 31 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 31.

Line 32--Enter line 30 minus line 31.

Line 33--Enter the amount of allowable bad debts for deductibles and coinsurance for ESRD services reimbursed under the composite rate system from Worksheet I-5, line 11.

Allowable bad debts (Exclude bad debts for professional services)

Line 34--Enter from your records allowable bad debts for deductibles and coinsurance net of recoveries for other services, excluding professional services. Do not include ESRD bad debts. These are reported on line 33. Bad debts associated with ambulance services rendered (since these costs are reimbursed on a fee basis) are not allowable. If recoveries exceed the current year's bad debts, lines 34 and 35 will be negative.

Line 35--Multiply the amount (including negative amounts) on line 34 times 70 percent (hospitals and subproviders only). The reduction does not apply to Critical Access Hospitals.

For cost reporting periods that begin on or after October 1, 2012, multiply the amount (including negative amounts) on line 34 times 65 percent (hospitals and subproviders only).

For CAHs *with cost reporting periods beginning on or after October 1, 2012, multiply the amount on line 34 (including negative amounts) times 88 percent. For cost reporting periods beginning on or after October 1, 2013, multiply the amount on line 34 times 76 percent. For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 34 times 65 percent.*

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

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

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

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

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

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

Line 40--Enter the result of line 37, plus or minus line 39 *and its subscripts not previously identified*, minus line*s* 38 *and 39.99.*

Line 40.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 40].

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

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

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

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

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

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

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

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

Line 93--Enter the time value of money.

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

NOTE: If a cost report is reopened more than one time, subscript lines 90 through 93, respectively, one time for each time the cost report is reopened.

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

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

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

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

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

The column headings designate two categories of payments:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OR

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

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

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

Lines *11* - 29--Reserved for future use.

Inpatient Hospital Services Under IPPS & CAH--

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 5--For title XVIII, enter in column 1 the total number of days in which program swing bed-SNF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 10 and 11. For titles V or XIX, enter in column 1 the total number of days in which program swing

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

The following reconciliation format is recommended:

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

NOTE: See §4026.1.

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

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

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

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

Line 10--Line 8 minus line 9.

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

Line 12--Enter line 10 minus line 11.

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

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

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

Line 16--Enter any other adjustments.

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

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

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

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

Line 19.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 19].

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

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

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

4033. WORKSHEET E-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT

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

Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA
Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS
Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS
Part IV - Calculation of Medicare Reimbursement Settlement Under LTCH PPS
Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement (CAHs)
Part VI - Calculation of Reimbursement Settlement - All Other Health Services for Part A Services for Title XVIII PPS SNFs
Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services

4033.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA--Use Worksheet E-3, Part I to calculate Medicare reimbursement settlement under TEFRA for *cancer and children's* hospitals.

Line Descriptions

Line 1--Enter the amount from Worksheet D-1, Part II, line 63.

Line 2--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-4, Part III, column 1, line 69. *If you are not an approved CTC do not complete line 2.*

Line 3--For hospitals that have elected to be reimbursed for the services of teaching physicians on the basis of *reasonable* cost, enter the amount from Worksheet D-5, Part II, column 3, line 20.

Line 4--Enter the sum of lines 1, 2 and 3.

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

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full.

This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

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

Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

Line 9--Enter the Part A coinsurance.

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

Line 11--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 11 and 12 will be negative.

Line 12--Multiply the amount (including negative amounts) from line 11 by 70 percent *for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.*

Line 13--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 11.

Line 14--Enter the sum of lines 10 and 12.

Line 15--Enter the amount from Worksheet E-4, line 49 for the hospital component only.

Line 16--*DO NOT USE THIS LINE.*

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

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

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

Line 18.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 18].

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

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

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

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

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

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

Line Descriptions

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

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

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

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

Line 4--For providers that trained residents in the most recent **cost reporting period filed on or before November 15, 2004** (response on Worksheet S-2, Part I, line 71, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period filed on or before November 15, 2004. See FR, volume 69, No. 219, dated November 4, 2004, page 66922 for a detailed explanation.

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

Line 5--*If the response to Worksheet S-2, Part I, line 71, column 2 is "Y" and your facility* did not train residents in the most recent cost report filed before November 15, 2004, but *qualifies* to receive a cap adjustment under *42 CFR* 412.424(d)(1)(iii)*(D) enter the new program cap adjustment on this line. Do not complete this line until the new program growth period has ended using the method described in 42 CFR 413.79(e)(1)(i) and (ii). If your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the cap adjustment accordingly.*

Line 6--Enter the current year unweighted FTE resident count *excluding* **FTEs** in the *new program growth period. FTEs in the new program growth period are reported on line 7.* If your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year *following the new program growth period* of the first new program, then prorate the FTE count accordingly.

Line 7--Enter the current year unweighted FTE count for residents in *the* new *program growth period*. Complete this line only during the *new program growth period* of the first new program's existence. If your fiscal year end does not correspond to the program year end, and *this* cost reporting period includes the beginning of the program year *following the* new program *growth period of the first new program*, then prorate the FTE count accordingly.

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

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

Beginning with the program year *following the new program growth period* of the first new program's existence, enter the lower of the FTE count on line 6 or the FTE count on line 5. Add to this count the FTEs on line 7 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year *following the* new program *growth period of the first new program*.

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

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

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

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

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

Line 14--*DO NOT USE THIS LINE*.

Line 15--For IPFs or IPF subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of *reasonable* cost, enter the amount from Worksheet D-5, Part II, column 3, line 20.

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

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

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

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

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

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

Line 18--Enter line 16 minus line 17.

Line 19--Enter the Part A deductibles.

Line 20--Enter line 18 minus line 19.

Line 21--Enter the Part A coinsurance.

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

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

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

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

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

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

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

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

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

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

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

Line 31.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 31].

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

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

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

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

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

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-*0*4, *c*hapter 3, §190.7.2.3 - §190.7.2.5.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-*0*4, *c*hapter 3, §190.7.2.3 - §190.7.2.5.)

Line 53--Enter the time value of money.

NOTE: If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

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

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

Line Descriptions

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

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

Line 3--IRF LIP payment, enter the result of {(1 + (line 2) + (L1/L2)) to the .4613 power - 1} times (line 1). L1 = IRF Medicaid Days from Worksheet S-2, Part I, columns 1 through *5*, line 25. L2 = IRF total days from Worksheet S-3, Part I, column 8, lines 1 or 17 and subscripts as applicable plus employee discount days (S-3, Part I, column 8, line 30 (line 31 for IRF subproviders)).

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

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

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

Line 5.01--For IRFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment in accordance with FR, volume 76, No. 151, dated August 5, 2011, page 47846.

Line 6--*If the response to Worksheet S-2, Part I, line 76, column 2 is "Y" and your facility did* not train residents in the most recent cost reporting period ending on or before November 15, 2004, and qualifies to receive a cap adjustment (see FR Vol. 70, No. 156, page 47929, dated August 15, 2005) *enter the new cap adjustment on this line.* Do not complete this line until the *new program growth period has ended using the method described in 42 CFR 413.79(e)(1)(i) and (ii).* If your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year *following the new program growth period* of the first new program, then prorate the cap adjustment accordingly.

Line 7--Enter the current year unweighted FTE resident count *excluding* **FTEs** in the new program *growth period*. *FTEs in the new program growth period are reported on line 8.* If your fiscal year end does not correspond to the program year end and *this* cost reporting period includes the beginning of the *program year following the new program growth period of the first new program*, then prorate the *FTE* count accordingly.

Line 8--Enter the current year unweighted FTE count for residents in *the* new *program growth period*. Complete this line only during the *new program growth period* of the first new program's existence. If your fiscal year end does not correspond with the program year end, and *this* cost reporting period includes the beginning of the program year *following the new program growth period* of the first new program, then prorate the *FTE* count accordingly.

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

For providers that qualify to receive a cap adjustment (see FR Vol. 70, No. 156, page 47929, dated August 15, 2005), during the *new program growth period* of the first new program's existence enter the FTE count from line 8.

Beginning with the program year *following the new program growth period* of the first new program's existence, enter the lower of the FTE count on line 7 or the FTE count on line 6. Add to this count the FTEs on line 8 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year *following the new program growth period* of the first new program.

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

Line 11--Enter the *teaching* adjustment factor by adding 1 to the ratio of line 9 to line 10. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the *teaching* adjustment factor. This is expressed mathematically as {(1 + (line 9 / line 10)) to the .6876 power - 1}.

Line 12--Enter the *teaching* adjustment by multiplying line 1 by line 11.

Line 13--Enter the sum of lines 1, 3, 4 and 12.

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

Line 15--*DO NOT USE THIS LINE.*

Line 16--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-5, Part II, column 3, line 20.

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

Line 18--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:

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

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

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

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

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

Line 19--Enter line 17 minus line 18.

Line 20--Enter the Part A deductibles.

Line 21--Enter line 19 less line 20.

Line 22--Enter the Part A coinsurance.

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

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

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

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

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

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

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

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

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

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

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

Line 32.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 32].

Line 33--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 34 the amount on line 5.99.

Line 35--Enter line 32 minus the sum of lines *32.01,* 33 and 34. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 36--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See *CMS Pub. 15-2, chapter 1,* §115.2.) Attach a schedule showing the details and computations.

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

Line 50--Enter the original outlier amount from *W*orksheet E-3, Part III, line 4.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, *c*hapter 3, §140.2.8 - §140.2.10.

Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, *c*hapter 3, §140.2.8 - §140.2.10)

Line 53--Enter the time value of money.

NOTE: If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

4033.4 Part IV - Calculation of Medicare Reimbursement Settlement Under LTCH PPS--Use Worksheet E-3, Part IV to calculate Medicare reimbursement settlement under LTCH PPS for hospitals. (See 42 CFR 412, subpart O.)

Line Descriptions

Line 1--Enter the net Federal LTCH PPS payment including short stay outlier payments. Obtain this information from the PS&R and/or your records.

Line 2--Enter the high cost outlier payments. Obtain this from the PS&R and/or your records.

Line 3--Enter the sum of lines 1 and 2.

Line 4--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable.

Line 5--*DO NOT USE THIS LINE*.

Line 6--For hospitals that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter the amount from Worksheet D-5, Part II, column 3, line 20.

Line 7--Enter the sum of lines 3, 4, 5 and 6.

Line 8--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:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 8. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 8 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 8 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 9--Enter line 7 minus line 8.

Line 10--Enter the Part A deductibles.

Line 11--Enter line 9 less line 10.

Line 12--Enter the Part A coinsurance.

Line 13--Enter the result of subtracting line 12 from line 11.

Line 14--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 14 and 15 will be negative.

Line 15--Multiply the amount (including negative amounts) from line 14 by 70 percent *for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.*

Line 16--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 14.

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

Line 18--Enter the amount from Worksheet E-4, line 49 for the hospital.

Line 19--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 20--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

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

Enter on line 21.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, *chapter 1,* §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 22--Enter the sum of lines 17, 18, and 19 plus or minus lines 20 and 21.

Line 22.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 22].

Line 23--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 24 the amount on line 5.99.

Line 25--Enter line 22 minus the sum of lines *22.01,* 23 and 24. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 26--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See *CMS Pub. 15-2, chapter 1,* §115.2.) Attach a schedule showing the details and computations.

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

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

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, *c*hapter 3, §150.26 - §150.28.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, *c*hapter 3, §150.26 - §150.28)

Line 53--Enter the time value of money.

NOTE: If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

Computation of Reimbursement Settlement

Line 18--*D*o not complete this line.

Line 19--Enter the sum of lines 6 and 17.

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

Line 21--*Do* not complete this line.

Line 22--Enter line 19 minus line 20.

Line 23--Enter from PS&R or your records the coinsurance billed to Medicare beneficiaries.

Line 24--Enter line 22 minus line 23.

Line 25--Enter from your records program allowable bad debts net of recoveries. If recoveries exceed the current year's bad debts, lines 25 and 26 will be negative.

Line 26--No reduction is required for critical access hospitals *for cost reporting periods beginning prior to October 1, 2012, enter the amount from line 25*.

Multiply the amount from line 25 (including negative amounts) by 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 27--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 25.

Line 28--Enter the sum of lines 24 and *26*.

Line 29--Enter any other adjustments. For example, if you change the recording of vacation pay from cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-1, *chapter 21,* §2146.4.) Specify the adjustment in the space provided.

Enter on line 29.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, *chapter 1,* §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 30--Enter line 28, plus or minus line 29.

Line 30.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 30].

Line 31--Enter interim payments from Worksheet E-1, column 2, line 4. For contractor final settlement, report on line 32 the amount from line 5.99.

Line 33--Enter line 30 minus the sum of lines *30.01,* 31 and 32. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 34--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See *CMS Pub. 15-2, chapter 1,* §115.2.) Attach a schedule showing the details and computations for this line.

4033.6 Part VI - Calculation of Reimbursement Settlement - All Other Health Services for Title XVIII Part A PPS SNF Services-- For title XVIII SNFs reimbursed under PPS, complete this part for settlement of Part A services. For Part B services, all SNFs complete Worksheet E, Part B.

When this part is completed for a component, show both the hospital and component numbers.

Computation of Net Costs of Covered Services

Line Descriptions

Prospective Payment Amount

Line 1--Compute the sum of the following amounts obtained your books and records or from the PS&R:

- The Resource Utilization Group (RUG) payments made for PPS discharges during the cost reporting period, and
- The RUG payments made for PPS transfers during the cost reporting period.

Line 2--Enter the amount from Worksheet D, Part III, column 9, line 44.

Line 3--Enter the amount from Worksheet D, Part IV, column 11, line 200.

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

Line 5--Do not use this line as vaccine costs are included on line 1 of Worksheet E, Part B. Line 5 is shaded on Worksheet E-3, Part VI.

Line 6--Enter any deductible amounts imposed.

Line 7--Enter any coinsurance amounts.

Line 8--Enter from your records program allowable bad debts for deductibles and coinsurance net of bad debt recoveries. If recoveries exceed the current year's bad debts, lines 8 and 9 will be negative.

Line 9--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount must also be reported on line 8. This amount is reported for statistical purposes only *for cost reporting periods beginning prior to October 1, 2012*.

Line 10--DRA 2005 SNF Bad Debt--Calculate this line as follows *for cost reporting periods beginning prior to October 1, 2012*: [((line 8 - line 9) * 7*0 percent*) + line 9]. This is the adjusted SNF reimbursable bad debt in accordance with DRA 2005, section 5004.

*In accordance with DRA 2005 SNF Bad Debt as amended by section 3201(b) of the Middle Class Tax Relief and Job Creation Act of 2012, calculate this line as follows: for cost reporting periods beginning on or after October 1, 2012, calculate this line as follows: [((line 8 - line 9) * 65 percent) + (line 9 * 88 percent)]. For cost reporting periods beginning on or after October 1, 2013, calculate this line as follows: [((line 8 - line 9) * 65 percent) + (line 9 * 76 percent)]. For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 8 by 65 percent.*

Line 11--Enter the title XVIII reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include on this line the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, Part III, line 85.

Line 12--Enter the result of line 4 plus line 5 minus the sum of lines 6 and 7 plus lines 10 and 11.

Line 13--Enter the amounts paid or payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer for inpatient services. Enter only the primary payer amounts applicable to Part A routine and ancillary services.

Line 14--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc., enter the adjustment. (See CMS Pub. 15-1, *chapter 21,* §2146.4.) Specify the adjustment in the space provided.

Enter on line 14.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, *chapter 1,* §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 15--Enter the result of line 12, plus or minus 14, minus line 13.

Line 15.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 15].

Line 16--For title XVIII, enter the total interim payments from Worksheet E-1, column 2, line 4.

*Line 17--*For contractor final settlement, report the amount from *Worksheet E-1, column 2,* line 5.99.

Line 18--Enter line 15 minus the sum of the amounts on lines *15.01,* 16 and 17. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 19--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See *CMS Pub. 15-2, chapter 1,* §115.2.) Attach a schedule showing the details and computations.

4033.7 Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services--*This worksheet* calculates reimbursement for titles V or XIX services for hospitals, subproviders, other nursing facilities and ICF/MRs.

Use a separate copy of this part for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of this part to indicate the component and program for which it is used. When this part is completed for a component, show both the hospital and component numbers. Enter check marks in the appropriate spaces to indicate the applicable reimbursement method for inpatient services (e.g., TEFRA, OTHER).

Computation of Net Costs of Covered Services

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs.

Cost Reimbursement

Hospital/CAH or Subprovider - Worksheet D-1, Part II, line 49
Skilled Nursing Facility, Other Nursing Facility, ICF/MR - Worksheet D-1, Part III, line 86.
If Worksheet S-2, line 92 is answered "yes", and multiple Worksheets D-1 are prepared, add the multiple Worksheets D-1 and enter the result.

TEFRA

Hospital or Subprovider - Worksheet D-1, Part II, line 63

NOTE: If you are a new provider reimbursed under TEFRA, use Worksheet D-1, Part II, line 49.

Line 2--Enter the cost of outpatient services for titles V or XIX which is the sum of Worksheet D, Part V, columns 6 and 7 and subscripts where applicable.

Line 3--For titles V and XIX, enter in column 1 the amount paid or payable by the State program for organ acquisition.

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

Line 5--Enter in column 1 the amounts paid or payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer for inpatient services for titles V and XIX.

Line 6--Enter in column 2 the primary payer amounts applicable to outpatient services for titles V and XIX.

Line 7--Enter line 4 minus the sum of lines 5 and 6.

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

Line Descriptions

Lines 8 - 11--These lines provide for the accumulation of charges which relate to the reasonable cost on line 4.

Line 35--Enter in column 1 the reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include the amount on this line in the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, Part III, line 85.

Line 36--Enter the sum of lines 31, 34, and 35 minus the sum of lines 32 and 33 in columns 1 and 2, respectively.

Line 37--Enter any other adjustments in columns 1 and 2, respectively. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-1, *chapter 21,* §2146.4.) Specify the adjustment in the space provided.

Line 38--Enter the result of line 36 plus or minus line 37 in columns 1 and 2, respectively.

Line 39--Enter the amount from Worksheet E-4, line 31 in column 1.

Line 40--Enter the sum of lines 38 and 39 in columns 1 and 2, respectively.

Line 41--For titles V and XIX, obtain interim payments from your records and enter in columns 1 and 2, respectively.

Line 42--Enter the result of line 40 minus line 41, in columns 1 and 2, respectively. Transfer the sum of columns 1 and 2 to Worksheet S, Part III, column 1 (Title V) or column 5 (Title XIX), line as appropriate.

Line 43--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations.

4034. WORKSHEET E-4 - DIRECT GRADUATE MEDICAL EDUCATION (GME) AND ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Use this worksheet to calculate each program's payment (i.e., titles XVIII, V, and XIX) for direct graduate medical education (GME) costs as determined under 42 CFR 413.75 through 413.83. This worksheet applies to the direct graduate medical education cost applicable to interns and residents in approved teaching programs in hospitals and hospital-based providers. Complete this worksheet if the response to line 56 of Worksheet S-2, Part I is yes. The direct medical education costs of the nursing school and paramedical education programs continue to be paid on a reasonable cost basis as determined under 42 CFR 413.85. However, the nursing school and paramedical education costs, formerly paid through the ESRD composite rate as an exception, are paid on this worksheet on the basis of reasonable cost under 42 CFR 413.85. Effective for cost reporting periods beginning on or after October 1, 1997 the unweighted direct graduate medical education FTE is limited to the hospital's FTE count for the most recent cost reporting period ending on or before December 31, 1996. This limit applies to allopathic and osteopathic residents but excludes dentistry and podiatry. The GME payment is also based on the inclusion of Medicare HMO patients treated in the hospital. This worksheet will also calculate payment for direct GME as determined under 42 CFR 413.79(c)(3) and (4) and IME as determined under 42 CFR 412.105(f)(1)(iv)(B) and (C) for hospitals that received an adjustment (reduction or increase) to their FTE resident caps for direct GME and/or IME under section 422 of Public Law 108-173.

NOTE: Do not complete this worksheet for a cost reporting period prior to the base period used for calculating the per resident amount (PRA) in situations where the hospital did not train residents in approved residency training programs or did not participate in the Medicare program during the base period but either condition changed in a cost reporting period beginning on or after July 1, 1985. 42 CFR 413.77(e)(1) specified that in this situation, any GME costs for the cost reporting period prior to the base period are reimbursed on a reasonable cost basis.

Also, do not complete this worksheet for residents training in the general acute care part of a CAH since the associated costs are reimbursed on a reasonable cost basis.

Complete this worksheet if this is the first month in which residents were on duty during the first month of the cost reporting period or if residents were on duty during the entire prior cost reporting period. (See 42 CFR 413.77(e)(1).)

This worksheet consists of five sections:

1. Computation of Total Direct GME Amount
2. Computation of Program Patient Load
3. Direct Medical Education Costs for ESRD Composite Rate - Title XVIII only
4. Apportionment of Medicare Reasonable Cost (title XVIII only)
5. Allocation of Medicare Direct GME Costs Between Part A and Part B

Computation of Total Direct GME Amount--This section computes the total approved amount.

Line Descriptions

Line 1--Enter the unweighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. If this cost report is less than a full 12 months, contact your contractor. (42 CFR 413.79(c)(2)) Also include here the 30 percent increase to the count for qualified rural hospitals (42 CFR 413.79(c)(2)(i)), and the increase due to primary care residents that were on approved leaves of absence (42 CFR 413.79(i)). Temporarily reduce the cap of a hospital that closed a program(s), if the regulations at 42 CFR 413.79(h)(3)(ii) are applicable. (Effective 10/1/2001.)

Line 2--Enter the unweighted resident FTE count for allopathic and osteopathic programs that meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1)) *or (e)(3)*, the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995, *but before October 1, 2012. For hospitals that began training residents in a new program for the first time on or after October 1, 2012, the cap is effective beginning with the sixth program year (see 77 FR August 31, 2012, 53417)*. For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited or begun on or after January 1, 1995, and before August 6, 1997 *is reported on this line and* is effective in the fourth program year of each of those new programs (see 66 FR August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 1. *Do not report new program FTEs during the time frame prior to the effective date of the hospital's FTE cap on this line. New program FTEs during the time frame prior to the effective date of the hospital's FTE cap are reported on* line 15. *For urban hospitals that already have an FTE cap on line 1 but start a rural track program in accordance with 42 CFR 413.75(k),* enter the unweighted allopathic or osteopathic FTE count for residents in all years of the rural track program that meet the criteria for an add-on to the cap under 42 CFR 413.79(k). If the rural track program is a new program under 42 CFR 413.79(l) and *the urban hospital* qualifies for a cap adjustment under *42 CFR* 413.79(e)(1) or (e)(3), do not report FTE residents in the rural track program on this line *during the time frame prior to the effective date of the hospital's FTE cap.*

Line 3--Enter the section 422 reduction amount to the direct GME cap as specified under 42 CFR 413.79(c)(3).

Line 3.01--Enter the section 5503 reduction amount to the direct GME cap as specified under 42 CFR 413.79(m). If this cost report straddles July 1, 2011, then calculate the prorated section 5503 reduction amount off the cost report and enter the result on this line. (Prorate the cap reduction amount by multiplying it by the ratio of the number of days from July 1, 2011, to the end of the cost reporting period to the total number of days in the cost reporting period). Otherwise enter the full cap reduction amount.

Line 4--Enter the adjustment (increase or decrease) for the unweighted resident FTE count for allopathic or osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(f), and (63 FR 26 336 May 12, 1998), and (67 FR 50069 August 1, 2002).

Line 4.01--Enter, as applicable, all or a portion of the amount of the FTE cap slots the hospital was awarded under section 5503 of ACA. The amount of the section 5503 award that is reported on this line is the amount of the section 5503 award that is being "used" in this cost reporting period. In the 5-year evaluation period following implementation of section 5503 (that is, July 1, 2011 through June 30, 2016), at least 75 percent of the slots are to be "used" for additional primary care and/or general surgery residents, while 25 percent of the amount that is reported may be (but need not be) "used" for other purposes. During the 5-year evaluation period, failure to meet the requirements at 42 CFR 413.79(n)(2) of the regulations means loss of a hospital's section 5503 slots. Therefore, do not automatically report the full amount of the section 5503 slots; only enter the amount of the section 5503 award that equates to at least 75 percent of the FTEs being "used" for additional primary care and/or general surgery FTEs, and no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting *period. If the amount reported on Worksheet S-2, Part I, line 61.02, column 3, is less than the amount on line 61.01, column 3, then report 0 on this line.*

Line 4.02--Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. Further subscript this line (lines 4.03 through 4.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to

determine the effective date of the cap increase. If the section 5506 award is phased in over more than one effective date, only report the portions of the section 5506 award as they become effective. If the effective date of the cap increase is not the same as your fiscal year begin date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period.)

Line 5--Enter the result of line 1 plus line 2 minus line 3 minus line 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus subscripts as applicable. However, if the resulting cap is less than zero, enter zero on this line.

Line 6--Enter the unweighted resident FTE count for allopathic or osteopathic programs for the current year from your records, other than those in the initial years of the program , i.e., the program has not yet completed one cycle of the program (the "period of years" or the minimum accredited length of the program. The residents in programs within the "period of years" are exempt from the rolling average rules. (42 CFR 413.79(d)(5) and (e).) Contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or greater than 3 years. Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)).

Line 7--Enter the lesser of lines 5 or 6.

Line 8--Enter in column 1, the weighted FTE count for primary care physicians and OB/GYN residents in an allopathic or osteopathic program for the current year other than those in the period of years of the program that meet the criteria for an exception to the rolling average rules. Enter in column 2, 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 rolling average rules. (42 CFR 413.79(d)(5) and (e)). Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)). *Enter in column 3 the sum of columns 1 and 2.*

Line 9--If line 6 is less than or equal to line 5, enter the amounts from line 8, columns 1 and 2, in columns 1 and 2 of this line. Otherwise, multiply the amount in each column of line 8 by (line 5/line 6). Enter in column 3 the sum of columns 1 and 2. (42 CFR 413.79(c)(2)(iii).)

Line 10--Enter in column 2 the weighted dental and podiatric resident FTE count for the current year.

Line 11--Enter in column 1, the amount from column 1, line 9. Enter in column 2, the sum of the amounts in column 2, lines 9 and 10.

Line 12--Enter in column 1, the weighted FTE count for primary care residents for the prior year, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific primary care program included in Form 2552-96, *Worksheet E-3, Part IV,* line 3.22 or Form 2552-10, *Worksheet E-4,* sum of lines 15 and 16 of the prior year's cost report. If subject to the cap in the prior year Form 2552-96 cost report, report the result of *Worksheet E-3, Part IV,* line 3.07 times (line 3.04/line 3.05). If subject to the cap in the prior year Form 2552-10 cost report, report the result of *Worksheet E-4,* column 1, line 8 times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the prior year, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that

specific nonprimary care program included in Form 2552-96, *Worksheet E-3, Part IV,* line 3.16 or Form 2552-10, *Worksheet E-4,* sum of lines 15 and 16 of the prior year's cost report. If subject to the cap in the prior year Form 2552-96 cost report, report the result of *Worksheet E-3, Part IV,* line 3.08 times (line 3.04/line 3.05) plus line 3.11. If subject to the cap in the prior year Form 2552-10 cost report, report the result of *Worksheet E-4,* column 2, line 8 times (line 5/line 6) plus line 10.

Line 13--Enter in column 1, the weighted FTE count for primary care residents for the cost reporting year before last, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific primary care program included in Form 2552-96, line 3.22 or for 2552-10, sum of lines 15 and 16 of that year's cost report. If subject to the cap in the year before last Form 2552-96 cost report, report the result of line 3.07 times (line 3.04/line 3.05). If subject to the cap in that year Form 2552-10 cost report, report the result of column 1, line 8 times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the cost reporting year before last, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific nonprimary care program included in Form 2552-96, line 3.16 or Form 2552-10, sum of lines 15 and 16 of that year's cost report. If subject to the cap in the cost reporting year before last, Form 2552-96 cost report, report the result of line 3.08 times (line 3.04/line 3.05) plus line 3.11. If subject to the cap in that year Form 2552-10 cost report, report the result of column 2, line 8 times (line 5/line 6) plus line 10.

Line 14--Enter the rolling average FTE count in each column, by adding lines 11 through 13 and dividing by 3.

Line 15--Enter the weighted number of FTE residents in the initial years of a program that meets the exception to the rolling average rules in column 1 for primary care and in column 2 for nonprimary care FTEs.

Line 16--Enter the temporary weighted FTE residents that were displaced by program or a hospital closure in column 1 for primary care and in column 2 for nonprimary care FTEs, which you would not be able to count without a temporary cap adjustment. (42 CFR 413.79(h).)

Line 17--Enter the sum of lines 14 through 16.

Line 18-- Enter in column 1, the primary care and OB/GYN per resident amount. Enter in column 2, the nonprimary care per resident amount.

Line 19--Enter the result of multiplying lines 17 times line 18. Enter in column 3, the sum of columns 1 and 2.

Line 20--Section 422 Direct GME FTE Cap--Enter the number of unweighted allopathic and osteopathic direct GME FTE resident cap slots the hospital received under 42 CFR §413.79(c)(4).

Line 21--Direct GME FTE Resident Unweighted Count Over/Under the Cap--Subtract line 7 from line 6 and enter the result here. If the result is zero or negative, the hospital does not need to use the direct GME section 422 additional cap and lines 22 through 24 will not be completed.

Line 22--Section 422 Allowable Direct GME FTE Resident Count--If the count on line 21 is less than or equal to the count on line 20, then divide line 8 by line 6, and multiply the resulting ratio by the amount on line 21. If the count on line 21 is greater than the count on line 20, then divide line 8 by line 6, and multiply the resulting ratio by the amount on line 20.

Line 23--Enter the locality adjusted national average per resident amount as specified at 42 CFR section 413.77(g), inflated to the hospital's cost reporting period.

Line 24--Enter the product of lines 22 and 23. This is the allowable section 422 GME cost.

Line 25--Enter the sum of lines 19 and 24. This is the total Part A direct GME cost.

Computation of Program Patient Load--This section computes the ratio of program inpatient days to the total inpatient days. For this calculation, total inpatient days include inpatient days of the hospital along with its subproviders, including distinct part units excluded from the prospective payment system. Record hospital inpatient days of Medicare beneficiaries whose stays are paid by risk basis HMOs and organ acquisition days as non-Medicare days. Do not count inpatient days applicable to nursery, hospital-based SNFs and other nursing facilities, and other non-hospital level of care units for the purpose of determining the Medicare patient load.

Line Descriptions

Line 26--Enter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 8 through 12, and 16 through 18, and subscripts, as applicable. For titles V or XIX, enter the amounts from columns 5 or 7, respectively, sum of lines 1, 8 through 12, and 16 through 18, and subscripts, as applicable. For title XVIII, enter in column 2, Medicare managed care days from Worksheet S-3, Part I, column 6, lines 2, 3 and 4. For title XIX, enter in column 2, Medicaid managed care days from Worksheet S-3, Part I, column 7, lines 2, 3 and 4.

Line 27--Transfer to columns 1 and 2, respectively, the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, and 16 through 18 and subscripts as applicable.

Line 28--In each column, divide line 26 by line 27 and enter the result (expressed as a decimal). Column 1 is the Title XVIII Part A inpatient utilization and column 2 is the Medicare managed care inpatient utilization.

Line 29--Multiply the amount on line 25, column 1, by the amount reported in each column of line 28.

Line 30--In column 2, enter the amount on line 29, column 2 multiplied by the reduction factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. This is the reduction for direct GME payments for Medicare managed care (Medicare+Choice).

Line 31--Enter the sum of columns 1 and 2, line 29, less the amount in column 2, line 30.

Direct Medical Education Costs for ESRD Composite Rate Title XVIII Only--This section computes the title XVIII nursing school and paramedical education costs applicable to the ESRD composite rate. These costs are reimbursable based on the reasonable cost principles under 42 CFR 413.85 separate from the ESRD composite rate.

Line Descriptions

Line 32--Enter the amount from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94.

Line 33--Enter the amount from Worksheet C, Part I, column 8, sum of lines 74 and 94. This amount represents the total charges for renal and home dialysis.

Line 34--Divide line 32 by line 33, and enter the result. This amount represents the ratio of ESRD direct medical education costs to total ESRD charges.

Line 35--Enter from your records the Medicare outpatient ESRD charges.

Line 36--Enter the result of multiplying line 34 by line 35. This represents the Medicare outpatient ESRD costs. Transfer this amount to Worksheet E, Part B, line 29.

Apportionment of Medicare Reasonable Cost of GME--This section determines the ratio of Medicare reasonable costs applicable to Part A and Part B. The allowable costs of GME 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 37--Include the Part A reasonable cost for the entire hospital complex computed by adding the following amounts:

- Hospital and Subprovider(s) - Sum of each Worksheet D-1, Part II, line 49;
- Hospital-Based HHAs - Worksheet H-4, Part I, column 1, line 1;
- Swing Bed-SNF - Worksheet E-2, line 1, column 1;
- Hospital-Based PPS SNF - Sum of Worksheet D-1, Part III, line 74 and Worksheet E-3, Part VI, column 1, line 4.

Line 38--Enter the organ acquisition costs from Worksheet(s) D-4, Part III, column 1, line 69.

Line 39--Enter the cost of teaching physicians from Worksheet(s) D-5, Part II, column 3, line 20.

Line 40--Enter the total Medicare Part A primary payer amounts for the hospital complex from the applicable worksheets.

- PPS hospital and/or subproviders - Worksheet E, Part A, line 60;
- TEFRA hospital and/or subproviders - Worksheet E-3, Part I, line 5;
- IPF PPS hospital and/or subproviders - Worksheet E-3, Part II, line 17;
- IRF PPS hospital and/or subproviders - Worksheet E-3, Part III, line 18;
- LTC PPS hospital - Worksheet E-3, Part IV, line 8;
- Cost reimbursed hospital and/or subproviders - Worksheet E-3, Part V, line 5;
- Hospital-based HHAs - Each Worksheet H-4, Part I, column 1, line 9;
- Swing Bed SNF and/or NF - Worksheet E-2, column 1, line 9; and
- Hospital-based PPS SNF - Worksheet E-3, Part VI, column 1, line 13.

Line 41--Enter the sum of lines 37 through 39 minus line 40.

Line 42--Enter the Part B Medicare reasonable cost. Enter the sum of the amounts on each title XVIII Worksheet E, Part B, columns 1 and 1.01, sum of lines 1, 2, 9, 10, 22, and 23; Worksheet E-2, column 2, line 8; Worksheet H-4, Part I, sum of columns 2 and 3, line 1; Worksheet J-3, column 1, line 1; and Worksheet M-3, line 16.

Line 43--Enter the Part B primary payer amounts. Enter the sum of the amounts on each Worksheet E, Part B, line 31; Worksheet E-2, column 2, line 9; Worksheet H-4, Part I, sum of columns 2 and 3, line 9; Worksheet J-3, line 4*; Worksheet M-3, sum of columns 1 and 2, line 17*.

Line 44--Enter line 42 minus line 43

Line 45--Enter the sum of lines 41 and 44.

Line 46--Divide line 41 by line 45, and enter the result.

Line 47--Divide line 44 by line 45, and enter the result.

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

Line Descriptions

Line 48--Enter the amount from line 31.

Line 49--Complete for title XVIII only. Multiply line 46 by line 48, and enter the result. If you are a hospital subject to IPPS, transfer this amount to Worksheet E, Part A, line 52. Although this amount includes the Part A GME payments for subproviders, for ease of computation, transfer this amount to the primary hospital component worksheet only. If you are freestanding facility subject to TEFRA, transfer this amount to Worksheet E-3, Part I, line 15. If you are a freestanding IPF PPS, transfer this amount to Worksheet E-3, Part II, line 27. If you are a freestanding IRF PPS, transfer this amount to Worksheet E-3, Part III, line 28. If you are a freestanding LTCH PPS, transfer this amount to Worksheet E-3, Part IV, line 18.

Line 50--Complete for title XVIII only. Multiply line 47 by line 48, and enter the result. Transfer this amount to Worksheet E, Part B, line 28. Although this amount includes the Part B GME payments for subproviders, for ease of computation, transfer this amount to the hospital component only.

SECTIONS 4035 THROUGH 4039 ARE RESERVED FOR FUTURE USE.

4045.2 Part II - Computation of HHA Reimbursement Settlement.--

Line 10--Enter in column 1 the amount in Part I, column 1, line 1 less the amount in column 1, line 9. Enter in column 2 the sum of the amounts from Part I, columns 2 and 3, line 1 less the sum of the amounts in columns 2 and 3 on line 9. This line will only include pneumococcal, influenza, hepatitis B and injectable osteoporosis drugs reduced by primary payor amounts.

Lines 11 through 24--Enter in column 1 only for lines 11 through 14, as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 only on lines 15 and 16, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter on lines 18 through 20 the total DME, oxygen, prosthetics and orthotics payments, respectively, associated with home health PPS services (bill types 32 and 33). For lines 18 through 20 do not include any payments associated with services paid under bill type 34X. Obtain these amounts from your PS&R report.

Line 21--Enter in column 2 the Part B deductibles billed to program patients. Include any amounts of deductibles satisfied by primary payer payments.

Line 23--If there is an excess of reasonable cost over customary charges in any column on line 8, enter the amount of the excess in the appropriate column.

Line 25--Enter in column 2 all coinsurance billable to program beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of the costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 21 and primary payment amounts in column 3, line 9 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 27--Enter the allowable bad debts in the appropriate columns. If recoveries exceed the current year's bad debts, line 27 will be negative. *This line is shaded as HHAs cannot generate bad debts.*

Line 28--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 27. *This line is shaded as HHAs cannot generate bad debts.*

Line 29--Enter the result of line 26 plus 27.

Line 30--Enter any other adjustments. For example, enter an adjustment from changing the recording of vacation pay from the cash basis to accrual basis. (See CMS Pub. 15-1, *chapter 21,* §2146.4.)

Line 31--Enter the result of line 29 plus or minus line 30.

Line 31.01--Enter the sequestration adjustment amount from the PS&R report.

Line 32--Enter the interim payment amount from Worksheet H-5, line 4. For contractor final settlement, report on line 33 the amount from Worksheet H-5, line 5.99. For titles V and XIX, enter the interim payments from your records.

Line 34--The amounts show the balance due the provider or the program *by entering the result of line 31 minus the sum of lines 31.01, 32 and 33.* Transfer to Worksheet S, Part III, line 9 as applicable.

Line 35--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See *CMS Pub. 15-2, chapter 1,* §115.2.) A schedule showing the supporting details and computations for this line must be attached.

4050. WORKSHEET I-3 - DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

To accomplish the allocation of your direct and indirect costs reported on Worksheet I-1 to the different services provided in the department, you must maintain renal department statistics. To facilitate the allocation process, the format of Worksheets I-2 and I-3 is identical.

Line 1--Transfer the amounts on Worksheet I-2, line 1, columns 1 through 10 to Worksheet I-3, line 1, columns 1 through 10.

Lines 2 through 16--Enter on these lines and in the appropriate columns, the statistic for allocating costs to the appropriate line item. The statistical basis used in each column is defined in the column heading and on Worksheet I-1.

NOTE: If you wish to change your allocation basis for a particular general cost center, you must receive written approval from your contractor before the start of your cost reporting period for which the alternative method is used. (See §4017 for Worksheets B and B-1.)

Line 12--Enter, in the area provided, the number of inpatient dialysis treatments furnished during the cost reporting period.

Line 17--Add the statistical basis for each column, except columns 9 and 10.

Line 18--Calculate the unit cost multiplier by dividing the amount on line 1 by the total statistical basis on line 17 for each column. Multiply the unit cost multiplier by the statistical base, and enter the cost on the appropriate line and column number on Worksheet I-2.

Column Descriptions

Column 1--Use the square footage of the renal department to allocate capital and maintenance building costs.

Column 2--Use percentage of time to allocate capital and maintenance equipment costs.

Columns 3 and 4--Use paid hours to allocate registered nurses and direct patient care salary.

Column 5--Use total direct patient care salaries in columns 4 and 5 of Worksheet I-2 to allocate employee benefits.

Columns 6 and 7--Use cost of requisitions to allocate drug and medical supply costs.

Column 8--Use routine laboratory charges to allocate laboratory costs.

Column 10--Use subtotal costs in column 9, Worksheet I-2 to allocate overhead cost. To compute the unit cost multiplier, transfer the amount from Worksheet I-2, line 17, column 9 to Worksheet I-3, line 17, column 10. Do not allocate overhead costs to lines 14 (EPO) or 15 (Aranesp).

4051. WORKSHEET I-4 - COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

This worksheet records the apportionment of total outpatient cost to the types of dialysis treatment furnished by you and shows the computation of expenses of dialysis items and services that you furnished to Medicare dialysis patients. This information is used for overall program evaluation, determining the appropriateness of program reimbursement rates, and meeting statutory requirements for determining the cost of ESRD care.

Complete separate worksheets to report the costs of the renal dialysis department and the home program dialysis department.

If you have more than one renal dialysis and/or home dialysis department, submit one Worksheet I-4 combining the renal dialysis departments and/or one Worksheet I-4 combining the home dialysis departments as only one average composite rate will apply to each modality. Enter on the combined Worksheet I-4 each provider's satellite number if you are separately certified as a satellite facility.

In accordance with section 1881(b)(12)(A) of the Act, as added by section 623(d)(1) of MMA 2003, the ESRD payment is replaced by a calculated ESRD composite rate.

Section 153(b) of MIPPA amended section 1881(b) of the Act to require the implementation of an ESRD bundled payments system effective January 1, 2011.

For cost reporting periods that straddle January 1, 2011, report the rates for each modality on Worksheet I-4 as follows: For the portion of the cost reporting period prior to January 1, 2011, enter the average composite rate for each modality in column 7. For the portion of the cost reporting period on and after January 1, 2011, enter the average ESRD PPS payment rate for each modality in column 7.02. For cost reporting periods that straddle January 1, 2012, January 1, 2013, and January 1, 2014, report the average ESRD PPS payment rate for each modality on Worksheet I-4 as follows: For the portion of the cost reporting period prior to January 1, enter the average ESRD PPS payment rate for each modality in column 7.01. For the portion of the cost reporting period on and after January 1, enter the average ESRD PPS payment rate for each modality in column 7.02.

Columns 1 through 3 refer to total outpatient statistics, i.e., to all outpatient dialysis services furnished, whether reimbursed directly by the program or not.

Column 1--Enter on the appropriate lines the total number of outpatient treatments by type for all renal dialysis patients from your records. These statistics include all treatments furnished to all patients in the outpatient renal department, both Medicare and non-Medicare.

Column 2--Enter on the appropriate lines the total cost transferred from Worksheet I-2, columns 11, lines as appropriate.

Column 3--Determine the amounts entered on the appropriate lines by dividing the cost entered on each line in column 2 by the number of treatments entered on each line in column 1.

Line 9--Report continuous ambulatory peritoneal dialysis (CAPD) in terms of weeks. Compute patient weeks by totaling the number of weeks each Method I patient was dialyzed at home using CAPD.

Line 10--Report continuous cycling peritoneal dialysis (CCPD) in terms of weeks. Compute patient weeks by totaling the number of weeks each Method I patient was dialyzed at home by CCPD.

Medicare Treatments

Columns 4 through 7 refer only to treatments furnished to Medicare beneficiaries that were billed to the facility and reimbursed by the program directly. (Amounts entered in these columns are reconcilable to your records.)

Column 4--Enter on the appropriate lines the number of treatments billed to the Medicare program directly. Obtain this information from your records and/or the PS&R. *For cost reporting periods that straddle January 1, 2011, enter on column 4 the total number of treatments or patient weeks billed to Medicare for services rendered prior to January 1, 2011.*

Column 4.01--For cost reporting periods that straddle January 1, 2012, January 1, 2013 or January 1, 2014, enter the total number of treatments or patient weeks billed to Medicare for services rendered prior to January 1.

Column 4.02--For cost reporting periods that straddle or begin January 1, 2011, January 1, 2012, or January 1, 2013, enter the total number of treatments or patient weeks billed to Medicare for services rendered on and after January 1. For cost reporting periods that straddle January 1, 2014, enter the total number of treatments or patient weeks billed to Medicare for services rendered on and after January 1.

For cost reporting periods beginning on or after January 1, 2014, enter the number of ESRD PPS treatments billed to Medicare in column 4 and eliminate columns 4.01 and 4.02.

Column 5--Determine the amounts entered on the appropriate lines by multiplying the number of treatments entered on each line in column 4 by the average cost per treatment entered on the corresponding line in column 3. *For cost reporting periods that straddle or begin on or after January 1, 2011, enter total expenses determined by multiplying the sum of columns 4, 4.01, and 4.02 by the average cost per treatment entered on each corresponding line in column 3.* Transfer the total expenses from this column, line 11 to Worksheet I-5, line 1. If you complete a Worksheet I-4 for renal dialysis and a Worksheet I-4 for home dialysis, add the sum of the cost from this column, line 11, and transfer the total to Worksheet I-5, line 1.

Column 6--Total Program Payment--Enter the total program payment by the type of treatment for the reporting period. Since this amount is calculated on a patient basis and is case mix adjusted, the total program payment will be provider specific for each modality. *For cost reporting periods that straddle January 1, 2011, enter in column 6 the total program payment by the type of treatment for services rendered prior to January 1, 2011. For cost reporting periods beginning on or after January 1, 2014, enter the total program payment by the type of treatment. Obtain this from the PS&R. Transfer the total from column 6, line 11, to Worksheet I-5, line 2, column 1.*

Column 6.01--For cost reporting periods that straddle January 1, 2012, January 1, 2013 or January 1, 2014, enter the total program payment by the type of treatment for Medicare for services rendered prior to January 1. Obtain this from the PS&R. Transfer the total from column 6.01, line 11, to Worksheet I-5, line 2.01, column 1.

Column 6.02--For cost reporting periods that straddle or begin January 1, 2011, January 1, 2012, or January 1, 2013, enter the total program payment by the type of treatment for Medicare for services rendered on and after January 1. For cost reporting periods that straddle January 1, 2014, enter the total program payment by the type of treatment for services rendered on and after January 1. Obtain this from the PS&R. Transfer the total from column 6.02, line 11, to Worksheet I-5, line 2.02, column 1.

For cost reporting periods beginning on or after January 1, 2014, enter the total program payment by the type of treatment in column 6 and eliminate columns 6.01 and 6.02.

The ESRD *Medicare* payment rate is an average payment calculated based on the total Medicare payments by type of treatment divided by the total ESRD *Medicare* treatments.

Column 7--Average Payment Rate--*For cost reporting periods that straddle January 1, 2011, for the portion of the cost reporting period prior to January 1, 2011, e*nter the total average payment rate by the type of treatment for the reporting period. Determine the amounts entered on the appropriate lines by dividing the total payments on each corresponding line in column 6 by the number of treatments entered on each line in column 4.

Column 7.01--For cost reporting periods that straddle January 1, 2012, January 1, 2013, or January 1, 2014, report the average ESRD PPS payment rate for each modality in column 7.01 for the portion of the cost reporting period prior to January 1 by entering the result of column 6.01 divided by column 4.01.

Column 7.02--For cost reporting periods that straddle or begin January 1, 2011, January 1, 2012, or January 1, 2013, report the average ESRD PPS payment rate for each modality in column 7.02 for the portion of the cost reporting period on and after January 1 by entering the result of column 6.02 divided by column 4.02. For cost reporting periods that straddle January 1, 2014 report the average ESRD PPS payment rate for each modality in column 7.02 for the portion of the cost reporting period on and after January 1.

The ESRD composite payment rates and the ESRD PPS payment rates are average payments calculated based on the total Medicare payments (by type of treatment) divided by the total corresponding ESRD treatments per the facility's PS&R data. For example, the total Medicare payment for hemodialysis is divided by the total ESRD hemodialysis treatments.

For cost reporting periods beginning on or after January 1, 2014, enter all ESRD PPS payment rates in column 7, and eliminate columns 7.01 and 7.02 and.

Line 11--Enter in columns 1 and 4 the sum total of lines 1 through 8. Enter in columns 2, 5, and 6 the sum total of lines 1 through 10.

Line 12--Report "total provider treatments" on this line. This line is informational only. This line will be used for contractor verification. Continuous cycling peritoneal dialysis (CCPD) and continuous ambulatory peritoneal dialysis (CAPD) are daily treatment modalities, and ESRD facilities are paid the equivalent of three hemodialysis treatments for each week that CCPD and CAPD treatments are provided.

Compute hemodialysis equivalent treatments for lines 9 and 10 by multiplying the number of weeks reported in column 1 times 3 treatments for each week. Add to this amount the treatments computed on line 11, column 1.

4052. WORKSHEET I-5 - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

This worksheet provides for the calculation of reimbursable Part B bad debts relating to outpatient renal dialysis treatments. If you have completed more than one Worksheet I-2 (i.e., one for renal dialysis department and one for home program dialysis), make a consolidated bad debt computation.

Part I - Calculation of Reimbursable Bad Debts Title XVIII – Part B.--*Under the composite rate payment system for services prior to January 1, 2011, the contractor pays the facility its allowable ESRD bad debts, up to the facility's unreimbursed reasonable costs as determined under Medicare principles. Under the ESRD PPS payment system, effective for dates of service on and after January 1, 2011, the contractor pays the facility for allowable ESRD bad debts, up to the facility's unreimbursed reasonable costs for those items and services associated with the basic case-mix adjusted composite rate portion of the ESRD PPS payment rate. Allowable bad debts must relate to specific Medicare deductibles and coinsurance amounts.*

Determination of bad debt amounts for the basic case-mix adjusted composite rate payment portion of the ESRD PPS payment, is based on the percentage of basic composite rate payment costs to total costs on a facility specific basis. The facility specific composite rate percentage is applied to the facility's total bad debt amounts associated with the ESRD PPS payment. The resulting bad debt amount is used to determine the allowable Medicare bad debt payment in accordance with 42 CFR §§413.89 and 413.178 of the regulations. During the transition periods, apply the facility specific composite cost percentage to the bad debt amounts associated with the transition portion of the ESRD PPS payment.

The resulting bad debt amount will be added to the bad debt amount associated with the transition portion of the facility's ESRD reasonable costs to determine the total allowable Medicare bad debt (For example, a facility that does not elect 100 percent PPS, will be in transition period 1 for services rendered beginning January 1, 2011 through December 31, 2011. Under transition period 1, services rendered during this period are paid based on 75 percent composite rate and 25 percent ESRD PPS payment rate. The facility specific composite cost percentage will be applied to 25 percent of the bad debts and the resulting bad debt amount will be added to the transitional 75 percent to determine the total allowable bad debt pertaining to services rendered during this period).

EXCEPTION: *The transition period payment method will not apply to ESRD services rendered on and after January 1, 2011, by a facility that (1) elected 100 percent of the payment amount to be based on the ESRD PPS Payment, or (2) was certified for Medicare participation and began providing dialysis services on or after January 1, 2011.*

Column 1--Enter the total amounts by line description.

Column 2--This column is used to compute the appropriate reduction to each amount reported in column 1, based on the facility's transition period and application of their facility specific composite cost ratio.

Line 1--Enter the amount from Worksheet I-4, column 5, line 11. *The amount reported is reflective of the provider's calculated basic composite rate payment cost.*

Line 2--Enter the amount from Worksheet I-4, column 6, line 11. *For cost reporting periods that overlap January 1, 2011, enter in column 1* the amount from Worksheet I-4, column 6, line 11. *Enter in column 2, the amount reported in column 1. For cost reporting periods beginning on or after January 1, 2014, enter in column 1, the sum of the amount from Worksheet I-4, column 6, line 11. Enter in column 2 the amount reported in column 1 times the facility specific composite cost ratio from, line 14. For cost reporting periods beginning on or after January 1, 2014, do not complete lines 2.01 and 2.02.*

Line 2.01--Enter in column 1 the sum of the amount from Worksheet I-4, column 6.01, line 11. Enter in column 2 the portion of the amount reported in column 1 as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment. For cost reporting periods beginning on or after January 1, 2014, do not complete this line.

Line 2.02--Enter in column 1 the sum of the amount from Worksheet I-4, column 6.02, line 11. Enter in column 2 the portion of the amount reported in column 1 as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment. For cost reporting periods beginning on or after January 1, 2014, do not complete this line.

Line 2.03--Enter the sum of lines 2, 2.01 and 2.02 in columns 1 and 2 accordingly.

Line 2.04--Enter the amount for outlier payments applicable to Medicare (Part B) patients from your records. (Informational only)

Line 3--Enter the amount shown in your records for deductibles billed to Medicare (Part B) for dialysis treatments. *For cost reporting periods that overlap January 1, 2011, enter in column 1* the amount shown in your records for deductibles billed to Medicare (Part B) *patients* for dialysis treatments. *Include only deductibles amounts that are related to the payments listed on line 2, column 1, and apply to Medicare beneficiaries under the composite payment rate. Enter in column 2 the amount reported in column 1. For cost reporting periods beginning on or after January 1, 2014, enter in column 1 the amount shown in your records for deductibles billed to Medicare (Part B) patients. Enter in column 2 the amount reported in column 1 times the facility specific composite cost ratio from line 14.*

For cost reporting periods beginning on or after January 1, 2014, do not complete lines 3.01 and 3.02.

Line 3.01--Enter in column 1 the amount shown in your records for deductibles billed to Medicare (Part B) patients. Include only deductible amounts that are related to the payments listed on line 2.01, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2 the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment.

Line 3.02--Enter in column 1 the amount shown in your records for deductibles billed to Medicare (Part B) patients. Include only deductible amounts that are related to the payments listed on line 2.02, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2 the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment.

Line 3.03--Enter the sum of lines 3, 3.01 and 3.02, columns 1 and 2 respectively.

Line 4--Enter the amount shown in your records for coinsurance billed to Medicare (Part B) for dialysis treatments. *For cost reporting periods that overlap January 1, 2011, enter in column 1* the amount shown in your records for coinsurance billed to Medicare (Part B) *patients* for dialysis treatments. *Include only coinsurance amounts that are related to the payments listed on line 2, column 1, and apply to Medicare beneficiaries under the composite payment rate. Enter in column 2 the amount reported in column 1. For cost reporting periods beginning on or after January 1, 2014, enter in column 1 the amount shown in your records for coinsurance billed to Medicare (Part B) patients. Enter in column 2 the amount reported in column 1 times the facility specific composite cost ratio from line 14. .*

For cost reporting periods beginning on or after January 1, 2014, do not complete lines 4.01 and 4.02.

Line 4.01--Enter in column 1 the amount shown in your records for coinsurance billed to Medicare (Part B) patients. Include only coinsurance amounts that are related to the payments listed on line 2.01, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2 the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment.

Line 4.02--Enter in column 1 the amount shown in your records for coinsurance billed to Medicare (Part B) patients. Include only coinsurance amounts that are related to the payments listed on line 2.02, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2 the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment.

Line 4.03--Enter the sum of lines 4, 4.01 and 4.02, columns 1 and 2 respectively.

Line 5--Enter the uncollectible portion of the amounts entered on lines 3 and 4 reduced by any amount recovered during the cost reporting period. *For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 1 the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered prior to January 1, 2011. Transfer this amount to column 2.*

Line 5.01--Enter in column 1 the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2011, but before January 1, 2012. Enter in column 2, 75 percent of the amount in column 1, plus 25 percent of the amount in column 1 times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, do not complete this line, but complete line 5.04.

Line 5.02--Enter in column 1 the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2012, but before January 1, 2013. Enter in column 2, 50 percent of the amount in column 1, plus 50 percent of the amount in column 1 times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, do not complete this line, but complete line 5.04.

Line 5.03--Enter in column 1 the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2013, but before January 1, 2014. Enter in column 2, 25 percent of the amount in column 1, plus 75 percent of the amount in column 1 times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, do not complete this line, but complete line 5.04.

Line 5.04--Enter in column 1 the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2014. Enter in column 2, 100 percent of the amount in column 1, times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02 and elected 100 percent PPS, DO NOT complete lines 5.01, 5.02 or 5.03, but enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries for all services rendered on or after January 1, 2011. Enter in column 2, 100 percent of the amount in column 1, times the facility specific composite cost ratio on line 14.

Line 5.05--Enter in column 1 the sum of lines 5 through 5.04, column 1. This amount must reconcile to the provider's bad debt listing(s). Enter in column 2, the sum of lines 5 through 5.04, column 2.

Line 6--*Enter the result of line 5.05, column 2 (including negative amounts) times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.*

Line 7--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be included in the amount on line 5*.05, column 1, i.e., line 7 is a subset of line 5.05, column 1.*

Line 8--Enter the sum of lines 3 and 4, less line 5, *in column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 2, the sum of lines 3.03, column 2 and 4.03 column 2, less line 5.05, column 2.*

Line 9--Subtract line 3 from line 2, and enter 80 percent of the difference *in column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, subtract* line *3.03, column 2* from line *2.03, column 2*, and enter 80 percent of the difference *in column 2*.

Line 10--Enter the result of line 1 minus the sum of lines 8 and 9, *in column 1*. If the result is negative, enter zero and do not complete line 11. *For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 2, the result of line 1 minus the sum of lines 8 and 9, column 2. For cost reporting periods beginning on or after January 1, 2013, do not complete this line.*

Line 11--Enter *in column 1,* the lesser of line 5 or line 10, *column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, e*nter *in column 1,* the lesser of line 5*.05, column 2* or line 10, *column 2. For cost reporting periods that begin on or after October 1, 2012, enter in column 1, the lesser of line 6, column 2, or line 10, column 2. For cost reporting periods beginning on or after January 1, 2013, enter in column 1, the result of line 6, column 2.* Transfer th*e* amount *on this line* to Worksheet E, Part B, line 33.

Part II - Calculation of Facility Specific Composite Cost Percentage.--A facility specific composite cost percentage is applied to the facility's total bad debt amounts and associated cost data necessary to compute the ESRD facility bad debt payments. This percentage is computed by dividing your facility's basic composite rate costs by your total allowable expenses.

Line 12--For cost reporting periods that overlap or begin on or after January 1, 2011, enter the total allowable expenses from Worksheet I-4, column 2, line 11, plus Worksheet B-2, sum of the absolute values of lines 1 through 6, column 4.

Line 13--Enter total base composite rate costs from Worksheet I-4, column 2, line 11.

Line 14--Compute the facility specific composite cost percentage (line 13 divided by line 12).

Line 19--Enter the actual coinsurance billed to program patients (from your records).

Line 20--For title XVIII, enter the difference of line 17 minus line 19. For titles V and XIX, enter the difference of line 18 minus line 19.

Line 21--Enter allowable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records). If recoveries exceed the current year's bad debts, line 21 will be negative.

Line 22--*Enter the result of line 21 (including negative amounts) times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.*

Line 23--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 21.

Line 24--*E*nter the result of line 20 plus line 21. *For cost reporting periods beginning on or after October 1, 2012, enter the result of line 20 plus line 22.*

Line 25--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see CMS Pub. 15-1 *chapter 21,* §2146.4), enter the adjustment. Specify the adjustment in the space provided.

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

Line 26.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 26].

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

Line 28--For contractor final settlement, report on this line the amount from Worksheet J-4, line 5.99.

Line 29--Enter the balance due provider/program (line 26 minus lines *26.01,* 27 and 28), and transfer this amount to Worksheet S, Part III, columns as appropriate, lines as appropriate.

Line 30--Enter the program reimbursement effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with *CMS Pub. 15-2, chapter 1,* §115.2. Attach a schedule showing the supporting details and computation.

4056. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

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

Line Descriptions

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

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

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

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

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

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

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

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

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

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

Line 10--Enter the sum of the amounts on lines 1 through 9.

Line 11--Enter the cost of physician medical services furnished under agreement.

Line 12--Enter the expenses of physician supervisory services furnished under agreement.

Line 14--Enter the sum of the amounts on lines 11 through 13.

Lines 15 through 20--Enter the expenses of other health care costs.

Line 20--If you answered yes on Worksheet S-8, line 15 report on this line the amount of reimbursable graduate medical education costs from Worksheet B, Part I, sum of columns 21 and 22, lines 88 (RHC) and/or 89 (FQHC), as applicable. To claim GME the RHC/FQHC must have provided a "substantial amount" toward the cost of the intern and residents.

Line 21--Enter the sum of the amounts on lines 15 through 20.

Line 22--Enter the sum of the amounts on lines 10, 14, and 21. Reduce that result by the amount reported on line 20 if you are entitled to claim GME costs on line 20. Transfer this amount to Worksheet M-2, line 10.

Lines 23 through 27--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 27--If you have incurred non-allowable costs associated with graduated medical education, report on line 26 the non-allowable costs.

Line 28--Enter the sum of the amounts on lines 23 through 27. Transfer the total amount in column 5 to Worksheet M-2, line 11.

Line 29--Enter the overhead expenses directly costed to the facility. These expenses may include rent, insurance, interest on mortgage or loans, utilities, depreciation of buildings and fixtures, depreciation of equipment, housekeeping and maintenance expenses, and property taxes. Submit with the cost report supporting documentation to detail and compute the facility costs reported on this line.

Line 30--Enter the expenses related to the administration and management of the RHC/FQHC that are directly costed to the facility. These expenses may include office salaries, depreciation of office equipment, office supplies, legal fees, accounting fees, insurance, telephone service, fringe benefits, and payroll taxes. Submit with the cost report supporting documentation to detail and compute the administrative costs reported on this line.

Line 31--Enter the sum of the amounts on lines 29 and 30. Transfer the total amount in column 5 to Worksheet M-2, line 14.

Line 32--Enter the sum of the amounts on lines 22, 28, and 31. Do not include the amount reported on line 20 for GME. This is the total facility cost. This amount should agree with the amount reported for RHC and FQHC on Worksheet A, column 7 reduced by any amounts claimed on line 20 above.

4067. WORKSHEET M-2 - ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Use this worksheet only if you operate a certified provider-based RHC or FQHC as part of your complex. If you have more than one provider-based RHC and/or FQHC, complete a separate worksheet for each RHC and FQHC facility.

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

Column descriptions

Column 1--Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility's practice. (See CMS *Pub.* 100-04, chapter 9, §40.3 for a definition of FTEs).

Column 2--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2463(a) defining a visit.

Column 3--Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each nonphysician practitioner. You are not subject to the productivity standards if you answered "Yes" to question 12 of Worksheet S-8. If so, then enter the revised standards established by you and your contractor.

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

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

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

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

Line descriptions

Line 1--Enter the number of FTEs and total visits furnished to facility patients by staff physicians working at the facility on a regular ongoing basis. Also include on this line, physician data (FTEs and visits) for services furnished to facility patients by staff physicians working under contractual agreement with you on a regular ongoing basis in the RHC*/FQHC* facility. These physicians are subject to productivity standards. (See 42 CFR *405.2468(d)(2)(v).)*

Line 4--Enter the total of lines 1 through 3 for columns 1, 2 and 4.

Line 5--Enter the number of FTEs and total visits furnished to facility patients by visiting nurses working at the facility. Visiting nurses provide skilled nursing services to the homebound for services which require the skills of a nurse based on the complexity of the service, e.g., intravenous or intramuscular injections or insertions of catheters. (See CMS Pub. 100-02, chapter 13, §180).

Line 6--Enter the number of FTEs and total visits furnished to facility patients by clinical psychologists working at the facility. Clinical psychologist services may include the diagnosis, treatment and consultation of a patient. (See CMS Pub. 100-02, chapter 13, §140).

Line 7--Enter the number of FTEs and total visits furnished to facility patients by clinical social worker working at the facility. Clinical social worker services may include the diagnosis, treatment and consultation of a patient. (See CMS Pub. 100-02, chapter 13, §140).

Line 7.01--Enter the number of FTEs for registered dieticians or nutritional professionals and total visits furnished to FQHC patients for medical nutrition therapy (MNT) services provided in FQHCs. MNT services apply to FQHCs only. (See CMS Pub. 100-02, chapter 13, §210.2.4).

Line 7.02--Enter the number of FTEs for registered dieticians or nutritional professionals and total visits furnished to FQHC patients for diabetes self-management training (DSMT) services provided in FQHCs. DSMT services apply to FQHCs only. (See CMS Pub. 100-02, chapter 13, §210.2.4).

Line 8--Enter the total of lines 4 through 7 (and subscripts).

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

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

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

Line 11--Enter the total nonreimbursable costs from Worksheet M-1, column 7, line 28.

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

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

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

Line 15--Enter the overhead costs incurred by the parent provider allocated to the RHC/FQHC. This amount is the difference between the total costs after cost allocation on Worksheet B, Part I, column 26 and Worksheet B, Part I, column 0. If GME costs are claimed on line 20 of Worksheet M-1, do not include the GME costs allocated to the RHC/FQHC in columns 21 and 22 of Worksheet B, Part I.

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

Line 17--If you are claiming allowable GME cost (line 20 of Worksheet M-1 completed), divide the total intern and resident visits reported on Worksheet S-8, line 15, column 5 by the total visits for the facility (sum of lines 8 and 9, column 5 above), multiply the result by line 16 above, and enter that amount. If you are not claiming GME enter -0-.

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, the sum of line 10 (cost of RHC/FQHC health care services) and line 19 (overhead costs applicable to RHC/FQHC services).

4068. WORKSHEET M-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet applies to title XVIII only and provides for the reimbursement calculation. Use this worksheet to determine the interim all inclusive rate of payment and the total program payment due you for the reporting period for each RHC or FQHC being reported.

Determination of Rate For RHC/FQHC Services.--Worksheet M-3 calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line descriptions

Line 1--Enter the total allowable cost from Worksheet M-2, line 20.

Line 2--Report vaccine costs on this line from Worksheet M-4.

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

Line 4--Enter the greater of the minimum or actual visits by the health care staff from Worksheet M-2, column 5, line 8.

Line 5--Enter the visits made by physicians under agreement from Worksheet M-2, column 5, line 9.

Line 6--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

For services rendered from January 1, 2010, through December 31, 2013, the maximum rate per visit entered on line 8 and the outpatient mental health treatment service limitation applied on line 14 both correspond to the same time period (partial calendar year). Consequently, both are entered in the same column and no further subscripting of the columns is necessary.

Lines 8 and 9--The limits are updated every January 1. However, the possibility exists that limits may also be updated other than on January 1. Complete columns 1, 2 and 3, if applicable (add a column 3 for lines 8-14 if the cost reporting overlaps 3 limit update periods) of lines 8 and 9 to identify costs and visits affected by different payment limits for a cost reporting period that overlaps January 1. If only one payment limit is applicable during the cost reporting period (calendar year reporting period), complete column 2 only.

Line 8--Enter the per visit payment limit. Obtain this amount from CMS *Pub. 100-04, §20.6* or from your contractor.

NOTE: If you are based in a small rural hospital with less than 50 beds (the bed count is based on the same calculation used on Worksheet E, Part A, line 4), in accordance with 42

CFR §412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2.

NOTE: RHCs that are based in a small urban hospital with less than 50 beds (as calculated above) will also be exempt from the per visit limit.

For RHCs based in small urban hospitals transfer the adjusted cost per visit (line 7) to line 9, column 1 and/or 2.

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

Calculation of Settlement.--Complete lines 10 through 29 to determine the total program payment due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period. Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

Line descriptions

Line 10--Enter the number of program covered visits excluding visits subject to the outpatient mental health services limitation from your contractor records.

Line 11--Enter the subtotal of program cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered program beneficiary visits for RHC/FQHC services during the reporting period).

Line 12--Enter the number of program covered visits subject to the outpatient mental health services limitation from your contractor records.

Line 13--Enter the program covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14--Enter the limit adjustment. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: For services rendered through December 31, 2009, the limitation is 62.50 percent; services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; services from January 1, 2013 through December 31, 2013, the limitation is 81.25 percent; and services on or after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health treatment service limit percentage. This limit applies only to therapeutic services, not initial diagnostic services.

NOTE: Section 4104 of ACA eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. RHCs and FQHCs must provide detailed HCPCS coding for preventive services to ensure coinsurance and deductible are not applied. Providers must maintain this documentation to apply the appropriate reductions on lines 16.03 and 16.04.

Line 15--Enter the amount of GME pass through costs determined by dividing the program intern and resident visits reported on Worksheet S-8, line 15 by the total visits reported on Worksheet S-8, line 15, column 5. Multiply that result by the allowable GME costs equal to the sum of Worksheet M-1, column 7, line 20 and Worksheet M-2, line 17. For cost reporting

periods that overlap January 1, 2011 prorate the result using a ratio of days prior to and on or after January 1, 2011 for each column. For cost reporting periods beginning on or after January 1, 2011, do not use column 1 and enter the result in column 2.Line 16--For cost reporting periods

that overlap January 1, 2011, enter in column 1 the sum of lines 11, 14, and 15, column 1 and in column 2, the sum of lines 11, 14, and 15, column 2. For

cost reporting periods beginning on or after January 1, 2011, do not use column 1 and enter the total program cost in column 2. This is equal to the sum of the amounts in columns 1 and 2, respectively (and 3 if applicable), lines 11, 14, and 15.

Line 16.01--Enter the total program charges from the contractor's records (PS&R). For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in column 2.

Line 16.02--Enter the total program preventive charges from the provider's records. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program preventive charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in column 2.

Line 16.03--Enter the total program preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16, column 2.

Line 16.04.--Enter the total program non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program non- preventive costs ((line 16 minus lines 16.03 and 18) times .80) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program non- preventive costs ((line 16, column 2, minus lines 16.03 and 18, column 2) times .80)in column 2.

Line 16.05--Enter the total program costs. For cost reporting periods that overlap January 1, 2011, enter total program costs (line 16 times .80) for services rendered prior to January 1, 2011 in column 1, and enter the sum of lines 16.03 and 16.04, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the sum of lines 16.03 and 16.04, in column 2.

Line 17--Enter the primary payer amounts from your records.

Line 18--Enter the amount credited to the RHC's program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the contractor from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the contractor. FQHCs enter zero on this line as deductibles do not apply.

Line 19--Enter the coinsurance amount applicable to the RHC or FQHC for program patient visits on lines 10 and 12 as recorded by the contractor from clinic bills processed during the reporting period. This line captures data for informational and statistical purposes only. This line does not impact the settlement calculation.

Line 20--Enter the net program costs, excluding vaccines. For cost reporting periods that overlap January 1, 2011, enter the result of subtracting the amount on line 17 from the amount on line 16.05, columns 1 and 2. For cost reporting beginning on or after January 1, 2011, enter the result of subtracting the amount on line 17 from the amount on line 16.05, column 2.

Line 21--Enter the amount from Worksheet M-4, line 16.

Line 22--Enter the total allowable Medicare cost, sum of the amounts on lines 20 and 21.

Line 23--Enter your total allowable bad debts, net of recoveries, from your records. If recoveries exceed the current year's bad debts, line 23 will be negative.

Line 23.01--Enter the result of line 23 (including negative amounts) times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 24--Enter the gross *allowable* bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 23.

Line 25--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see Pub. 15, *Provider Reimbursement Manual, Part* 1, *section* 2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 26--*Enter* the sum of lines 22 and 23 plus or minus line 25. *For cost reporting periods beginning on or after October 1, 2012, enter the sum of lines 22 and 23.01 plus or minus line 25.*

Line 26.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 26].

Line 27--Enter the total interim payments from Worksheet M-5 made to you for covered services furnished to program beneficiaries during the reporting period (from contractor records).

Line 28--For *contractor use only, enter the* on line 5.99 of Worksheet M-5.

Line 29--Enter the total amount due to/from the program (line 26 minus line*s 26.01,* 27 and 28). Transfer this amount to Worksheet S, Part III, column 3, line 10 and/or 11 as applicable.

Line 30--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal costfinding process. (See CMS Pub. 15-1, *chapter 1*, §115.2.) A schedule showing the supporting details and computations must be attached.

4069. WORKSHEET M-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of these vaccines. Additionally, only use this worksheet for vaccines rendered to patients who, at the time of receiving the vaccine(s), were not inpatients or outpatients of the parent provider. If a patient simultaneously received vaccine(s) with any Medicare covered services as an inpatient or outpatient, those vaccine costs are reimbursed through the parent provider and cannot be claimed by the RHC and FQHC.

To accommodate vaccines other than the seasonal influenza vaccines covered by Medicare, subscript column 2 (add column 2.01 and 2.02, if necessary). The data entered in all columns (1, 2, and applicable subscripts) for lines 4, 11, and 13 are mutually exclusive. That is, the vaccine costs, the total number of vaccines administered, and the total number of Medicare covered vaccines shall only be represented one time in the appropriate column.

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

Line 2--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4--Enter the cost of the pneumococcal and influenza vaccine medical supplies from your records.

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

Line 6--Enter the amount from Worksheet M-1, column 7, line 22. This is your total direct cost of the facility.

Line 7--Enter the amount from Worksheet M-2, line 16.

Line 8--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9--Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10--Enter the sum of the amounts on lines 5 and 9.

Line 11--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12--Enter the cost per pneumococcal and influenza vaccine injections by dividing the amount on line 10 by the number on line 11.

Line 13--Enter the number of program pneumococcal and influenza vaccine injections from your records or the PS&R.

Line 14--Enter the program cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15--Enter the total cost of pneumococcal and influenza vaccines and their administration by entering the sum of the amount in column 1, line 10 and the amount in column 2 (and applicable subscripts), line 10.