Medicare

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

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

Transmittal 23 **Date: February 2011**

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NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates Chapter 36, Hospital and Hospital Health Care Complex Cost Report, (Form CMS-2552-96). This transmittal also reflects further clarification to existing instructions and incorporates select Federal Register provisions. The effective dates for instructional changes will vary due to various implementation dates.

Significant Revisions:

- Worksheet S-2 - Lines 25.07 through 25.09 (and applicable lines 25.10 through 25.59) are added in accordance with the Federal Register, volume 75, number 226, dated Wednesday, November 24, 2010, page 72140 as stipulated by the Patient Protection and Affordable Care Act (ACA) of 2010, §5504 to capture the full-time equivalents (FTEs) for intern and resident training at non-provider sites.
- Worksheet S-7 - General instructions and worksheets are revised to reflect a previously omitted resource utilization group (RUGs) “CD1” effective for services rendered on or after October 1, 2010.
- Worksheet E, Part A - Lines 24.94 through 24.96 - In accordance with ACA of 2010, §§3125 and 10314 amends §1886(d)(12) of the Act to establish a temporary improvement to the Medicare inpatient hospital payment adjustment for low volume hospitals effective for discharges occurring during Federal fiscal years 2011 and 2012.
    - Worksheet E, Part A - Lines 52, 53, 55 and 56 are clarified to distinguish capital from operating in the calculation of the outlier reconciliation adjustment.
- Worksheet E, Part B - Lines 50 and 51 clarify the calculation of the outlier reconciliation adjustment.
- Worksheet E-3, Part I - Lines 50 through 53 clarify the calculation of the outlier reconciliation adjustment.
- Edits:
    - Added edits 1096E and 1143S.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after November 30, 2010.

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.

If the facility operates an Intermediate Care Facility/Mental Retarded (ICF/MR) subscript line 7 to 7.01 and enter the data on that line. Note: Subscripting is allowed only for the purpose of reporting an ICF/MR. FIs will reject a cost report attempting to report more than one nursing facility (9/96).

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

Line 9--This is a distinct part HHA that has been issued an HHA identification number and which meets the requirements of §§1861(o) and 1891 of the Act. If you have more than one hospital-based HHA, subscript this line, and report the required information for each HHA. Do not use this line 10.

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

Line 12--This is a distinct part hospice and separately certified component of a hospital which meets the requirements of §1861(dd) of the Act. No payment designation is required in columns 4, 5, and 6. (10/00) Do not use this line 13.

Line 14--This line is used by rural health clinics (RHC) and/or Federally qualified health clinics (FQHC) which have been issued a provider number and meet the requirements of §1861(aa) of the Act. If you have more than one RHC, report on lines 14 through 14.09. For FQHCs, report on lines 14.10 through 14.19. Report the required information in the appropriate column for each. (See Exhibit 2, Table 4, Part IV, page 36-755.) RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-4, chapter 9, §30.8. Do not subscript this line if you elect to file under the consolidated cost reporting method. See section 3608.2 for further instructions.

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

Line 16--If this facility operates a renal dialysis 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 17--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of your operations which generally cover a consecutive 12 month period of your operations. (See CMS Pub. 15-II, §§102.1-102.3 for situations where you may file a short period cost report.)

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

1 = Voluntary Nonprofit, Church
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

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

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

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

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

- Those hospitals properly identified by a distinct type of facility code in the third digit of the Medicare provider number; or

- Those hospitals that are certified as other than long term care hospitals, but which have lengths of stay greater than 25 days.

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

Line 21--Indicate in column 1 if your hospital is either urban or rural at the end of the cost reporting period. Enter 1 for urban or 2 for rural. Indicate in column 2 if your facility is geographically classified or located in a rural area and contains 100 or fewer beds (see Worksheet E, Part A, line 3). Enter yes or “N” for no. (Effective after 8/1/2000s and before 2/29/04 FYE)

Line 21.01--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)?(Effective for FYB 10/1/09) Enter in column 2 “Y” for yes or “N” for no.

Line 21.02--Has your facility received a geographic reclassification after the first day of the cost reporting period from rural to urban or vice versa? Enter “Y” for yes and “N” for no. If yes, report in column 2 the effective date. If the effective date is other than the beginning date of the provider’s fiscal year, subscript Worksheet E, Part A. (4/30/03s) (on or before 2/29/04 FYE)

Line 21.03--Indicate in column 1 your hospital's actual geographic location by entering either 1 for Urban or 2 for Rural. If you answer Urban in column 1, indicate a "Y" for yes and "N" for no in column 2 if you have received either a Wage or Standard Geographic reclassification to a Rural location. If column 2 is “Y” enter in column 3 the effective date. Does this facility contain 100 (see Worksheet E, Part A , line 3) or fewer beds in accordance with 42 CFR 412.105? Enter in column 4 “Y” for yes or “N” for no. (2/29/04) Enter in column 5 the CBSA number of the provider. (12/31/2006)

Line 21.04--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. (2/29/04)

Line 21.05--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. (2/29/04)

Line 21.06--Effective for services rendered after December 31, 2005, does the hospital qualify

for the three year transition of hold harmless payments for small rural hospitals under the prospective payment system for hospital outpatient department services, under DRA, section 5105 or the extension of this provision under MIPPA, section 147 effective for services rendered from January 1,

2009, through December 31, 2009? Enter , "Y" for yes or "N" for no. Also see CR 4367, transmittal 877, dated February 24, 2006 and CR 6320, transmittal 1657, dated December 31, 2008, as applicable. (1/1/2006s) This response impacts the TOPs calculation on worksheet E, Part B, line 1.06.

Line 21.07--Effective for services rendered from January 1, 2009, through December 31, 2009, does the hospital qualify as a SCH with 100 or fewer beds reimbursed under the prospective payment system for hospital outpatient department services, under MIPPA 147? Enter "Y" for yes or "N" for no. Also see CR 6320, transmittal 1657, dated December 31, 2008. This response impacts the TOPs calculation on worksheet E, Part B, line 1.06. (1/1/2009s)

Line 21.08--Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on Worksheet S-3, Part I, line 29, column 5 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 the 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. (10/1/2009b)

Line 22--Are you classified as a referral center? Enter "Y" for yes and "N" for no. See 42 CFR 412.96.

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

Line 23.01--If this is a Medicare certified kidney transplant center, enter the certification date in column 2 and termination date in column 3. Also complete Worksheet D-6.

Line 23.02--If this is a Medicare certified heart transplant center, enter the certification date in column 2 and termination date in column 3. Also complete Worksheet D-6.

Line 23.03--If this is a Medicare certified liver transplant center, enter the certification date in column 2 and termination date in column 3. Also complete Worksheet D-6.

Line 23.04--If this is a Medicare certified lung transplant center, enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-6.

Line 23.05--If Medicare pancreas transplants are performed, enter the more recent date of July 1, 1999 (coverage of pancreas transplants) or the certification dates for kidney transplants and termination date in column 3. Also, complete Worksheet D-6.

Line 23.06--If this is a Medicare certified intestinal transplant center, for services rendered on or after October 1, 2001, enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-6.

Line 23.07--If this is a Medicare certified islet transplant center, with an effective date for discharges on or after October 1, 2004, enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-6.

Line 24--If this is an organ procurement organization (OPO), enter the OPO number in column 2, the termination date in column 3.

Line 24.01--If this is a Medicare transplant center; enter the CCN (provider number) in column 2, the certification date or recertification date (after December 26, 2007) in column 3.

Line 25--Is this a teaching hospital or is your facility affiliated with a teaching hospital and

receiving payment for I&R? Enter "Y" for yes and "N" for no.

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

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

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

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

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

Line 25.05--Has your facility's direct GME FTE cap (column 1), or IME FTE cap (column 2), been reduced under 42 CFR 413.79(c)(3) or 42 CFR 412.105(f)(1)(iv)(B)? Enter "Y" for yes *or* "N" for no in the applicable column. (Impacts Worksheet E, Part A; E-3, Part IV; and E-3 Part VI.)

Line 25.06--Has your facility received additional direct GME (column 1) resident cap slots or IME (column 2) resident cap slots under 42 CFR 413.79(c)(4) or 42 CFR 412.105(f)(1)(iv)(C)? Enter "Y" for yes *or* "N" for no in the applicable column. (Impacts Worksheet E, Part A; E-3, Part IV; and E-3, Part VI.)

Line 25.07--Has your facility trained residents in non-provider settings during the 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. Complete lines 25.07 through 25.09 (and applicable subscripts) for IME effective for discharges occurring on or after July 1, 2010 and for GME effective for cost reporting periods beginning on or after July 1, 2010.

Line 25.08--If line 25.07 is yes, enter in column 1 the unweighted number of non-primary care FTE residents attributable to rotations occurring in all non-provider settings.

Line 25.09--If line 25.07 is yes, enter the unweighted number of primary care FTE residents attributable to rotations occurring in all non-provider settings for each primary care specialty program in which you train residents. Use lines 25.09 through 25.59 as necessary to identify the program name in column 1, the program code in column 2 and the number of unweighted primary care resident FTEs in that program in column 3.

Line 26--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. Enter the beginning and ending dates of SCH status on line 26.01. Use line 26.02 if more than 1 period is identified for this cost reporting period and enter multiple dates. Note: Worksheet C Part II must be completed for the period not classified as SCH (9/96). Multiple dates are created where there is a break in the date between SCH status, i.e., for calendar year provider SCH status dates are 1/1/00-6/30/00 and 9/1/00-12/31/00.

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

Line 28--If this facility contains a hospital-based SNF, which has been granted an exemption from the cost limits in accordance with 42 CFR 413.30(e), enter "Y" for yes and "N" for no (not applicable for cost reporting periods beginning on or after July 1, 1998). For cost reporting periods beginning on or after July 1, 1998 are all patients identified as managed care patients or

did your facility fail to treat Medicare eligible patients (no utilization). Enter “Y” for yes or “N” for no. If no complete lines 28.01 and 28.02 and Worksheet S-7 (7/98).

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

Line 28.02--Enter the updated hospital based SNF facility rate supplied by your fiscal intermediary if you have not transitioned to 100 percent SNF PPS payment. Enter in column 2

the classification of the SNF at the end of the cost reporting period, either (1) for urban or (2) for rural. Enter in column 3 the SNF’s CBSA code. Where the cost reporting period overlaps October 1, 2005, enter in column 3 the SNF’s CBSA code for services rendered prior to October 1, 2005, and enter in column 4 the SNF’s CBSA code for services rendered on or after October 1, 2005. For cost reporting periods which begin on or after October 1, 2005, enter in column 4 the SNF’s CBSA code. If you are located in a rural area enter your State code as your CBSA or CBSA code, as applicable.

Lines 28.03 through 28.20--A notice published in the August 4, 2003, **Federal Register**, Vol. 68, No. 149 provided for an increase in RUG payments to Hospital based Skilled Nursing Facilites (SNF) for payments on or afterOctober 1, 2003, however, this data is required for cost reporting periods beginning on or after October 1, 2003. Congress expected this increase to be used for direct patient care and related expenses. Subscript line 28 into the following lines: 28.03 - Staffing, 28.04 - Recruitment, 28.05 - Retention of Employees, 28.06 - Training, and 28.07-28.20 - Other. Enter in column 1 the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. For each line, indicate in column 2 whether the increased RUG payments received for cost reporting periods beginning on or after October 1, 2003 reflects increases associated with direct patient care and related expenses by responding “Y” for yes. Indicate “N” for no if there was no increase in spending in any of these areas. If the increased spending is in an area not previously identified in areas one through four, identify on the “Other (Specify)” line(s), the cost center(s) description and the corresponding information as indicated above.

Line 29--Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional reimbursement method? Enter "Y" for yes and “N” for no. For CAHs the response is always “N” as the optional reimbursement method is not available to CAHs.

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

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

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

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

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

reporting periods beginning on or after October 1, 2009, do not complete this question.

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

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

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

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

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

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

Line 36--Do you elect the fully prospective payment methodology for capital costs? (See 42 CFR 412.340.) (This also includes providers that were previously hold harmless, but are now considered 100 percent fully prospective for purposes of completing Worksheet L, Part I in lieu of Worksheet L, Part II.) Enter "Y" for yes or "N" for no in the applicable columns. (For cost reporting periods beginning on or after October 1, 2001, the response is always “Y”, except for new providers under 42 CFR 412.304(c)(2), with initial cost reporting periods beginning on or after October 1, 2002, for which the response maybe “N” for the provider’s first 2 years.) Questions 36 and 37 are mutually exclusive.

Line 36.01--Does your facility qualify and receive payments for capital disproportionate share in accordance with 42 CFR 412.320? Enter "Y" for yes and "N" for no. If you are eligible as a result of the Pickle amendment, enter "P" instead of "Y."

NOTE: Questions 37 and 37.01 are not applicable for cost reporting periods beginning on or after October 1, 2008.

Line 37--Do you elect the hold harmless payment methodology for capital costs? (See 42 CFR 412.344.) Enter "Y" for yes or "N" for no in the applicable columns. (Not applicable for cost reporting periods beginning on or after October 1, 2001, except for the third thru tenth cost reporting period of new providers under 42 CFR 412.324(b)(2) certified prior to October 1, 1999. If a new provider’s response is “Y”, complete Worksheet A, line 90 and Worksheet B, Parts II and III.)

Line 37.01--If you are a hold harmless provider, are you filing on the basis of 100 percent of the Federal rate even though payment on this basis may result in lower payment under the hold harmless blend? Enter "Y" for yes or "N" for no in the applicable columns. (Not applicable for cost reporting periods beginning on or after October 1, 2001, except for the third thru tenth cost reporting periods of new providers under 42 CFR 412.324(b)(2) certified prior to October 1, 1999.)

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

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

Do not complete line 56 for cost reporting periods beginning on or after January 1, 2006.

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

Line 58--Are you an Inpatient Rehabilitation Facility (IRF) or do you contain an IRF subprovider? Enter in column 1 “Y” for yes and “N” for no. If you are an IRF or if the hospital complex contains an IRF subprovider, have you made the election for 100 percent Federal PPS reimbursement? Enter in column 2 “Y” for yes and “N” for no. Complete only column 2 for cost reporting period beginning on or after January 1, 2002 and before October 1, 2002. The response in column 2 determines the IRF payment system, i.e., a response of “N” indicates the payment system as “T” for TEFRA or TEFRA BLEND and follows the TEFRA calculation while a response of “Y” indicates the payment system as “P” for PPS and follows the PPS calculation. All IRFs will be reimbursed at 100 percent Federal PPS for cost reporting periods beginning on or after 10/1/2002.

Line 58.01--If this facility is an IRF or contains an IRF subprovider (response to line 58, 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.

Line 59--Are you a Long Term Care Hospital (LTCH)? Enter in column 1 “Y” for yes and “N” for no. If you are a LTCH, have you made the election for 100 percent Federal PPS reimbursement? Enter in column 2 “Y” for yes and “N” for no. The election must be made in writing 30 days prior to the start of your cost reporting period. Only complete column 2 for cost reporting period beginning on or after 10/1/2002 and before 10/1/2006. The response in column 2 determines the LTCH payment system, i.e., a response of “N” indicates the payment system as “T” for TEFRA or TEFRA BLEND and follows the TEFRA calculation while a response of “Y” indicates the payment system as “P” for PPS and follows the PPS calculation. All LTCHs will be reimbursed at 100 percent Federal PPS for cost reporting periods beginning on or after 10/1/2006. LTCHs can only exist as independent /freestanding facilities.

Line 60--Are you an Inpatient Psychiatric Facility (IPF) or do you contain an IPF subprovider? Enter in column 1 “Y” for yes and “N” for no. If you are a IPF or if the hospital complex contains an IPF subprovider, is this a new facility in accordance with CR 3752 (dated 3/4/2005)? Enter in column 2 “Y” for yes and “N” for no. Only complete column 2 for cost reporting period

beginning on or after 1/1/2005 and before 1/1/2008. The response in column 2 determines the IPF payment blend during the transition, i.e., a response of "Y" indicates a new provider that will be paid at 100% of the PPS amount. A response of "N" indicates the payment system as "T" for TEFRA or TEFRA BLEND and follows the TEFRA calculation while a response of "Y" indicates the payment system as "P" for PPS and follows the PPS calculation. All IPFs will be reimbursed at 100 percent Federal PPS for cost reporting periods beginning on or after 1/1/2008.

Line 60.01--If this facility is an IPF or is an IPF subprovider, were residents training in this facility **in the most recent cost report filed 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 §412.424(d)(1)(iii)? 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.

Line 61--Is the hospital part of a multi-campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes, "N" for no. (4/30/2008)

Line 62--If you responded "Y" to question 61, 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, CBSA in column 4, and the FTE count for this campus in column 5. If additional campuses exist, subscript this line as necessary. (4/30/2008)

Line 63--Was this cost report filed using the PS&R (either in its entirety or for total charges and days only)? Enter "Y" for yes or "N" for no in column 1. If "Y", enter the "paid through" date in column 2 (mm/dd/yyyy).

Line 64--Did this facility incur and report costs in the "Implantable Devices Charged to Patients"(line 55.30) 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.

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

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

NOTE: Public Law 105-33 (Balanced Budget Act of 1997) requires that all SNFs be reimbursed under PPS for cost reporting periods beginning on and after July 1, 1998. Therefore, SNFs will not be reimbursed under demonstration procedures for cost reporting periods beginning on and after that date.

For cost reporting periods beginning on or after July 1, 2001 (or providers who have elected 100 percent Federal rate) the only data required to be reported are the days associated with each RUG in column 3.01 (regardless of the periods designated) and for cost reporting periods beginning on or after July 1, 2002, the swing beds days in column 4.06.

Effective for services rendered on and after January 1, 2006, nine new RUGS are introduced into the reimbursement calculation on this worksheet as follows: Line 3.01 - RUX, Line 3.02 - RUL, Line 6.01 - RVX, Line 6.02 - RVL, Line 9.01 - RHX, Line 9.02 - RHL, Line 12.01 - RMX, Line 12.02 -RML, and Line 14.01 - RLX.

Effective for services rendered on and after October 1, 2010, *23* new RUGS are introduced into the reimbursement calculation on this worksheet as follows:

Line 45.01 - ES3,
Line 45.02 - ES2,
Line 45.03 - ES1,
Line 45.04 - HE2,
Line 45.05 - HE1,
Line 45.06 - HD2,
Line 45.07 - HD1,
Line 45.08 - HC2,
Line 45.09 - HC1,
Line 45.10 - HB2,
Line 45.11 - HB1,
Line 45.12 - LE2,
Line 45.13 - LE1,
Line 45.14 - LD2,
Line 45.15 - LD1,
Line 45.16 - LC2,
Line 45.17 - LC1,
Line 45.18 - LB2,
Line 45.19 - LB1,
Line 45.20 - CE2,
Line 45.21 - CE1,
Line 45.22 - CD2,
Line 45.23 - CD1.

The default line is line 45.00 and the default designation code is AAA.

Column Descriptions

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

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

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

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

line 24 and will be generated from the PS&R or your records.

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

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

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

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

Column 5--Calculate the amount attributable to the demonstration for each revenue group by multiplying the rate in column 3 by the days in column 3.01 (rounded to zero) plus the rate in column 4 multiplied by the days in column 4.01 (rounded to zero) (Column 4 times column 4.01 for calendar year providers). Enter the total on line 46. Transfer this amount to Worksheet E-3, Part V, line 6. For cost reporting periods beginning on or after July 1, 1998, multiply columns 3, 4 , and 4.02 times columns 3.01, 4.01, and 4.03 (columns 4 times column 4.01 for cost reporting periods beginning October 1) respectively, rounded to zero and add the three results. This becomes the Federal amount. For services rendered on and after April 1 through September 30, 2000, increase the Federal rate by 20 percent for the following RUGs: RHC, RMC, RMB, SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, and CA1. Multiply the Federal amount by the appropriate transition period percentage, i.e., 25 percent, 50 percent, 75 percent, or 100 percent identified on worksheet S-2 line 28.01, column 1. Add to the Federal amount the result of the calculation of (total days from columns 3.01, 4.01 and 4.03 multiplied by the facility specific rate (that result rounded to zero) identified on worksheet S-2, line 28.02, column 1) times the reciprocal percentage applied to the Federal rate, i.e., 75 percent, 50 percent, 25 percent, or 0 percent. Enter the result on the appropriate line for each RUG. Enter the total of column 5 on line 46. Transfer this amount to Worksheet E-3, Part III, column 2, line 24.

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

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

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

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

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

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

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

For hospitals and subproviders transfer column 7, line 101 to Worksheet D-1, Part II, column 1, line 51. If you are a PPS hospital or subprovider, also transfer this amount to Worksheet E, Part A, line 15. For SNFs, NFs, and ICF/MRs for titles XVIII and XIX, for cost reporting periods beginning on or after July 1, 1998, transfer the amount on line 101 to Worksheet E-3, Part III, line 29 (7/98).

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

NOTE: Columns 8 and 9 will be subscripted to reflect to separate columns for worksheet D, Part V, columns 5.03 and 5.04, if applicable. (8/2000). *See column 9 for additional subscripting instructions.*

Column 9--Multiply the ratio in column 5 by the charges in column 8 to determine the program's share of pass through costs applicable to titles XVIII, Part B, V or XIX (if applicable) outpatient ancillary services, as appropriate (8/*20*00). For cost reporting periods *which straddle* 4/1/2003, multiply the ratio in column 5.01 by the charges in *c*olumn 8 (and subscripts). *If you provide outpatient services under OPPS (hospital), transfer the sum of line 101, columns 9, 9.01 and 9.02 to Worksheet E, Part B, line 1.07.*

For hospitals and subproviders transfer column 7, line 101 to Worksheet D-1, Part II, column 1, line 51. If you are a PPS hospital or subprovider, also transfer this amount to Worksheet E, Part A, line 15. For SNFs, NFs, and ICF/MRs for titles XVIII and XIX, for cost reporting periods beginning on or after July 1, 1998, transfer the amount on line 101 to Worksheet E-3, Part III, line 29 (7/98).

3621.5 Part V - Apportionment of Medical and Other Health Services Costs.--This worksheet provides for the apportionment of costs applicable to hospital outpatient services reimbursable under titles V, XVIII, and XIX, as well as inpatient services reimbursable under title XVIII, Part B. Title XVIII is reimbursed in accordance with 42 CFR 413.53. Do not complete this worksheet for an RPCH component that has elected the all-inclusive payment method for outpatient services. (See Worksheet S-2, lines 30 through 30.02.) Payment under the all-inclusive payment method for outpatient services is computed on Worksheet C, Part V. Critical access hospitals do not complete columns 2 through 4 and 6 through 8 of this worksheet. Providers exempt from outpatient PPS (i.e., SNFs, CAHs, & swing bed SNFs), complete columns 5 and 9. All other providers subscript columns 5 and 9 as necessary.

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

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

For cost reporting periods that end on or after October 1, 1997, and before September 30, 1998, subscript columns 2 through 4 and 6 through 8 and report the charges and cost during the period for services prior to October 1, 1997, in columns 2 through 4 and 6 through 8 and report the charges and costs for the periods on or after October 1, 1997, and before September 30, 1998 in columns 2.01 through 4.01 and 6.01 through 8.01. The subscripting is required as a result of the

change in calculating the different payment methodologies on Worksheet E, Parts C, D, and E regarding the application of deductibles and coinsurance. Subscripting is not required for cost reporting periods ending on or after September 30, 1998. Revert back to reporting the charges and costs for these services in columns 2 through 4 and 6 through 8. For services rendered on and after August 1, 2000, outpatient services are subject to prospective payment. For cost reporting periods that overlap the effective date, subscript the columns to accommodate the proper reporting of cost reimbursement prior to August 1, 2000, and prospective payment on and after August 1, 2000.

Columns 1, 1.01 and 1.02--Enter on each line in column 1 and 1.02, for hospital and subprovider components, the ratio from the corresponding line on Worksheet C, Part II, columns 8 and 9, respectively, for services rendered prior to August 1, 2000. For SCH (full cost reporting period), RPCH/CAH, SNF, NF, and swing bed services, enter on each line in column 1 the ratio from the corresponding line on Worksheet C, Part I, column 9. Enter in column 1.01 the ratio from the corresponding line on Worksheet C, Part I, column 9 for services on and after August 1, 2000.

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

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

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

Columns 5, 5.01 and 5.02--For title XVIII, enter the charges for outpatient services not included in any other column in Part V. For SNFs for services rendered which overlap the effective date of January 1, 1998, for physical, occupational and speech therapy (lines 50 through 52) subscript this column and report charges before January 1, 1998, in column 5 and on and after January 1, 1998, in column 5.01. Subscripting is not required for cost reporting periods beginning on or after January 1, 1998. For hospitals claiming ambulance services for cost reporting periods which overlap October 1, 1997, subscript column 5. Enter on line 65, column 5 the charges relating to the period on or after October 1, 1997, and in column 5.01 the charges relating to prior to October 1, 1997. For cost reporting periods beginning on or after October 1, 1997, do not complete column 5.01 for ambulance. Exclude charges for which costs were excluded on Worksheet A-8. For example, CRNA costs reimbursed on a fee schedule are excluded from total cost on Worksheet A-8. For titles V and XIX, enter the appropriate outpatient service charges. Do not include charges for vaccine, i.e., pneumococcal, flu, hepatitis, and osteoporosis. These charges are reported on Worksheet D, Part VI. Do not include in Medicare charges any charges identified as MSP/LCC.

Effective August 1, 2000, enter in column 5 the services prior to August 1, 2000, paid based on cost. In column 5.01 enter the charges for services rendered on or after August 1, 2000, paid subject to the prospective payment system. These charges should not include services paid under the fee schedule such as physical therapy, speech pathology or occupational therapy. Create separate subscripted column (e.g. 5.03, 5.04) when a cost reporting period overlaps the effective dates for the various transitional corridor payments and when a provider experiences a geographic reclassification from urban to rural. However, no subscripting is required when a provider geographically reclassifies from rural to urban. In column 5.02 enter the charges for services rendered on and after August 1, 2000, e.g., for drugs and supplies related to ESRD dialysis (excluding EPO, and any drugs or supplies paid under the composite rate), and corneal tissue.

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

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

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

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

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

Line 21--Enter the program reimbursable bad debts, reduced by the bad debt recoveries. If recoveries exceed the current year's bad debts, line 21 and 21.01 will be negative.

Line 21.01--Enter line 21 (including negative amounts) times 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999, and 70 percent for October 1, 2000 and thereafter.

Line 21.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 21. (4/1/2004b)

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

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

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

Effective for Federal 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 for discharges occurring during Federal fiscal years 2011 and 2012. For cost reporting periods which begin before May 1, 2010, and overlap October 1, 2010, enter on lines 24.94 (and if necessary, lines 24.95 and 24.96) the Medicare inpatient payment adjustment for low volume hospitals as applicable in accordance with the instructions in a forthcoming Change Request (CR). The forthcoming CR will provide instructions regarding the source(s) from which the entered amounts can be obtained and will specify in which situations line 24.95 (and if necessary line 24.96) must be completed. Identify the line label on each line as "Low Volume Adjustment Payment." Where difference low volume adjustment percentages apply during the cost reporting period, identify the label on each line as "Low Volume Adjustment Payment-1" increasing the number by one for each additional payment that applies. The low volume adjustment payment must also be recorded on Worksheet E-1 as part of an interim payment.

Effective for cost reporting periods which end during Federal fiscal years 2011 and 2012, enter on line 24.97 the additional payment in accordance with the Health Care and Education Reconciliation Act (HCERA) of 2010, section 1109 which establishes an additional payment (one payment for each year) for qualifying providers under section 1886(d) of the Act. Identify the line label as "HCERA Payment." This payment must also be recorded on Worksheet E-1 as an interim payment. Effective for discharges occurring on or after October 1, 2008, enter on line 24.98 the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in Change Request 5860, transmittal 1509, dated May 9, 2008.

Only FI/contractors complete line 24.99 by entering the sum of lines 52, 53, 55, and 56.

Line 25--If you are filing under the fully prospective payment methodology for capital costs or on the basis of 100 percent of the Federal rate under the hold harmless methodology, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. For providers paid under the hold harmless reasonable cost methodology, compute gains or losses on the disposal of old assets in accordance with CMS Pub. 15-1, §§132-134.4. For gains or losses on new capital, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. (See 42 CFR 413.134(f)(1).)

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

Enter the amount of any excess depreciation taken as a negative amount.

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

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

Line 28--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 28.01. Include in interim payment the amount received as the estimated nursing and allied health managed care payments.

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

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

Lines 31 through 49 were intentionally skipped to accommodate future revisions to this worksheet.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART A. LINES 50 THROUGH 56 ARE FOR CONTRACTOR USE ONLY.

Line 50--Enter the original operating outlier amount from line 2.01 sum of all columns of this worksheet.

Line 51--Enter the original capital outlier amount from worksheet L, part I, line 3.01.

Line 52--Enter the operating outlier reconciliation *adjustment* in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5-§20.1.2.7

Line 53--Enter the capital outlier reconciliation *adjustment* amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7

Line 54--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 55--Enter the *operating* time value of money for operating related expenses.

Line 56--Enter the *capital* time value of money for capital related expenses.

NOTE: If a cost report is reopened more than one time, subscript lines 50 through 56, respectively, one time for each time the cost report is reopened.

For all other hospital*s* enter one of the following:

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

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

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

For services rendered January 1, 2004, through December 31, 2005, for small rural hospitals and small rural SCHs:

a. If line 1.02 is < line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y" and Worksheet E, Part A, line 3 is =< 100 enter the result of line 1.04 minus line 1.02.
b. If line 1.02 is < line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y", and Worksheet E, Part A, line 3 is =< 100, and Worksheet S-2, line 26 is => 1 (sole community hospitals (SCH)) enter the result of line 1.04 minus line 1.02.

For cost reporting periods beginning on or after January 1, 2004, through services rendered on or before December 31, 2005, for rural SCHs:

a. If line 1.02 is < line 1.04 or Worksheet S-2, line 26 response is => 1 (number of periods SCH status in effect) enter the result of line 1.04 minus line 1.02.

NOTE: For purposes of TOPs, a hospital is considered rural if it is geographically rural, classified to rural for wage index purposes, or classified to rural for the standardized amount purposes. For example, a hospital that is geographically rural is always considered rural for TOPs, even if it is reclassified to urban for the wage index and/or standardized amount. A hospital that is geographically urban, but reclassified to rural for the wage index and/or standardized amount, is considered rural for purposes of TOPs.

In accordance with DRA 2005, section 5105, as amended by MIPPA 2008, section 147, and ACA 2010, section 3121 for services rendered January 1, 2006, through December 31, 2010, rural hospitals with 100 or fewer beds that are not SCHs are entitled to hold harmless TOPs:

a. For services rendered January 1, 2006, through December 31, 2006, if Worksheet S-2, line 21.06, is "Y", enter 95 percent of (line 1.04 minus line 1.02).

b. For services rendered January 1, 2007, through December 31, 2007, if Worksheet S-2, line 21.06, is "Y", enter 90 percent of (line 1.04 minus line 1.02).

c. For services rendered January 1, 2008, through December 31, 2010, if Worksheet S-2, line 21.06, is "Y", enter 85 percent of (line 1.04 minus line 1.02).

In accordance with MIPPA 2008, section 147, for services rendered January 1, 2009, through December 31, 2009, SCHs with 100 or fewer beds are entitled to hold harmless TOPs:

a. For services rendered January 1, 2009, through December 31, 2009, if Worksheet S-2, line 21.07, column 1, is "Y", enter 85 percent of (line 1.04 minus line 1.02).

In accordance with ACA 2010, section 3121, for services rendered January 1, 2010, through December 31, 2010, SCHs (and EACHs), regardless of bed size, are entitled to hold harmless TOPs:

a. For services rendered January 1, 2010, through December 31, 2010, if Worksheet S-2, line 21.07, column 2, is "Y", enter 85 percent of (line 1.04 minus line 1.02).

Line 1.07--Enter the *outpatient ancillary* pass through amount from worksheet D, Part IV, columns 9, 9.01 and 9.02, line 101.

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

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

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

Line 4--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost (see 42 CFR 415.160 and CMS Pub. 15-I, §2148), enter the amount from Worksheet D-9, Part II, column 3, line 17.

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

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

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

Line Descriptions

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

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

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

Line 6--For total charges for medical and other services, enter the sum of Worksheet D, Part V, columns 5 and 5.01 (for hospitals and subproviders with cost reporting periods which overlap October 1, 1997, for ambulance services, and SNFs with cost reporting periods beginning prior to January 1, 1998), line 104 and Worksheet D, Part VI, line 2. For cost reporting periods overlapping 8/1/2000 and after, for hospital and subprovider services, enter the sum of D, Part V, columns 5, 5.02, and 10, line 104, plus D, Part VI, line 2.

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

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

When the primary payment does not satisfy the beneficiary's liability, include the covered charges in program charges, and include the charges in charges for cost apportionment purposes. Enter the primary payer payment on line 26 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 26.

Line 25--Enter line 23 minus line 24.

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

Line 27--Enter from your records reimbursable 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 26. Bad debts associated with ambulance services rendered on or after April 1, 2002 (implementation of the cost/fee blend) are not allowable. If recoveries exceed the current year's bad debts, line 27 and 27.01 will be negative.

Line 27.01--Multiply the amount (including negative amounts) on line 27 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; and 55 percent for October 1, 1999; 70 percent for October 1, 2000 and thereafter (hospitals and subproviders only). The reduction does not apply to Critical Access Hospitals.

Line 27.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 27. (4/1/2004b)

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

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

Line 30--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. For cost reporting periods ending on or after June 30, 2006, enter on line 30.99 the MSP-LCC reconciliation amount. Obtain this amount from the PS&R.

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

Line 32--Enter the result of line 28, plus or minus lines 30 and 31 minus lines 29 and 30.99. Line 30.99 would only be included for cost reporting periods ending on or after June 30, 2006.

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

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

to Part B and report that Part B portion on line 34.01. Maintain the necessary documentation to support the amount of the reclassification.

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

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

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART B. LINES 50 THROUGH 54 ARE FOR CONTRACTOR USE ONLY. (Effective for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009.)

Line 50--Enter the original outlier amount from line 1.02 *(*sum of all columns*) prior to the inclusion of line 54 of Worksheet E, Part B*.

Line 51--Enter the operating outlier reconciliation *adjustment* amount in accordance with CMS Pub. 100-4, Chapter 4, §10.7.2.2 - §10.7.2.4.

Line 52--Enter the rate used to calculate the time value of money. (See CMS Pub. 100-4, Chapter 4, §10.7.2.2 - §10.7.2.4.)

Line 53--Enter the time value of money.

Line 54--Enter sum of lines 51 and 53.

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.

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

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

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

Line Descriptions

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

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

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

Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

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

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

Line 11--Enter program reimbursable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 11 and 11.01 will be negative.

Line 11.01--Multiply the amount (including negative amounts) from Line 11 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999; and 70 percent for October 1, 2000 and all subsequent periods.

Line 11.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 11. (4/1/2004b)

Line 12--Enter the sum of lines 10 and 11.01.

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

Line 13.01--For IRF cost reporting periods beginning on or after January 1, 2002, LTCH cost reporting periods beginning on or after October 1, 2002, and IPF cost reporting periods beginning on or after January 1, 2005, enter the routine service other pass through costs from Worksheet D, Part III, column 8, line 25 for a freestanding facility or line 31 for the subproviders. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101. For IRFs, LTCHs, or IPFs reimbursed on a blended TEFRA rate percentage (worksheet S-2, line 58, 59, or 60, respectively, column 2 equals "N") reduce the pass through amounts by the TEFRA blend percentage used on line 1.01 for IRFs, IPFs, and LTCHs, respectively. After the respective transition periods have elapsed do not reduce this line as these facilities are entitled to 100 percent of other pass through costs.

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

Line 15--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, sequestration, etc, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. FIs only complete line 15.99 by entering the sum of lines 51 and 53.

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

Line 17--Enter the sum of lines 12, 13, and 13.01 plus or minus lines 15 and 16 minus line 14.

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

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

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

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

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-3, PART I. LINES 50 THROUGH 53 ARE FOR INTERMEDIARY USE ONLY.

Line 50-- *For IRFs, e*nter the original outlier amount from worksheet E-3, Part I, line 1.05. *For LTCHs, enter the sum of lines 1.02 and 1.05 from Worksheet E-3, Part I. For IPFs, enter the original outlier amount from worksheet E-3, Part I, line* 1.09.

Line 51--Enter the outlier reconciliation *adjustment* amount. *For IRFs, see CMS Pub. 100-04, Chapter 3, §140.2.8 - §140.2.10. For LTCHs, see CMS Pub. 100-04, Chapter 3, §150.26 - §150.28. For IPFs, see CMS Pub. 100-04, Chapter 3, §190.7.2.3 - §190.7.2.5.*

Line 52--Enter the interest rate used to calculate the time value of money. *For IRFs, see CMS Pub. 100-04, Chapter 3, §140.2.8 - §140.2.10. For LTCHs, see CMS Pub. 100-04, Chapter 3, §150.26 - §150.28. For IPFs, see CMS Pub. 100-04, Chapter 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.

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

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

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs:

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