

**3600. GENERAL**

The Paperwork Reduction Act of 1995 requires that you be informed why information is collected and what the information is used for by the government. Section 1886(f)(1) of the Act requires the Secretary to maintain a system of cost reporting for Prospective Payment System (PPS) hospitals, which includes a standardized electronic format. In accordance with §§1815(a), 1833(e), and 1861(v)(1)(A) of the Act, providers of service participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.20(b) requires cost reports on an annual basis. In accordance with these provisions, all hospital and health care complexes to determine program payment must complete Form-CMS-2552-96 with a valid OMB control number. Besides determining program payment, the data submitted on the cost report support management of the Federal programs, e.g., data extraction in developing cost limits. The information reported on Form CMS-2552-96 must conform to the requirements and principles set forth in 42 CFR, Part 412, 42 CFR, Part 413, and in the Provider Reimbursement Manual, Part I. The filing of the cost report is mandatory and failure to do so results in all payments to be deemed overpayment and 100 percent withhold until the cost report is received. (See PRM 15 II §100.) Except for the compensation information the cost report information is considered public record under the freedom of information act 45 CFR Part 5. The instructions contained in this chapter are effective for hospitals and hospital health care complexes with cost reporting periods ending on or after September 30, 1996.

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

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

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

**NOTE:** Public reporting burden for this collection of information is estimated to average 106 hours per response, and record keeping burden is estimated to average 551 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to:

- o Center for Medicare and Medicaid Services  
7500 Security Boulevard  
Mail Stop C5-03-03  
Baltimore, MD 21244-1855
- o The Office of Information and Regulatory Affairs  
Office of Management and Budget  
Washington, DC 20503

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

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

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

The cost report is designed to accommodate a health care complex with multiple entities. If a health care complex has more than one entity reporting (except skilled nursing facilities and nursing facilities which can not exceed more than one hospital-based facility), add additional lines for each entity by subscribing the line designation. For example, subprovider, line 2, Worksheet S, Part II is subscripted 2.00 for subprovider I and 2.01 for subprovider II.

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

Similarly, add lines 31.00 and 31.01 to Worksheets A, B, Parts I through III, B-1, C, Part I, D, Parts I and III, and Worksheet L-1, Parts I and II. For multiple use worksheets such as Worksheet D-1, add subprovider II to the existing designations in the headings and the corresponding component number.

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

**3600.1 Rounding Standards for Fractional Computations.**--Throughout the Medicare cost report, required computations result in fractions. The following rounding standards must be employed for such computations. When performing multiple calculations, round after each calculation.

1. Round to 2 decimal places:
  - a. Percentages
  - b. Averages, standard work week, payment rates, and cost limits
  - c. Full time equivalent employees
  - d. Per diems, hourly rates
2. Round to 3 decimal places:
  - a. Payment to cost ratio
3. Round to 4 decimal places:
  - a. Wage adjustment factor
  - b. Medicare SSI ratio

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

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

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

A&G	-	Administrative and General
AHSEA	-	Adjusted Hourly Salary Equivalency Amount
ARRA	-	American Recovery and Reinvestment Act of 2009
ASC	-	Ambulatory Surgical Center
BBA	-	Balanced Budget Act
BBRA	-	Balanced Budget Reform Act
BIPA	-	Benefits Improvement and Protection Act
CAH	-	Critical Access Hospitals (10/97)
CAPD	-	Continuous Ambulatory Peritoneal Dialysis
CAP-REL	-	Capital-Related
CBSA	-	Core Based Statistical Areas
CCN	-	CMS Certification Number (formerly known as a provider number)
CCPD	-	Continuous Cycling Peritoneal Dialysis
CCU	-	Coronary Care Unit
CFR	-	Code of Federal Regulations
CMHC	-	Community Mental Health Center
CMS	-	Center for Medicare and Medicaid Services
COL	-	Column
CORF	-	Comprehensive Outpatient Rehabilitation Facility
CRNA	-	Certified Registered Nurse Anesthetist
CTC	-	Certified Transplant Center
<i>DPP</i>	-	<i>Disproportionate Patient Percentage</i>
DRA	-	Deficit Reduction Act of 2005
DRG	-	Diagnostic Related Group
DSH	-	Disproportionate Share
EACH	-	Essential Access Community Hospital
ESRD	-	End Stage Renal Disease
FQHC	-	Federally Qualified Health Center
FR	-	Federal Register
FTE	-	Full Time Equivalent
GME	-	Graduate Medical Education
HHA	-	Home Health Agency
HMO	-	Health Maintenance Organization
HSR	-	Hospital Specific Rate
I & Rs	-	Interns and Residents
ICF/MR	-	Intermediate Care Facility for the Mentally Retarded (9/96)
ICU	-	Intensive Care Unit
IME	-	Indirect Medical Education
INPT	-	Inpatient
IPF	-	Inpatient Psychiatric Facility
IRF	-	Inpatient Rehabilitation Facility
<i>LDP</i>	-	<i>Labor, Delivery and Postpartum</i>

LIP	-	Low Income Patient
LOS	-	Length of Stay
LCC	-	Lesser of Reasonable Cost or Customary Charges
LTCH	-	Long Term Care Hospital
MA	-	Medicare Advantage (previously known as M+C)
M+C	-	Medicare + Choice (also known as Medicare Part C)
MCP	-	Monthly Capitation Payment
MDH	-	Medicare Dependent Hospital (10/97)
MED-ED	-	Medical Education
MIPPA	-	Medicare Improvements for Patients and Providers Act of 2008
MMA	-	Medicare Prescription Drug Improvement and Modernization Act of 2003
MSA	-	Metropolitan Statistical Area (10/97)
MS-DRG	-	Medicare Severity Diagnosis-Related Group
MSP	-	Medicare Secondary Payer
NF	-	Nursing Facility
NHCMQ	-	Nursing Home Case Mix and Quality Demonstration
NPI	-	National Provider Identifier
OBRA	-	Omnibus Budget Reconciliation Act
OLTC	-	Other Long Term Care
OOT	-	Outpatient Occupational Therapy
OPD	-	Outpatient Department
OPO	-	Organ Procurement Organization
OPPS	-	Outpatient Prospective Payment System
OPT	-	Outpatient Physical Therapy
OSP	-	Outpatient Speech Pathology
ORF	-	Outpatient Rehabilitation Facility
PBP	-	Provider-Based Physician
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PRO	-	Professional Review Organization
PS&R	-	Provider Statistical and Reimbursement System
PT	-	Physical Therapy
RCE	-	Reasonable Compensation Equivalent
RHC	-	Rural Health Clinic
RPCH	-	Rural Primary Care Hospitals
RT	-	Respiratory Therapy
RUG	-	Resource Utilization Group
SCH	-	Sole Community Hospitals
SCHIP	-	State Children Health Insurance Program
SNF	-	Skilled Nursing Facility
SSI	-	Supplemental Security Income
TEFRA	-	Tax Equity and Fiscal Responsibility Act of 1982
TOPS	-	Transitional Outpatient Payment System
UPIN	-	Unique Physician Identification Number
WKST	-	Worksheet

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

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

Where applicable, at the end of select paragraphs and/or sentences the effective date (s) is indicated in parentheses ( ) for cost reporting periods ending on or after that date, i.e., (12/31/01).

Dates followed by a “b” are effective for cost reporting periods beginning on or after the specified date, i.e., (1/1/01b). Dates followed by an “s” are effective for services rendered on or after the specified date, i.e., (4/1/01s). Instructions not followed by an effective date are effective retroactive back to 9/30/96 (transmittal 1).

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

#### Part I - Departmental Cost Adjustments and Cost Allocations

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

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

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
11	D-4	Read §3624. Complete entire worksheet. A separate copy of this worksheet must be completed for each applicable health care program for each applicable provider component.
12	D-1, Parts II-III	Read §§3622.2 and 3622.3. The hospital and subprovider(s) must complete Part II, lines 39-48 and lines 61-66. Only the hospital-based SNF and hospital-based NF must complete Part III, lines 67-80.
13	D-2, Parts I-III	Read §§3623-3623.3. Complete only those parts that are applicable. Do not complete Part III unless both Parts I and II are completed.
14	H-4 (Part II)	Read §§3645 and 3645.2. Complete, if applicable.
15	S-5	Read §3607. Complete, if applicable.
16	I-2, Parts I and II	Read §§3650-3650.1. Complete lines 1-32 for all columns. Complete a separate Worksheet I-2 if the provider reports costs in both the renal dialysis department and the home program dialysis separately from the renal dialysis ancillary cost center
17	D-1 (Parts II and III)	Complete lines 50-59 in Part II, when applicable, and lines 83-88 in Part III.
18	L	Read §3660. Complete applicable sections.
19	I-2 (Parts I and II)	Complete lines 33 and 34 for all columns in Part I and line 33, columns 25 and 26 in Part II.
20	D-9 (Parts I and II)	Read §§3626-3626.2. Complete entire worksheet, if applicable.
21	D-6 (Parts I-IV)	Read §§3625-3625.4. Complete only if hospital is a certified transplant center.

Part III - Calculation and Apportionment of Hospital-Based FacilitiesA. Title XVIII - For SNF Only.--

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
1	Wkst. E-3, Part II	Read §3633.2. Complete lines 1-6 and 23-25.
2	Wkst. E, Part B	Read §3630.2. Complete lines 1-6, 20, and 24.
3	Wkst. I-3	Read §3651. Complete a separate worksheet for renal dialysis department(s) and a separate worksheet for home program dialysis department(s).
4	Wkst. I-4	Read §3652. Complete entire worksheet.
5	Wkst. E, Part B	Complete lines 26 and 22.
6	Wkst. E-1	Read §3631. Complete lines 1-4.
7	Wkst. E-3, Part II	Complete line 32.
8	Wkst. E, Part B	Complete line 33.

B. Title XVIII - For SNFs Reimbursed Under PPS; and Titles V and XIX - For Hospital, Subprovider(s), SNF and ICF/MRs.--

	<u>PPS</u>	<u>TEFRA</u>	<u>COST</u>
10	Wkst. E-3, Part III. Read §3633.3. Complete lines 33, 36, 38, and 57.	Wkst. E-3, Part III. Read §3633.3. Complete lines 33, 36, 38, and 57.	Wkst. E-3, Part III. Read §3633.2. Complete lines 33, 36, 38, and 57.
11	N/A	Wkst. E-3, Part III. Complete line 15.	N/A

C. Titles V and XIX - For Swing Bed-NF.--

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
12	Wkst. E-2	Read §3632. Complete a separate copy of this worksheet for each applicable health care program for each applicable provider component. Only entries applicable to title XVIII are made in column 2. Complete lines 9, 13, 17, and 19 of column 1 for titles V and XIX and columns 1 and 2 for title XVIII.
13	Wkst. E-1	Read §3631. Complete lines 1-4 for title XVIII swing bed-SNF only.

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
14	Wkst. E-2	Complete line 19.
D. <u>Title XVIII Only - For Home Health Agency.--</u>		
15	Wkst. H-4, Parts I-II	Read §3645. Complete worksheet when applicable.
16	Wkst. S-4	Read §3606. Complete worksheet when applicable.
17	Wkst. H-5, Parts I-II	Read §§3646, 3646.1, and 3646.2, and complete worksheet when applicable.
18	Wkst. H-6, Part I	Read §§3647 and 3647.1. Complete columns 1-12, lines 1-16.
19	Wkst. H-6, Part II	Read §3647.2. Complete columns 1 through 3, lines 1-5.
20	Wkst. H-7	Read §3648. Complete lines 1-27, columns 1-3.
21	Wkst. H-8	Complete columns 1-4, lines 1-4.
E. <u>Titles V, XVIII, and XIX - For CORF, CMHC, and OPPT/OOT/OSP.--</u>		
22	Wkst. S-6	Read §3608. Complete worksheet when applicable.
23	Wkst. J-1, Part I	Read §§3656 and 3656.1. Complete lines 1-16, columns 0-27.
24	Wkst. J-1, Part II	Read §3656.2. Fully complete.
25	Wkst. J-1, Part I	Complete columns 26 and 27.
26	Wkst. J-2, Parts I-II	Read §§3657-3657.2. Fully complete worksheet.
27	Wkst. J-4	Read §3658. Complete lines 1-4 for title XVIII only.
28	Wkst. J-3	Read §3657. Complete lines 1-5, 8, 11, 13, and 18.
F. <u>Titles XVIII and XIX - For Provider Based-Hospice</u>		
29 lines.	Wkst. S-9	Read §3609.1 Complete Parts I and II all
30	Wkst. K	Read §3634. Fully complete worksheet
31	Wkst. K-1	Read §3634.1 Fully complete worksheet
32	Wkst. K-2	Read §3634.2 Fully complete worksheet

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
33	Wkst. K-3	Read §3634.3 Fully complete worksheet
34	Wkst. K-4, Part I & II	Read §3634.4 Fully complete worksheets
35	Wkst K-5, Parts I, II & III	Read §3634.5-8 Fully complete worksheets
36	Wkst K-6	Read §3634.9 Fully complete worksheet
<u>Titles V, XVIII, and XIX - For Rural Health Clinics/Federally Qualified Health Clinics</u>		
<u>(1/98)</u>		
37	Wkst S-8	Read §3608.2. Complete worksheet when applicable.
38 columns	Wkst M-1	Read §3662. Complete lines 1 - 30 and 1 - 7.
39 columns	Wkst M-2	Read §3663. Complete lines 1 - 18 and 1 - 5.

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
40	Wkst M-3	Read §3664. Complete all lines.
41	Wkst M-4	Read §3665. Complete all lines.
42	Wkst. M-5	Read §3666. Complete lines 1-4 for title XVIII only.
<u>Part IV - Calculation of Reimbursement Settlement</u>		
1	Wkst. E-3, Part IV	Read §3632.4. Complete entire worksheet when applicable.
2	Wkst. E-3, Part II	Read §3633.2. Complete through line 22 of this worksheet for title XVIII for each applicable provider component subject to the cost reimbursement system.
3	Wkst. E-3, Part III	Read §3633.3. Complete through line 23 for titles V and XIX for each applicable provider component.
4	Wkst. E, Part B	Read §3630.2. Complete through line 16 for title XVIII for each applicable provider component.
5	Wkst. E, Part C	Read §3630.3 and complete lines 1-13.
6	Wkst. E, Part D	Read §3630.4 and complete lines 1-13, columns as appropriate.
7	Wkst. E, Part E	Read §3630.5 and complete lines 1-13, columns as appropriate.
8	Wkst. E, Part B	Read §3630.2. Complete remainder of this worksheet for title XVIII for each applicable provider component.
9	Wkst. E, Part A	Read §§3630 and 3630.1. Complete remainder of this worksheet for title XVIII for each applicable provider component subject to PPS.
10	Wkst. E, Part C	Read §3630.3. Complete remainder of wkst.
11	Wkst. E, Part D	Read §3630.4. Complete remainder of wkst.
12	Wkst. E, Part E	Read §3630.5. Complete remainder of wkst.
13	Wkst. E-3, Part I	Read §3633.1. Complete remainder of this worksheet for title XVIII for each applicable provider component subject to TEFRA.
14	Wkst. E-3, Part II	Read §3633.2. Complete remainder of this worksheet for title XVIII for each applicable

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
		provider component subject to cost reimbursement system
15	Wkst. E-3, Part III	Read §3633.3. Complete remainder of this worksheet for titles V and XIX for each applicable provider component and for title XVIII SNFs Reimbursed under PPS.
16	Wkst. E-2	Read §3632. A separate copy of this worksheet must be completed for each applicable health care program for each applicable provider component.
17	Wkst. H-7, Part I	Read §§3648 and 3648.1. Complete this worksheet when applicable.
18	Wkst. H-7, Part II	Read §§3648 and 3648.2. Complete this worksheet when applicable.
19	Wkst. J-3	Read §3658. Complete the remainder of this worksheet when applicable. A separate copy of this worksheet must be completed for each applicable health care program.

Part V - Additional Data

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
1	Wkst. H-1	Read §3642. Complete this worksheet when applicable.
2	Wkst. H-2	Read §3643. Complete this worksheet when applicable.
3	Wkst. H-3	Read §3644. Complete this worksheet when applicable.
4	Wkst. H	Read §3641. Complete this worksheet when applicable.
5	Wkst. G	Read §3640. All providers maintaining fund type accounting records must complete this worksheet. Nonproprietary providers which do not maintain fund type records complete the General Fund column only.
6	Wkst. G-1	Complete entire worksheet.
7	Wkst. G-2, Parts I and II	Complete entire worksheet.
8	Wkst. G-3	Complete entire worksheet.
9	Wkst. S, Parts I and II	Read §§3603.1 and 3603.2. Complete Part II entirely. Then complete Part I.

## 3602. SEQUENCE OF ASSEMBLY

The following examples of assembly of worksheets are provided so all providers are consistent in the order of submission of their annual cost report. All providers using Form HCFA-2552-96 must adhere to this sequence. If worksheets are not completed because they are not applicable, do not include blank worksheets in the assembly of the cost report.

3602.1 Sequence of Assembly for Non-Proprietary Hospital Participating in Medicare and Subject to Prospective Payment System.--

<u>Form HCFA</u>	<u>Worksheet</u>	<u>Part</u>
2552-96	S	I & II
2552-96	S-2	
2552-96	S-3	I, II, & III
2552-96	A	
2552-96	A-6	
2552-96	A-7	
2552-96	A-8	
2552-96	B	I
2552-96	B	II
2552-96	B	III
2552-96	B-1	
2552-96	B-2	
2552-96	C	I & II
2552-96	D	I - VI
2552-96	D-1	
2552-96	D-4	
2552-96	E	A
2552-96	E	B
2552-96	E	C
2552-96	E	D
2552-96	E	E
2552-96	E-1	
2552-96	E-3	IV
2552-96	G	
2552-96	G-1	
2552-96	G-2	
2552-96	G-3	
2552-96	L	
2552-96	L-1	I
2552-96	L-1	II
2552-96	L-1	III

3602.2 Sequence of Assembly for Proprietary Health Care Complex Participating in Titles V, XVIII, and XIX.--Cost report worksheets are assembled in alpha-numeric sequence starting with the "S" series, followed by A, B, C, etc.

<u>Form HCFA</u>	<u>Worksheet</u>	<u>Part</u>	<u>Health Care Program (Title)</u>	<u>Component</u>
2552-96	S	I & II		
2552-96	S-2			
2552-96	S-3	I - III		
2552-96	S-4		XVIII	Hospital-Based HHA
2552-96	S-5		XVIII	Renal Dialysis Dept

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

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

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

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

The intermediary should indicate in the appropriate box whether this is the initial cost report (first cost report for the provider number, for this fiscal intermediary), final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened. The intermediary should also indicated in HCRIS on line 1, column 3 of worksheet S the following codes that correspond to the filing status of the cost report: 1=As submitted; 2=Settled; 3=Settled with Audit; 4=Reopened; and 5=Amended.

The intermediary indicates general information about this cost report. This data is submitted as alpha-numeric data in the HCRIS file as follows:

Line 1, Column 1--Enter the cost report status code of 1 for as submitted, 2 for settled, 3 for settled with audit, 4 for reopened, 5 for amended. (Refer to section 10.3 of Chapter 8 of Office of Financial Management Manual Pub 100-06.)

Line 1, Column 2--Enter the date (mm/dd/yyyy) an accepted cost report was received from the provider.

Line 1, Column 3-- Enter I for initial, enter F for final, or enter N for neither. An initial report is the very first cost report the FI submits for a particular provider number. It may not be the first cost report ever for this provider number which may have been handled by a previous FI, but it would be the initial cost report for the new FI.

A final report is the terminating cost report for a particular provider number. If, for example, the provider terminated in 2004, but the 1998 cost report was reopened and submitted after the submission of the 2004 report, the 2004 report is still considered the final report for the provider.

If a provider does have a cost report that is both an initial and final report for a particular year then this field should contain an I if the cost report is an as submitted report, and a F if the cost report is a settled report.

Line 1, Column 4--If this is a reopened cost report, enter the number of times the cost report has been reopened. This field should only be completed if the cost report status code in line 1, column 1 is 4.

Line 2, Column 2--Enter the 5 position Fiscal Intermediary Number.

Line 2, Column 4--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2, 3 or 4.

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

Check the appropriate box to indicate whether you are filing electronically or manually. For electronic filing, indicate on the appropriate line the date and time corresponding to the creation of the electronic file. This date and time remains as an identifier for the file by the intermediary and is archived accordingly. This file is your original submission and is not to be modified.

**3603.2 Part II - Settlement Summary**--Enter the balance due to or due from the applicable program for each applicable component of the complex. Transfer settlement amounts as follows:

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

<u>Hospital/ Hospital Component</u>	<u>Title V</u>	<u>FROM</u>		<u>Title XIX</u>
		<u>Title XVIII Part A</u>	<u>Title XVIII Part B</u>	
SNF	Wkst. E-3, Part III, Line 58	Wkst. E-3, Part II, line 33 or Wkst. E-3, Part III line 58	Wkst. E, Part B, line 35	Wkst. E-3, Part III, line 58
NF, ICF/MR (9/96)	Wkst. E-3, Part III, line 58	N/A	N/A	Wkst. E-3, Part III, line 58

<u>FROM</u>				
<u>Hospital/ Hospital Component</u>	<u>Title V</u>	<u>Title XVIII Part A</u>	<u>Title XVIII Part B</u>	<u>Title XIX</u>
Home Health Agency	Wkst. H-7, Part II, sum of cols. 1&2, line 26	Wkst. H-7, Part II, col.1, line 26	Wkst. H-7, Part II, col. 2, line 26	Wkst. H-7, Part I, sum of cols. 1 & 2, line 26
Outpatient Rehabilitation Providers	Wkst. J-3, line 28	N/A	Wkst. J-3, line 28	Wkst. J-3, line 28
Rural Health Clinic/ Federally Qualified Health Clinic (1/98)	Wkst. M-3 line 25	N/A	Wkst. M-3 line 25	Wkst. M-3 line 25

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

The information required on this worksheet is needed to properly identify the provider. The responses to all lines are Yes or No unless otherwise indicated by the type of question.

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

Lines 2 through 17--Enter on the appropriate lines and columns indicated the names, provider identification numbers, and certification dates of the hospital and its various components, if any. Column 2.01 is reserved for future use. Indicate for each health care program the payment system applicable to the hospital and its various PPS hospital or subprovider checks O for all cost reporting periods through the end of its first 12 month cost reporting period. The 12 month cost reporting period also becomes the TEFRA base period unless an exemption under 42 CFR 413.40(f) is granted. If such an exemption is granted, check O through the end of the exemption period. The last 12 month period of the exemption is the TEFRA base period. Cost reimbursement designation of O is no longer applicable for TEFRA facilities for periods beginning on or after October 1, 1997.

Line 2--This is an institution which meets the requirements of §1861(e) or §1861(mm)(1) of the Act and participates in the Medicare program or is a Federally controlled institution approved by CMS.

Line 3--This is a portion of a general hospital which has been issued a subprovider identification number because it offers a clearly different type of service from the remainder of the hospital, e.g., long term psychiatric. See CMS Pub. 15-I, chapter 23, for a complete explanation of separate cost entities in multiple facility hospitals. While an excluded unit in a hospital subject to PPS may not meet the definition of a subprovider, treat it as a subprovider for cost reporting purposes. If you have more than one subprovider, subscript this line. Cost reimbursement designation of O is no longer applicable for TEFRA facilities for periods beginning on or after October 1, 1997.

Line 4--This is a rural hospital with fewer than 100 beds that is approved by CMS to use these beds interchangeably as hospital and skilled nursing facility beds with payment based on the specific care provided. This is authorized by §1883 of the Act. (See CMS Pub. 15-I, §§2230-2230.6.) Effective for cost reporting periods beginning on or after July 1, 2002, Medicare swing-bed services will be paid under the SNF PPS system (indicate payment system as "P"). CAHs are reimbursed on a cost basis for swing-bed services and should indicate "O" as the payment system.

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

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

Line 7--This is a distinct part nursing facility which has been issued a separate identification number and which meets the requirements of §1905 of the Act. (See 42 CFR 442.300 and 42 CFR 442.400 for standards for other nursing facilities, for other than facilities for the mentally retarded, and for facilities for the mentally retarded.) If your state recognizes only one level of care, i.e., skilled, do not complete any lines designated as NF and report all activity on the SNF line for all programs. The NF line is used by facilities having two levels of care, i.e., either 100 bed facility all certified for NF and partially certified for SNF or 50 beds certified for SNF only and 50 beds certified for NF only.

If the facility operates an Intermediate Care Facility/Mental Retarded (ICF/MR) subscript line 7 to 7.01 and enter the data on that line. Note: 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 | 8 = Governmental, City-County        |
| 2 = Voluntary Nonprofit, Other  | 9 = Governmental, County             |
| 3 = Proprietary, Individual     | 10 = Governmental, State             |
| 4 = Proprietary, Corporation    | 11 = Governmental, Hospital District |
| 5 = Proprietary, Partnership    | 12 = Governmental, City              |
| 6 = Proprietary, Other          | 13 = Governmental, Other             |
| 7 = Governmental, Federal       |                                      |

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

1 = General Short Term	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:

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

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

Line 21--Indicate 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 and "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 and "N" for no in the applicable column. (Impacts Worksheet E, Part A; E-3, Part IV; and E-3, Part VI.)

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 Facilities (SNF) for payments on or after October 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.

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

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

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

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

Line 39--Do not use this line.

Line 40--Are there any related organization or home office costs claimed? Enter "Y" for yes or "N" for no *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* enter the *chain* name, home office number, FI/contractor number, street address, post office box (if applicable), the city, state, zip code of the home office on lines 40.01 through 40.03. Also, enter on line 40.01, column 2, the FI/ Contractor Name, who receives the Home Office *Cost Statement* and in column 3, the FI/Contractor Number.

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 52.01--If you are a fully prospective or hold harmless provider, are you eligible for the special exception payment pursuant to 42 CFR 412.348(g)? Enter "Y" for yes or "N" for. If yes, complete Worksheet L, Part IV. (10/1/2001)

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

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

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

Line 56--Are you claiming ambulance costs? Enter a "Y" for yes or a "N" for no. If yes, enter in column 2, for services rendered on and after October 1, 1997, the ambulance payment per trip limit provided by your intermediary. The per trip rate is updated October 1st of each year. For cost reporting periods which overlap October 1, report the payment rate prior to October 1, on line 56, column 2 and the payment rate applicable for services on October 1 to the end of the cost reporting period on line 56.01. For cost reporting periods beginning October 1st no subscripting is required. If this is your first year of providing and reporting ambulance services, you are not subject to the payment limit, however you are still subject to the fee/cost blend. Enter a "Y" for yes or an "N" for no in column 3 (10/97). For services beginning on or after January 1, 2001 the limit will be changed to a calendar year basis. There is an additional update established by regulation for July 1, 2001. Report your ambulance trip limits (column 2) chronologically, in accordance with your fiscal year. Applicable chronological dates (column 0) should be 1/1/2001, 7/1/2001, 1/1/2002, 4/1/2002 (effective date of blend), 1/1/2003, 1/1/2004, 1/1/2005, and 1/1/2006. For services rendered on or after 4/1/2002, enter in column 4 the gross fee schedule amounts (from the PS&R or your records) for the reporting period. For services on and after 4/1/2002 through 12/31/2005 ambulance services will be subject to a blend until 100 percent fee schedule amount is transitioned on 1/1/2006. For cost reporting periods that straddle 1/1/2006, only report ambulance fee schedule amounts for services rendered before 1/1/2006.

CAHs exempt from the ambulance limits (Worksheet S-2, line 30.03, column 1 equals "Y") complete columns 1 and 2 only. (10/1/97b) If you are eligible for cost reimbursement of ambulance services for the entire cost reporting period complete line 56 only, no subscripts are required. A CAH exempt 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).

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

This worksheet consists of three parts:

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

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

Column Descriptions

Column 1--Effective for discharges occurring on or after October 1, 2004, refer to 42 CFR 412.105(b) and Vol. 69 of the Federal Register 154, dated August 11, 2004, page 49093 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, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes. (See CMS Pub. 15-I, §2205.)

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

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

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

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

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

Column 7--Enter the number of intern and resident full time equivalents (FTEs) in an approved program determined in accordance with 42 CFR 412.105(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 14 or 14.01 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.

Column 8--When interns and residents are used by the hospital to perform the duties of an anesthetist, the related FTEs must be excluded from the interns and residents count in column 9. (See 42 CFR 412.105(g)(iv)). Enter the FTEs relating to the interns and residents performing in anesthesiology who are employed to replace anesthesiologists. Do not include interns and residents in an approved anesthesiology medical education program. Do not complete effective for cost reporting periods beginning on or after August 1997.

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

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

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

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

### Line Descriptions

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

*Labor and delivery days (as defined in the instructions for line 29 of Worksheet S-3, Part I) must not be included on this line.*

Line 2--Enter title XVIII M+C and XIX HMO days and other Medicaid eligible days not included on line one. (10/97) Subscript this line for IRF subproviders to capture Medicaid HMO days in column 5. (1/1/02b)

Line 3--Enter the Medicare covered swing bed days (which are considered synonymous with SNF swing bed days) for all Title XVIII programs where applicable. See 42CFR 413.53(a)(2). Exclude all M+C days from column 4, include the M+C days in column 6.

Line 4--Enter the non-Medicare covered swing bed days (which are considered synonymous with NF swing bed days) for all programs where applicable. See 42CFR 413.53(a)(2).

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

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

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

*Labor and delivery days (as defined in the instructions for line 29 of Worksheet S-3, Part I) must not be included on this line.*

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

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

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

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

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

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

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

Line 19--Do not use this line.

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

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

Line 22--Do not use this line.

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

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

Line 26--Enter the total observation bed days in column 6. Subscript this line for the subprovider (9/96) when both providers are claiming observation bed costs. Divide the total number of observation bed hours by 24 and round up to the nearest whole day. These total hours should include the hours for observation of patients who are subsequently admitted 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.

*Effective for cost reporting periods beginning on or after October 1, 2009, do not enter any information on line 26, columns 5.01, 5.02, 6.01, and 6.02 since all the observation bed days (both those for the patients that are subsequently admitted as inpatients and those who are discharged) will be excluded from the computation of the disproportionate patient percentage (DPP) on Worksheet E, Part A, line 4.01 and will be deducted from the computation of the beds on Worksheet E, Part A, line 3 for purpose of calculating the indirect medical education (IME) and disproportionate share hospital (DSH) payments. See Federal Register, volume 74, number 165, date August 27, 2009, page 43905, effective for cost reporting periods beginning on or after October 1, 2009.*

Effective for cost reporting periods beginning on or after October 1, 2004 *and beginning before October 1, 2009*, for line 26 add (unshade) column 5 (total Medicaid observation bed days), subscript column 5 by adding column 5.01 (Medicaid observation bed days for patients who are subsequently admitted as inpatients but only the hours up to the time of admission), and column 5.02 (Medicaid observation bed days for patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge).

Additionally, *effective for cost reporting periods beginning on or after October 1, 2004, and beginning before October 1, 2009*, subscript column 6 by adding column 6.01 (Total observation bed days for patients who are subsequently admitted as inpatients but only the hours up to the time of admission) and column 6.02 (Total observation bed days for patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge).

The amount in column 5 must equal the sum of columns 5.01 and 5.02 and the amount in column 6 must equal the sum of columns 6.01 and 6.02. (10/1/2004b)

Line 27--Enter in column 4 the number of ambulance trips, as defined by section 4531(a)(1) of The BBA, provided for Medicare patients for ambulance services on or after October 1, 1997. For cost reporting periods that overlap October 1 and July 1, 2001 see §3604, line 56 for proper subscripting (10/97). Effective for services rendered on or after December 21, 2000, ambulance costs for a CAH are reimbursed on costs if Worksheet S-2, column 1, line 30.03 is answered yes. If yes, separate the trips in accordance with Worksheet S-2, line 56 and subscripts. For cost reporting periods that overlap January 1, 2006, subscript line 27 reporting the number of trips prior to January 1, 2006 on line 27 and the number of trips occurring on or after January 1, 2006 on line 27.01. Do not subscript this line for cost reporting periods beginning on or after January 1, 2006, but report all ambulance trips on this line.

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

*Line 29*--*Effective for cost reporting periods beginning on or after October 1, 2009, indicate in column 5 the count of labor/delivery days for Title XIX and in column 6 the total count of labor/delivery days for the entire facility.*

*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 PRM-1, section 2205.2). In the case where the maternity patient is in a single multipurpose labor, delivery and postpartum (LDP) 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 29. Maternity patients must be admitted to the hospital as an inpatient for their labor and delivery days to be included on line 29. These days must not be reported on Worksheet S-3, Part I, line 1 or line 12.*

**3605.2 Part II - Hospital Wage Index Information.**--This worksheet provides for the collection of hospital wage data which is needed to update the hospital wage index applied to the labor-related portion of the national average standardized amounts of the prospective payment system. It is important for hospitals to ensure that the data reported on Worksheet S-3, Parts II and III are accurate. Beginning October 1, 1993, the wage index must be updated annually. (See §1886(d)(3)(E) of the Act.) Congress also indicated that any revised wage index must exclude data for wages incurred in furnishing SNF services. Complete this worksheet for 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.

#### Column 1

Line 1--Enter from Worksheet A, column 1, line 101, the wages and salaries paid to hospital employees increased by amounts paid for vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay if not reported in column 1.

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

**NOTE:** Capital related salaries, hours, and wage-related costs associated with lines 1 through 4 of Worksheet A must be excluded from Worksheet S-3, Parts II and III.

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

PTO salary cost -- The required source for costs on Worksheet A is the general ledger (see Provider Reimbursement Manual, Part II, section 3610 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 FIs/MACs 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 FIs/MACs 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 minimum.

Lines 2 through 8.01--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 6 the salaries for employees associated with excluded areas lines 8 and 8.01 (10/97).

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

Do not include physician assistants, clinical nurse specialists, nurse practitioners, and nurse midwives. (10/00).

Line 3--Enter the non-physician anesthetist salaries included in line 1, subject to the fee schedule and paid under Part B by the carrier. Do not include salary costs for physician assistants, clinical nurse specialists, nurse practitioners, and nurse midwives. (10/99).

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

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

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

Line 7--If you are a member of a chain or other related organization as defined in CMS Pub 15-I, §2150, enter, from your records, the wages and salaries for home office related organization personnel that are included in line 1.

Lines 8 and 8.01--Enter the amount reported on Worksheet A, column 1 for line 34 for the SNF. On line 8.01, enter from Worksheet A, column 1, the sum of lines 21, 24, 31, 35, 35.01, 36, 64, 65, 68 through 71, 82 through 86, 89, 92 through 94, and 96 through 100 (10/00). DO NOT include on lines 8 and 8.01 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 8.01.

Line 9--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 8 and 8.01 Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and 6 respectively). For cost reporting periods beginning before October 1, 2000, DO NOT include costs for pharmacy and laboratory services furnished under contract and subscript this line to report these costs on line 9.01 and 9.02 respectively (10/97). For cost reporting periods beginning on or after October 1, 2000, DO NOT use lines 9.01 and 9.02, but include on line 9 contract pharmacy and laboratory wage costs as defined below in lines 9.01 and 9.02.

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 are 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 fiscal intermediary or MAC. 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 9.03 or 22.01; 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 Form CMS-339, 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 (10/00).

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

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

Line 9.01--Enter the amount paid for **pharmacy services** furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. Per instructions on Form CMS-339, submit to your fiscal intermediary the following for direct patient care pharmacy contracts: the types of services, wages, and associated hours (10/97).

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

Line 9.03--Enter the amount paid for **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 21 through 35 (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 9.03 include department directors, administrators, managers, ward clerks, and medical secretaries. Report only those personnel costs associated with the contract. DO NOT include on

line 9.03 any contract labor costs associated with lines 21 through 35 and subscripts for these lines. DO NOT include the costs for contract top level management: chief executive officer, chief operating officer, and nurse administrator; these services are included on line 9. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. (10/1/2003b).

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

Line 11--Enter the salaries and wage-related costs (as defined on lines 13 and 14) paid to personnel who are affiliated with a home office 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 7 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 12.

If a wage related cost associated with the home office is not "core" (as described in Part I of Exhibit 6 of the Form-CMS -339) and is not a category included in "other" wage related costs on line 14 (see Part II of Exhibit 6 of Form CMS-339 and line 14 instructions below), the cost cannot be included on line 11. For example, if a hospital's employee parking cost does not meet the criteria for inclusion as a wage-related cost on line 14, any parking cost associated with home office staff cannot be included on line 11 (10/97).

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

Lines 13 through 20--In general, the amount reported for wage-related costs must meet the "reasonable cost" provisions of Medicare. For example, in developing pension and deferred compensation costs, hospitals must comply with the requirements in 42 CFR 413.100 and the PRM, Part I, §§ 2140, 2141 and 2142 (see discussion in 70 FR 47369, August 12, 2005).

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. Hospital are required to complete Form CMS-339, Exhibit 6, section III, a reconciliation worksheet to aid hospital and intermediaries in implementing GAAP when developing wage-related costs. Upon request by the intermediary or CMS, hospitals must provide a copy of the GAAP pronouncement, or other documentation, showing that the reporting practice is widely accepted in the hospital industry and/or related field as support for the methodology used to develop the

wage-related costs. If a hospital does not complete Form CMS-339, exhibit 6 section 3, or, the hospital is unable, when requested, to provide a copy of the standard used in developing the wage-related costs, the intermediary may remove the cost from the hospital's Worksheet S-3 due to insufficient documentation to substantiate the wage-related cost relevant to GAAP. (4/30/2008)

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

**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 18, Part A teaching services on Line 18.01, and Part B (patient care services) on Line 19. Line 13 must not include wage-related costs that are associated with physician services.

Line 13--Enter the core wage-related costs as described in Exhibit 6 of Form CMS-339. (See note below for costs that are not to be included on line 13). Only the wage-related costs reported on Part I of Exhibit 6 are reported on this line. (Wage-related costs are reported in column 2, not column 1, of Worksheet A.)

**NOTE:** Do not include wage-related costs applicable to the excluded areas reported on lines 8 and 8.01. Instead, these costs are reported on line 15. Also, do not include the wage-related costs for physicians Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel. (See lines 11, 12, and 16 through 20.)

#### Health Insurance and Health-Related Wage Related Costs:

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

Line 14--Enter the wage-related costs that are considered an exception to the core list. (See note below for costs that are not to be included on line 14.) A detailed list of each additional wage-related cost must be shown on Exhibit 6, Part II of Form CMS-339. In order for a wage-related cost to be considered an exception, it must meet all of the following tests:

- a. The cost is not listed on Exhibit 6, Part I of Form CMS-339,
- b. The wage-related cost has not been furnished for the convenience of the provider,
- c. The wage-related cost is a fringe benefit as defined by the Internal Revenue Service and, where required, has been reported as wages to IRS (e.g., the unrecovered cost of employee meals, education costs, auto allowances), and

- d. The total cost of the particular wage-related cost 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 3, line 3). Wage-related cost exceptions to the core list are not to include those wage-related costs that are required to be reported to the Internal Revenue Service as salary or wages (i.e., loan forgiveness, sick pay accruals). Include these costs in total salaries reported on line 1 of this worksheet.

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

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

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

Lines 21 through 35--Enter the direct wages and salaries from Worksheet A column 1 for the appropriate cost center identified on lines 21 through 35, respectively, increased by the amounts paid for vacation, holiday, sick, and paid-time-off if not reported in column 1 of these lines. These lines provide for the collection of hospital wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. These lines are completed by all hospitals if the ratio of Part II, column 4, sum of lines 8 and 8.01 divided by the result of column 4, line 1 minus the sum of lines 2, 3, 4.01, 5, **5.01**, 6, 6.01, and 7 equals or exceeds a threshold of 15 percent. However, all hospitals with a ratio greater than 5 percent must complete line 13 of Part III for all columns. Calculate the percent to two decimal places for purposes of rounding.

Lines 22.01, 26.01, and 27.01--Enter the amount paid for services 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 22, 26, and 27), the amounts paid for services rendered by employees not under contract. (10/1/2003b)

Line 22.01--A&G costs are expenses a hospital incurs in carrying out its administrative and/or general management functions. Include on line 22.01 the contract services that are included on Worksheet A, line 6 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 Worksheet S-3, Part II, line 22.01. Do not include on line 22.01 the costs for top level management contracts (these costs are reported on line 9). Do not include on line 22.01 any costs for contract home office personnel (these costs are currently not included in the wage index).

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

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

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

Column 4--Enter on each line the number of **paid** hours corresponding to the amounts reported in column 3. Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave hours, paid time-off hours, and hours associated with severance pay. For Part II, lines 1 through 12 (including subscripts), lines 21 through 35 (including subscripts), and Part III, line 13, if the hours cannot be determined, then the associated salaries must not be included in columns 1 through 3 (10/97).

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

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

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

3605.3 Part III - Hospital Wage Index Summary--This worksheet provides for the calculation of 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 5--Follow the same instructions discussed in Part II, except for column 5, line 5.

Line 1--From Part II, enter the result of line 1 minus the sum of lines 2, 3, 4.01, 5, 5.01, 6, 6.01 (10/00), and 7 (10/97). Add to this amount line: 22.01, 26.01 and 27.01. (10/01/2003b)

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

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

Line 4--From Part II, enter the sum of lines 9, 9.03, 10, 11, and 12 and subscripts if applicable (10/97).

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

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

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

Line 13--Enter from Part II above, the sum of lines 21 through 35, including lines 22.01, 26.01, and 27.01. If the hospital's ratio for excluded area salaries to net salaries is greater than 5 percent, the hospital must complete all columns for this line. (See instructions in Part II, lines 21 through 35 for calculating the percentage.)

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

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

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

Line 2--Enter the unduplicated count of all individual patients and title XVIII patients receiving home visits or other care provided by employees of the agency or under contracted services during the reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count (column 5, line 2) may not equal the sum of columns 1 through 4, line 2. For purposes of calculating the unduplicated census, if a beneficiary has received healthcare in more than one CBSA, you must prorate the count of that beneficiary so as not to exceed a total of (1). A provider is to also query the beneficiary to determine if he or she has received healthcare from another provider during the year, e.g., Maine versus Florida for beneficiaries with seasonal residence. For cost reports that overlap October 1, 2000, subscript line 2 and enter the census count before October 1, 2000 on line 2 and on and after October 1, 2000 on line 2.01. For cost reporting periods that begin on or after October 1, 2000, no subscripting is required for line 2.

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

Enter the number of hours in your normal work week.

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

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

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

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

Line 19--For HHA services rendered on or after January 1, 2006, geographic areas are identified as CBSAs. Enter in column 1 the number of CBSAs and in column 1.01 the number of CBSAs you serviced during this cost reporting period (1/1/2006s).

Line 20--Identify each CBSA and/or Non-CBSA (rural) where the reported HHA visits are performed. Subscript the lines to accommodate the number of CBSA's you service. Rural CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the state of Maryland the rural CBSA code is 99921 and rural CBSA codes are assembled by placing the digits "99" in front of the two digit State code, e.g., for the state of Maryland the rural CBSA code is 9921.

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

In accordance with 42 CFR §413.20 and §1895 of the Social Security Act, home health agencies are mandated to transition from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

The statistics required on this worksheet pertain to home health services furnished on or after October 1, 2000. The data to be maintained, depending on the services provided by the agency, includes the number of aggregate program visits furnished in each episode of care payment category for each covered discipline, the corresponding aggregate program charges imposed in each episode of care payment category for each covered discipline, total visits and total charges for each episode of care payment category, total number of episodes and total number of outlier episodes for each episode of care payment category, and total medical supply charges for each episode of care payment category.

HHA Visits--See PRM II, chapter 32, §3205, page 32-13 for the definition of an HHA visit.

Episode of Care--Under home health PPS the 60 day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. Beneficiaries are covered for an unlimited number of non-overlapping episodes. The duration of a full length episode will be 60 days. An episode begins with the start of care date and must end by the 60<sup>th</sup> day from the start of care.

Less than a full Episode of Care--When 4 or fewer visits are provided by the HHA in a 60 day episode period, the result is a low utilization payment adjustment (LUPA). In this instance the HHA will be reimbursed based on a standardized per visit payment.

An episode may end before the 60<sup>th</sup> day in the case of a beneficiary elected transfer, or a discharge and readmission to the same HHA (including for an intervening inpatient stay). This type of situation results in a partial episode payment (PEP) adjustment.

When a beneficiary experiences a significant change in condition (SCIC) and subsequently, but within the same 60 day episode, elects to transfer to another provider a SCIC within a PEP occurs. Effective for episodes of care ending on or after January 1, 2008, do not complete column 5 for SCIC within PEP episodes.

A significant change in condition (SCIC) adjustment occurs when a beneficiary experiences a significant change in condition, either improving or deteriorating, during the 60 day episode that was not envisioned in the original plan of care. The SCIC adjustment reflects the proportional payment adjustment for the time both prior and after the beneficiary experienced the significant change in condition during the 60 day episode. Effective for episodes of care ending on or after January 1, 2008, do not complete column 6 for SCIC only episodes.

Use lines 21 through 32 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 33 and 35 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 36 identifies the total number of episodes completed for each episode payment category. Line 37 identifies the total number of outlier episodes completed for each episode payment category.

Outlier episodes do not apply to 1) Full Episodes without Outliers and 2) LUPA Episodes. Line 38 identifies the total medical supply charges incurred for each episode payment category. Column 7 displays the sum total of data for columns 1 through 6. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report and only pertain to services rendered on or after October 1, 2000.

When an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all statistical data (i.e., cost, charges, counts, etc...) associated with that episode of care will appear on the PS&R of the fiscal year in which the episode of care is concluded. Similarly, all data required in the cost report for a given fiscal year must only be associated with services rendered during episodes of care that conclude during the fiscal year. Title XVIII visits reported on this worksheet will not agree with the title XVIII visits reported on Worksheet H-6, sum of columns 6 and 7 line 14.

Columns 1 through 6--Enter data pertaining to title XVIII patients only for services furnished on or after October 1, 2000. Enter, as applicable, in the appropriate columns 1 through 6, lines 21 through 32, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episode of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only Episodes) will not include any visit counts and corresponding charges that appear in column 3 (LUPA Episode) and vice versa. This is true for all episode of care payment categories in columns 1 through 6.

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

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

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

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

Line 37--Enter in columns 2 and 4 through 6 for each episode of care payment category identified, respectively, the total number of outlier episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

**NOTE:** Lines 36 and 37 are mutually exclusive.

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

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

3607. 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-I, §2720. Enter on the combined Worksheet S-5 each renal dialysis provider's satellite number if you are separately certified as a satellite facility.

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 can not 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 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 (method I or II), 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 57 of Worksheet A (10/97).

Line 13.01--Based on the instructions contained on line 13, enter the amount of Epoetin included on line 64 (home dialysis program) from Worksheet A (10/97).

Line 14--Enter the number of EPO units furnished relating to the renal dialysis department.

Line 14.01--Enter the number of EPO units furnished relating to the home dialysis program.

Line 15--Identify how physicians are paid for medical services provided to Medicare beneficiaries. Under the monthly capitation payment (MCP) methodology, carriers 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 16--Enter the direct product cost net of discount and rebates for Darbepoetin Alfa (Aranesp) Include all Aranesp cost for patients receiving outpatient, home (method I or II), 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 57 of Worksheet A. (4/30/2008)

Line 17--Based on the instructions contained on line 16, enter the dollar amount of Aranesp included on line 64 (home dialysis program) from Worksheet A. (4/30/2008)

Line 18--Enter the number of micrograms (mcgrs) of Aranesp furnished relating to the renal dialysis department. (4/30/2008)

Line 19--Enter the number of micrograms of Aranesp furnished relating to the home dialysis program. (4/30/2008)

### 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.**

**3608. STATISTICAL DATA OUTPATIENT PROVIDERS**

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

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

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

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

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

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

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

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

**3608.2 Worksheet S-8 - Provider-Based Rural Health Clinic/Federally Qualified Health Center Provider Statistical Data (1/98).**--Effective with services rendered on and after January 1, 1998, in accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain separate statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based Federally qualified health centers (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility. RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-4, chapter 9, §30.8.

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

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

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

Line 9--Subscript line 9 as needed to list all physicians furnishing services at the RHC/FQHC. Enter the physician's name in column 1, and the physician's Medicare billing number in column 2. This line is not applicable for cost reporting periods ending on or after May 31, 2009.

Line 10--Subscript line 10 as needed to list all supervisory physicians. Enter the physician's name in column 1, and the number of hours the physician spent in supervision in column 2. This line is not applicable for cost reporting periods ending on or after May 31, 2009.

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

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

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

Line 14--Is this a consolidated cost report as defined in the Rural Health Clinic Manual? If yes, enter in column 2 the number of providers included in this report, complete line 15, and complete only one worksheet series M for the consolidated group. If no, complete a separate worksheet S-8 for each component accompanied by a corresponding worksheet M series.

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

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

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

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

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

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.

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

Column Descriptions

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

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

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

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

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

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

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

**Inpatient Respite Care Day** - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

**General Inpatient Care Day** - A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

#### COLUMN DESCRIPTIONS

Column 1--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Column 2--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 5 the total unduplicated Medicaid days.

Column 3--Enter only the unduplicated days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 5 the total unduplicated days.

Column 4--Enter only the unduplicated days applicable to the four types of care for all Medicaid hospice patients residing in a nursing facility. Enter on line 5 the total unduplicated days.

Column 5--Enter in column 5 only the days applicable to the four types of care for all other non Medicare or Medicaid hospice patients. Enter on line 5 the total unduplicated days.

Column 6--Enter the total days for each type of care, (i.e., sum of columns 1, 2 and 5). The amount entered in column 6, line 5 should represent the total days provided by the hospice.

**NOTE:** Convert continuous home care hours into days so that column 6 line 8 reflects the actual total number of days provided by the hospice.

#### 3609.3 Part II -Census Data.--

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

Line 6--Enter the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source.

The total under this line should equal the actual number of patients served during the cost reporting period for each program. Thus, if a patient's total stay overlapped two reporting periods, the stay should be counted once in each reporting period. The patient who initially elects the hospice benefit, is discharged or revokes the benefit, and then elects the benefit again within a reporting period is considered to be a new admission with a new election and should be counted twice.

A patient transferring from another hospice is considered to be a new admission and would be included in the count. If a patient entered a hospice under a payer source other than Medicare and then subsequently elects Medicare hospice benefit, count the patient once for each payer source.

The difference between line 6 and line 9 is that line 6 should equal the actual number of patients served during the reporting period for each program, whereas under line 9, patients are counted once, even if their stay overlaps more than one reporting period.

Line 7--Enter the total title XVIII Unduplicated Continuous Care hours billable to Medicare. When computing the Unduplicated Continuous Care hours, count only one hour regardless of number of services or therapies provided simultaneously within that hour.

Line 8--Enter the average length of stay for the reporting period. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payer source other than Medicare and Medicaid is not limited to the number of days under a hospice election. Line 5 divided by Line 6.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then reelects the Medicare hospice benefits for an additional 45 days, under a new benefit period and dies (patient B).

Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D was admitted with private insurance for 27 days, then their private insurance ended and Medicaid covered an additional 92 days. Patient E, with private insurance, received hospice care for 87 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the cost reporting period) is computed as follow:

Medicare Days (90 & 45 & 29)	164 days
Patient (A, B & C)	
Medicare Patients	/3
Average LOS Medicare	54.67 Days
Medicaid Days Patient D (92)	92 Days
Medicaid Patient	1
Average LOS Medicaid	92 Days
Other (Insurance) Days (87 & 27)	114 Days
Other Payments (D & E)	2
Average LOS (Other)	54 Days
All Patients (90+45+29+92+87+27)	370 Days
Total number of patients	6
Average LOS for all patients	61.67 Days

Enter the hospice's average length of stay, without regard to payer source, in column 6, line 11.

Line 9--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (See CMS Pub. 21 □204). However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and should be counted twice.

The total under this line should equal the unduplicated number of patients served during the reporting period for each program. Thus, you would not include a patient if their stay was counted in a previous cost reporting period. If a patient enters a hospice source other than Medicare and subsequently becomes eligible for Medicare and elects the Medicare hospice benefit, then count that patient only once in the Medicare column, even though he/she may have had a period in another payer source prior to the Medicare election. A patient transferring from another hospice is considered to be a new admission and is included in the count.

3609.4 Worksheet S-10-Hospital uncompensated Care Data--Section 112(b) of the Balance Budget Refinement Act (BBRA) requires that hospital submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated. This worksheet is applicable for short-term acute care hospitals only. Complete lines 1 through 16 for cost reporting periods ending on or after April 30, 2003, and ending before April 30, 2004. Complete lines 17 through 32 for cost reporting periods ending on or after April 30, 2003.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 14.02--What percentage of the amount on line 14.01 is from government funding? DO NOT COMPLETE THIS LINE.

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

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

#### Uncompensated Care Revenues

Line 17--Enter from your records revenues from uncompensated care.

Line 17.01--Enter from your records gross Medicaid revenues.

Line 18--Enter from your records revenues from state and local indigent care programs.

Line 19--Enter from your records Gross Medicaid revenues. Enter from your records revenues from the State Children's Health Insurance Program (SCHIP). Created in 1997, SCHIP is a State and Federal partnership to help children without health insurance, many of whom come from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance.

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

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

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

#### Uncompensated Care Cost

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

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

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

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

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

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

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

Line 30--Other uncompensated care charges from your books and records.

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

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