

## 4030. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

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

Worksheet E consists of the following two parts:

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

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

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

4030.1 Part A - Inpatient Hospital Services Under IPPS--

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

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

*For IPPS hospitals participating in Model 4 of the Bundled Payments for Care Improvement (BPCI) initiative, Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model, as will outlier payments and hospital capital payments (see Change Request 8196, dated February 15, 2013). Enter on lines 1.03 and 2.02, in column 1 the applicable payment data for the cost reporting period.*

Line Descriptions

Line 1--The amount entered on this line is the sum of the federal *specific* operating portion (DRG payments) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. *For cost reporting periods overlapping October 1, 2013, do not complete line 1, but complete lines 1.01 and 1.02. For cost reporting periods beginning on or after October 1, 2013, use this line and do not complete lines 1.01 and 1.02.*

*Line 1.01--For cost reporting periods that overlap October 1, 2013, enter the amount of the federal specific operating portion (DRG payments) paid for PPS discharges and transfers occurring prior to October 1, 2013. For example, a calendar year provider would include DRG payments for discharges occurring during the period of (January 1 through September 30). Do not complete for cost reporting periods beginning on or after October 1, 2013.*

*Line 1.02--For cost reporting periods that overlap October 1, 2013, enter the amount of the federal specific operating portion (DRG payments) paid for PPS discharges and transfers occurring on or after October 1, 2013. For example, a calendar year provider would include DRG payments for discharges occurring during the period of (October 1 through December 31). Do not complete for cost reporting periods beginning on or after October 1, 2013.*

*Line 1.03--Enter the amount of the federal specific operating portion (DRG payments) for Model 4 bundled payments for care improvement (BPCI) initiative, effective for discharges occurring on or after October 1, 2013.*

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

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

*Line 2.02--Effective for discharges occurring on or after October 1, 2013, enter the amount of outlier payments made for Model 4 BPCI discharges during the cost reporting period.*

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

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

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

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

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

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

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

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

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

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

Line 8.01--Enter, as applicable, all of or a portion of the amount of the FTE cap slots the hospital was awarded under section 5503 of the ACA. The amount of the section 5503 award that is reported on this line is the amount of the section 5503 award that is being "used" in this cost reporting period. In the 5-year evaluation period following implementation of section 5503 (that is, July 1, 2011 through June 30, 2016), at least 75 percent of the slots are to be "used" for additional primary care and/or general surgery residents, while 25 percent of the amount that is reported may be (but need not be) "used" for other purposes. During the 5-year evaluation period, failure to meet the requirements at 42 CFR 413.79(n)(2) of the regulations means loss of a hospital's section 5503 slots. Therefore, do not automatically report the full amount of the section 5503 award; only enter the amount of the section 5503 award that equates to at least 75 percent of the FTEs being "used" for additional primary care and/or general surgery FTEs, and

no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting period.

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

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

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

Calculation of the allowable current year FTEs:

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

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

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

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

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

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

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

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

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

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

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

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

Line 22--Calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times  $\{(1 + \text{line 21}) \text{ to the } .405 \text{ power} - 1\}$  times  $\{\text{the sum of lines 1, } 1.01, 1.02, 1.03 \text{ and } 3\}$ .

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

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

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

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

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

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

Line 28--IME Add On Adjustment--Enter the sum of lines 1, *1.01*, *1.02*, *1.03* and 3, multiplied by the factor on line 27.

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

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

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

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

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

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

Line 34--Multiply line 33 by line 1 *for cost reporting periods ending on or before September 30, 2013. Effective for cost reporting periods that overlap October 1, 2013, enter the sum of ((line 33 times line 1.01), plus ((line 33 times the sum of lines 1.02 and 1.03) times 25 percent))*. *For cost reporting periods beginning on or after October 1, 2013, multiply (line 33 times the sum of lines 1 and 1.03) times 25 percent.*

*Section 3133 of the ACA provides that for services occurring on or after October 1, 2013 a subsection (d) (i.e., IPPS hospital) hospital which is entitled to receive a DSH payment will receive two separately calculated payments. The "empirically justified Medicare DSH payment" which represents 25 percent of the amount the hospital would have received under 42 CFR 412.106(d) is calculated on line 34. The "additional payment for uncompensated care" payment is calculated on lines 35 through 36.*

*Uncompensated Care Adjustment--Section 3133 of the ACA: (1) provides that for discharges occurring on or after October 1, 2013, subsection (d) hospitals' Medicare DSH payments are reduced by 75 percent (to the empirically justified Medicare DSH payment); and (2) established an uncompensated care payment amount which represents the remaining 75 percent of the DSH payments and distributes a portion of this amount to each qualifying DSH hospital based on its share of uncompensated care. Effective for cost reporting periods overlapping or beginning on or after October 1, 2013, complete lines 35 through 36, columns 1 and 2, as applicable only if you are a subsection (d) hospital and answered yes to Worksheet S-2, Part I, line 22, column 1.*

*If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, columns 1 and 2 are "Y", do not complete lines 35 and 35.01. If Worksheet S-2, Part I, line 22.01, either column 1 or 2 is "N", complete only the column with the "N" response for lines 35 and 35.01. A response of "Y" for both questions indicates that a hospital uncompensated care payment has been pre-determined for your hospital for the applicable FFY.*

**NOTE:** *For cost reporting periods that overlap October 1, 2013, column 1 should be left blank and only column 2 should be completed.*

*Line 35--If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "N", enter in the corresponding column the full amount (for all eligible IPPS hospitals) available for uncompensated care payments for the appropriate FFY. For example, for a cost reporting period ending December 31, 2013, enter zero in column 1 for the portion of the cost reporting period that began prior to October 1, 2013, and enter the FFY14 uncompensated care payment amount of \$9,046,380,143 in column 2.*

*Line 35.01--If Worksheet S-2, Part I, line 22.01, column 1 or 2, is "N", enter the applicable factor 3 value determined by CMS for uncompensated care payments for the appropriate FFY in columns 1 and 2, respectively. If you are a new hospital, Worksheet S-2, Part I, line 47, column 2 is "Y", factor 3 must be calculated. In determining factor 3 the numerator is the current year cost report Medicaid days (Worksheet S-2, Part I, line 24, sum of columns 1 through 6) plus the SSI days published for the applicable FFY divided by the denominator which is a fixed amount obtained from the applicable FFY IPPS rule. For FFY14 the denominator is 36,429,747 (this represents the total IPPS hospitals Medicaid days and SSI days for FFY14). Round this factor 3 to 9 decimal places.*

*Line 35.02-- If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "Y", enter the hospital uncompensated care payment amount determined by CMS for the appropriate FFY in columns 1 and 2. If Worksheet S-2, Part I, line 22, column 1 is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2 is "N", then CMS did not determine the hospital uncompensated care payment amount for that FFY. Compute this amount by multiplying line 35 times line 35.01, for columns 1 and 2, respectively. If Worksheet S-2, Part I, line 22, column 1 is "N" and/or line 34 above is zero, enter zero on this line.*

*Line 35.03--Enter the pro rata share of the hospital's uncompensated care payment in columns 1 and 2. Enter in column 1 (line 35.02 times the number of days in the cost reporting period prior to October 1 divided by the total days in the cost reporting period). Enter in column 2 (line 35.02 times the number of days in the cost reporting period on or after October 1 divided by the total days in the cost reporting period).*

*For example, a calendar year cost reporting period January 1, 2013 through December 31, 2013, enter zero in column 1, for the period of (January 1, 2013 through September 30, 2013) this period is prior to FFY 14; enter in column 2, for the period of (October 1, 2013 through December 31, 2013 (FFY 14)), (92 days/365 days) times line 35.02, column 2.*

*Another example, a calendar year cost reporting period of January 1, 2014 through December 31, 2014, enter in column 1, for the period (January 1, 2014 through September 30, 2014 (FFY 14)), (273 days/365 days) times lines 35.02, column 1; enter in column 2, for the period of (October 1, 2014 through December 31, 2014 (FFY 15)), (92 days/365days times line 35.02, column 2).*

*Line 36--Enter the hospital's uncompensated care adjustment amount, (the sum of columns 1 and 2, line 35.03.)*

Lines 37 - 39--Reserved for future use.

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

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

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

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

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

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

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

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

Line 47--Enter the sum of lines 1, *1.01*, *1.02*, 2, 2.01, *2.02*, 29, 34, *36* and 46.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 60--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

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

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

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

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

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

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

Line 62--Enter from the PS&R or your records the deductibles billed to program patients *excluding deductibles and coinsurance associated with Model 4 BPCI payments*.

Line 63--Enter from the PS&R or your records the coinsurance billed to program patients *excluding deductibles and coinsurance associated with Model 4 BPCI payments*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 72--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For contractor final settlements, enter the amount reported on Worksheet E-1, column 2, line 5.99 on line 73. Included in *the* interim payments *are* the amounts received as the estimated nursing and allied health managed care payments *and capital, IME, DSH and outlier payments associated with Model 4 BPCI*.

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

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

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

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

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

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

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

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

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

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

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

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

#### Instructions For Completing Exhibit 4--

##### Low Volume Adjustment Calculation Schedule:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### Line Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXHIBIT 4

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE

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

**This page is reserved for future use.**

4030.2 Part B - Medical and Other Health Services--Use Worksheet E, Part B, to calculate reimbursement settlement for hospitals, subproviders, and SNFs.

Use a separate copy of Worksheet E, Part B, for each of these reporting situations. If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. Enter check marks in the appropriate spaces at the top of each page of Worksheet E to indicate the component program for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers. For purposes of prospective payment for outpatient services when the PCR transition date (applicable to cancer hospitals) (see the following paragraph), transitional outpatient payment calculation date, or geographic reclassification date (urban to rural only) (42 CFR 412.103 and 412.230) occurs at other than the cost report period beginning date, complete subscripted column 1.01 in addition to column 1 for lines 2 through 8 only. Order the subscripted columns chronologically as the transition dates or geographic reclassification corresponds to your fiscal year. The dates should also agree with the format on Worksheet D, Part V, columns 2, 2.01, 2.02 and 2.03, etcetera, if applicable.

In accordance with ACA 2010, section 3138, cancer hospitals (as defined in 42 CFR 412.23(f)) must utilize a predetermined PCR to calculate the corresponding transitional outpatient payment effective for services rendered beginning January 1, 2012. Where the cost reporting period overlaps a PCR revision date, subscript column 1 as indicated in the preceding paragraph to correspond to each unique PCR. For calendar year 2012 the PCR for cancer hospitals is 0.91, but is subject to change every calendar year. Enter the applicable PCR(s) on line 5, column 1 and applicable subscripts. See Federal Register, vol. 76, November 30, 2011, page 74206.

**NOTE:** If you are not a cancer or children's hospital or covered by ACA section 3121, do not complete lines 2 and 5 through 8.

#### Line Descriptions

Line 1--Enter the cost of medical and other health services for title XVIII, Part B. This amount also includes the cost of ancillary services furnished to inpatients under the medical and other health services benefit of Medicare Part B. These services are covered in this manner for Medicare beneficiaries with Part B coverage only when Part A benefits are not available. Obtain this amount from Worksheet D, Part V, line 202, columns 6 and 7, for hospitals and enter in column 1. For SNFs transfer the amount from Worksheet D, Part V, columns 6 and 7.

The following providers are temporarily eligible for hold harmless payments and must use columns 1 and 1.01 to correspond to the respective portion of the cost reporting period for lines 2 through 8. Rural hospitals with 100 or fewer beds whose reporting period overlaps December 31, 2012 are eligible through December 31, 2012; SCHs and EACHs regardless of bed size whose reporting period overlaps February 29, 2012 are eligible through February 29, 2012; and SCHs and EACHs with 100 or fewer beds whose reporting period overlaps December 31, 2012 are eligible through December 31, 2012, (Worksheet S-2, Part I, line 120, column 1 or 2 is "Y" for yes).

CAHs are not subject to transitional corridor payments, therefore lines 2 through 9 do not apply to CAHs. Transfer Worksheet D, Part V, columns 6 and 7, line 202.

Line 2--Enter the cost of medical and other health services reimbursed under OPSS from Worksheet D, Part V, column 5 and applicable subscripts, line 202. Subtract from this amount outpatient pass through costs reported on Worksheet D, Part IV, line 200, column 13.

Line 3--Enter the gross PPS payments received including payment for drugs and device pass through payments.

Line 4--Enter the amount of outlier payments made for outpatient PPS services rendered during the cost reporting period.

Contractors only, add or subtract as applicable to the gross PPS payments the total outlier reconciliation amount from line 94.

Line 5--Enter the hospital specific payment to cost ratio provided by your contractor. If a new provider does not file a full cost report for a cost reporting period that ends prior to January 1, 2001, the provider is not eligible for transitional corridor payments and should enter zero (0) on this line. (See PM A-01-51)

For cancer hospitals enter a PCR of 0.91 for services rendered during calendar year 2012. Obtain subsequent cancer hospital PCR updates from your contractor or applicable CMS publications.

Line 6--Enter the result of line 2 times line 5.

If the sum of lines 3 and 4 is < line 6 complete lines 7 and 8, otherwise do not complete lines 7 and 8.

Line 7--Enter the result of the sum of lines 3 and 4 divided by line 6.

Line 8--Enter the transitional corridor payment amount calculated based on the following:

- a. If the sum of lines 3 and 4 is < line 6 and Worksheet S-2, Part I, line 3, column 4 response is 3 or 7 (cancer or children's hospital), enter the result of line 6 minus the sum of lines 3 and 4.

In accordance with ACA 2010, section 3121, and MMEA of 2010, section 108, as amended by the Temporary Payroll Tax Cut Continuation Act of 2011, section 308, and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 to all SCHs and EACHs regardless of bed size; and from March 1, 2012 through December 31, 2012 to all SCHs and EACHs with 100 or fewer beds; and from January 1, 2010 through December 31, 2012 for rural hospitals with 100 or fewer beds.

- a. For services rendered January 1, 2010 through December 31, 2012, if Worksheet S-2, Part I, line 120, columns 1 or 2 is "Y", enter 85 percent of the result of line 6 minus the sum of lines 3 and 4.

Line 9--Enter the outpatient ancillary pass through amount from Worksheet D, Part IV, column 13, line 200.

Line 10--If you are an approved CTC, enter the cost of organ acquisition from Worksheet D-4, Part III, column 2, line 69 when Worksheet E is completed for the hospital or the hospital component of a health care complex. Make no entry on line 10 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 11--Enter the sum of lines 1 and 10.

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

**NOTE:** CAHs are not subject to the computation of the lesser of reasonable costs or customary charges. If the component is an CAH, do not complete lines 12 through 20. Instead, enter on line 21 the amount computed on line 11.

Line Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### Computation of reimbursement Settlement

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

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

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

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

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

For critical access hospitals (CAHs), enter the lesser of (line 21 minus the sum of lines 25 and 26) or 80 percent times the result of (line 21 minus line 25 minus 101% of lab cost (Worksheet D, Part V, column 6, lines 60, 61, and subscripts) minus 101% of costs not subject to deductible and coinsurance (Worksheet D, Part V, column 7, line 202). Add back the aforementioned 101% of lab cost and 101% of cost not subject to deductibles and coinsurance. Add to that result the sum of lines 22 and 23.

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

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

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

Line 31--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

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

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

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

Line 32--Enter line 30 minus line 31.

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

Allowable bad debts (Exclude bad debts for professional services)

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

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

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

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

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

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

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

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

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

*Line 39.98--Enter from the PS&R, the partial or full credits received from manufacturers for replaced devices. See CMS Pub. 100-04, chapter 4, §61.3.*

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

Line 40--Enter the result of line 37, plus or minus line 39 *and its* subscripts not previously identified, minus lines 38, *39.98* and 39.99.

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

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

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

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

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

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

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

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

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

Line 93--Enter the time value of money.

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

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

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

4031.1 Part I - Analysis of Payments to Providers for Services Rendered--

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

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

- Hospital-based HHAs use Worksheet H-5.
- Hospital-based outpatient rehabilitation facilities use Worksheet J-4.
- RHCs/FQHCs use Worksheet M-5.

The column headings designate two categories of payments:

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

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

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

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

DO NOT include fee-schedule payments for ambulance services rendered.

Line Descriptions

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

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

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

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

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

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

<u>Reimbursement Method</u>	<u>From Column</u>	<u>Transfer To</u>
Part B Payments	4	Wkst. E, Part B, line 41
<u>Part A Payments</u>		
IPPS	2	Wkst. E, Part A, line 72
TEFRA	2	Wkst. E-3, Part I, line 19
IPF PPS	2	Wkst. E-3, Part II, line 32
IRF PPS	2	Wkst. E-3, Part III, line 33
LTC PPS	2	Wkst. E-3, Part IV, line 23
Cost	2	Wkst. E-3, Part V, line 31
SNF PPS Title XVIII	2	Wkst. E-3, Part VI, line 16

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

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 8 ARE FOR CONTRACTOR USE ONLY. (EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)**

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

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

<u>Worksheet E-1, Column as Indicated</u>	<u>From Settlement Worksheet</u>
2	Wkst. E, Part A, line 74
4	Wkst. E, Part B, line 43
2	Wkst. E-3, Part I, line 21
2	Wkst. E-3, Part II, line 34
2	Wkst. E-3, Part III, line 35
2	Wkst. E-3, Part IV, line 25
2	Wkst. E-3, Part V, line 33
2	Wkst. E-3, Part VI, line 18

For swing bed-SNF services, column 2 must equal Worksheet E-2, column 1, line 22. Column 4 must equal Worksheet E-2, column 2, line 22.

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

Line 7--Enter in columns 2 and 4 the sum of lines 4 through 6. Enter amounts due the program as a negative number. These amounts must agree with amount due provider reported on Worksheet E, Part A, line 71; Worksheet E, Part B, line 40; Worksheet E-2, line 19; Worksheet E-3, Part I, line 18; Worksheet E-3, Part II, line 31; Worksheet E-3, Part III, line 32; Worksheet E-3, Part IV, line 22; Worksheet E-3, Part V, line 30; and Worksheet E-3, Part VI, line 15.

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

#### 4031.2 Part II - Calculation of Reimbursement Settlement for Health Information Technology-

### **THIS PART IS COMPLETED BY THE CONTRACTOR FOR STANDARD COST REPORTING PERIODS AND BY THE CONTRACTOR FOR NONSTANDARD COST REPORTING PERIODS.**

In accordance with the American Recovery and Reinvestment Act (ARRA) of 2009, section 4102, inpatient acute care services under IPPS (providers subject to section 1886(d) of the Act) and CAHs are eligible for health information technology (HIT) payments.

This part captures relevant data used to compute the HIT payment and records the single HIT initial payment paid by the contractor to the provider and any corresponding adjustments to this initial payment.

#### Data Collection Required for the Health Information Technology Calculation--

**NOTE:** Lines 1 through 7 must transfer data as indicated below for reporting periods which cover exactly 12 months (referred to as standard cost reporting periods and covers a range of 360 through 371 days). For cost reporting periods which cover other than exactly 12 months (less than or greater than 12 months (referred to as nonstandard cost reporting periods and covers a range of less than 360 days or greater than 371 days) lines 1 through 8 must be directly input by the contractor.

**NOTE:** For standard cost reporting periods, the provider will complete lines 30 and 31 in the "as filed" cost report and the amount computed on line 32 will be transferred to Worksheet S, Part III, column 4. For non-standard cost reporting periods, the "as filed" cost report will display zeros on all lines and a zero will be transferred from line 32 to Worksheet S, Part III, column 4. The contractor must complete this worksheet for nonstandard cost reporting periods.

Line 1--As defined in ARRA, §4102, transfer the total hospital discharges from Worksheet S-3, Part I, column 15, line 14.

Line 2--Transfer the Medicare days from Worksheet S-3, Part I, column 6, sum of lines 1 and 8 through 12.

Line 3--Transfer the Medicare HMO days from Worksheet S-3, Part I, column 6, line 2.

Line 4--Transfer the total inpatient days from Worksheet S-3, Part I, column 8, sum of lines 1 and 8 through 12.

Line 5--Transfer the hospital charges from Worksheet C, Part I, column 8, line 200.

Line 6--Transfer the hospital charity care charges from Worksheet S-10, column 3, line 20.

Line 7--CAHs only, transfer the reasonable costs to purchase certified HIT technology from Worksheet S-2, Part I, line 168.

Line 8--Calculate and enter the HIT payment in accordance with ARRA, §4102 as indicated below. This line can be overridden by the contractor in instances where the provider's circumstances require a customized HIT calculation.

For CAHs, if Worksheet S-2, lines 105 and 167 are both "Y" for yes, enter the result of  $\{(H1)/(line\ 4\ x\ H2)\} + .20$  times the amount on Worksheet S-2, Part I, **line 168**. (Note: the result of  $\{(H1)/(line\ 4\ x\ H2)\} + .20$  cannot exceed 100 percent.) The resulting amount must be fully expensed in the current reporting period. H1 = Line 2 plus line 3. H2 = Total charges from Worksheet C, Part I, column 8, line 200 minus charity care charges from Worksheet S-10, column 3, line 20 divided by Worksheet C, Part I, column 8, line 200.

OR

For acute care IPPS hospitals (§1886(d) of the Act), if Worksheet S-2, line 105 is "N" for no and line 167 is "Y" for yes, enter the result of  $\{(\$2,000,000.00 + H1) x \{(H2)/(line\ 4\ x\ H3)\} x H4\}$ . If line 1 is less than 1,150 discharges then H1 equals 0 (zero). If line 1 equals 1,150 through 23,000 discharges, then H1 equals the result of line 1 minus 1,149 times \$200. If line 1 is greater than or equal to 23,000 discharges then H1 = \$4,370,200 [that is: 23,000 minus 1,149 times \$200]. H2 = Line 2 plus line 3. H3 = Total charges from Worksheet C, Part I, column 8, line 200 minus charity care charges from Worksheet S-10, column 3, line 20 divided by Worksheet C, Part I, column 8, line 200. H4 = The transition factor from Worksheet S-2, Part I, line 169.

Line 9--If the EHR reporting period ending date on Worksheet S-2, line 170, column 2 is on or after April 1, 2013, enter the sequestration adjustment amount as follows: [2 percent times line 8].

Line 10--Calculate and enter the HIT payment after application of the sequestration adjustment by entering the result of line 8 minus line 9.

Lines 11 - 29--Reserved for future use.

#### Inpatient Hospital Services Under IPPS & CAH--

Line 30--Enter the initial (first) payment received for HIT assets for this cost reporting period. This initial payment is a single payment for the cost reporting period rather than a series of periodic interim payments during the period. This line must be completed by the providers for standard cost reporting periods and by the contractors for nonstandard cost reporting periods.

Line 31--Enter the sum of all additional initial payment adjustments, as applicable for this cost reporting period. Enter a positive amount on this line if the sum of the initial payment adjustments represents an increase to the initial payment. Enter a negative amount on this line if the sum of the initial payment adjustments represents a decrease to the initial payment.

Line 32--Balance Due Provider/(Program)--Calculate and enter the result of line 8 minus the sum of lines 30 and 31. Effective for cost reporting periods that overlap or begin on or after April 1, 2013, calculate and enter the result of line 10 minus the sum of lines 30 and 31. Transfer this amount to Worksheet S, Part III, column 4, line 1.

#### 4032. WORKSHEET E-2 - CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

This worksheet provides for the reimbursement calculation for swing bed services rendered to program patients under titles V, XVIII, and XIX. It provides for an accumulation of reimbursable costs determined on various worksheets within the cost report package. It also provides (under Part B) for the computation of the lesser of 80 percent of reasonable cost after deductibles or reasonable cost minus coinsurance and deductibles. These worksheets have been designed so that components must prepare a separate worksheet for swing bed-SNF title XVIII, Parts A and B, and separate worksheets for swing bed-NF for title V and title XIX. Use column 1 only on the worksheets for title V and title XIX. Indicate the use of each worksheet by checking the appropriate boxes.

Lines 1 - 9--Enter in the appropriate column on lines 1 through 7 the indicated costs for each component of the health care complex.

Line 1--Posthospital swing beds in rural hospitals (other than CAHs) are paid in accordance with SNF PPS. Enter the total PPS payments in column 1 or 2, as applicable, from the provider's books and records or the PS&R. (See 42 CFR 413.114(a)(2)) For CAHs, transfer 101 percent of the cost of swing-bed SNF inpatient routine services from Worksheet D-1, part II, line 66.

Do not use lines 2 and 3, column 1 for swing bed SNF PPS providers.

Line 2--Enter the cost of swing bed-NF inpatient routine services from Worksheet D-1, Part II, line 69 (titles V and XIX only). Make no entry on line 2 when Worksheet E-2 is used for swing bed-SNF.

Line 3--Enter the amount of ancillary services provided by swing bed-SNFs for vaccines that are cost reimbursed in column 2. CAHs transfer for title XVIII services 101 percent of the amounts from the applicable worksheets and for swing bed-SNF services that are cost reimbursed transfer 100 percent of the amount from the applicable worksheet:

Title V	from	Worksheet D-3, col. 3, line 200
Title XVIII, Part A	from	Worksheet D-3, col. 3, line 200
Title XVIII, Part B	from	The sum of Worksheet D, Part V, cols. 6 and 7, line 202
Title XIX	from	Worksheet D-3, col. 3, line 200

Enter title XVIII, Part B amounts only in column 2. Enter all other amounts in column 1.

Line 4--Enter (in column 1 for titles V and XIX and in column 2 for title XVIII) the per diem cost for interns and residents not in an approved teaching program transferred from Worksheet D-2, Part I, column 4, line 2.

Line 5--For title XVIII, enter in column 1 the total number of days in which program swing bed-SNF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 10 and 11. For titles V or XIX, enter in column 1 the total number of days in which program swing

bed-NF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 12 and 13. For title XVIII, enter in column 2 the total number of days in which Medicare swing bed beneficiaries were inpatients and had Medicare Part B coverage. Determine such days without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days.

The following reconciliation format is recommended:

Part A Inpatient Days	Plus	Part B Only Days	Minus	Part A Coverage But No Part B Days Coverage	Equals	Medicare Part B Days
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**NOTE:** See §4026.1.

Line 6--Enter the amount on line 4 multiplied by the number of days recorded on line 5. Also, if the hospital qualifies for the exception for graduate medical education payments in 42 CFR 413.77 (d)(1), enter the amount transferred from Worksheet D-2, Part II, column 7, line 30.

Line 7--If Worksheet E-2 is completed for a certified SNF, enter the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees applicable to the SNF.

Line 8--Enter the sum of lines 1 through 3, plus lines 6 and 7 for each column.

Line 9--Enter any amounts paid and/or payable by workmens' compensation and other primary payers. (See instructions to Worksheet E, Part A, line 60, in §4030.1 for further clarification.)

Line 10--Line 8 minus line 9.

Line 11--Enter the deductible billed to program patients. **DO NOT INCLUDE** deductible applicable to physician professional services. Obtain this amount from your records.

Line 12--Enter line 10 minus line 11.

Line 13--Enter from your records the amounts billed to program patients for coinsurance. **DO NOT INCLUDE** coinsurance billed to program patients for physician professional services.

Line 14--In column 2, enter 80 percent of the amount on line 12.

Line 15--Enter the lesser of line 12 less line 13 or line 14.

Line 16--Enter any other adjustments.

Line 17--When Worksheet E-2 is completed for Medicare, enter the amount of bad debts (net of bad debt recoveries) for billed deductibles and coinsurance (excluding bad debts for physician professional services and bad debts arising from covered services paid under a reasonable charge-based methodology or a fee-schedule) for Part A services in column 1 and for Part B services in column 2. If recoveries exceed the current year's bad debts, line 17 will be negative.

Line 17.01--For cost reporting periods that begin prior to October 1, 2012, enter the amount on line 17. For cost reporting periods that begin on or after October 1, 2012, calculate this line as follows:  $[(\text{line 17} - \text{line 18}) * 65 \text{ percent}] + (\text{line 18} * 88 \text{ percent})$ . For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows:  $[(\text{line 17} - \text{line 18}) * 65 \text{ percent}] + (\text{line 18} * 76 \text{ percent})$ . For cost reporting periods that begin on or after October 1, 2014, multiply the amount on line 17 by 65 percent.

Line 18--Enter the gross allowable bad debts for dual eligible beneficiaries. For cost reporting periods that begin prior to October 1, 2012, this amount is reported for statistical purposes only. This amount must also be reported on line 17.

Line 19--For title XVIII, Part A, enter in column 1 the sum of lines 15 and 17.01 plus or minus line 16. For title XVIII, Part B, enter in column 2 the sum of lines 15 and 17.01 plus or minus line 16. For titles V and XIX, enter in column 1 the sum of line 15, plus or minus line 16.

Line 19.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows:  $[(2 \text{ percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)}) \text{ times line 19}]$ .

Line 20--For title XVIII, enter in column 1 the amount from the appropriate Worksheet E-1, column 2, line 4, and enter in column 2 the amount from the appropriate Worksheet E-1, column 4, line 4. For contractor final settlement, report on line 21 the amount from line 5.99 for columns 2 and 4. For titles V and XIX, enter interim payments from your records.

Line 22--Enter the amount recorded on line 19 minus the sum of the amounts on lines 19.01, 20 and 21. This amount shows the balance due provider or the program. Transfer this amount to Worksheet S, Part III, columns as appropriate, lines 5 or 6 for the swing bed-SNF or the swing bed-NF, respectively.

Line 23--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the non-allowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the supporting details and computations for this line.

## 4033. WORKSHEET E-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT

The five parts of Worksheet E-3 are used to calculate reimbursement settlement:

- Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA
- Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS
- Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS
- Part IV - Calculation of Medicare Reimbursement Settlement Under LTCH PPS
- Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement (CAHs)
- Part VI - Calculation of Reimbursement Settlement - All Other Health Services for Part A Services for Title XVIII PPS SNFs
- Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services

4033.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA--Use Worksheet E-3, Part I to calculate Medicare reimbursement settlement under TEFRA for cancer and children's hospitals.

Line Descriptions

Line 1--Enter the amount from Worksheet D-1, Part II, line 63.

Line 2--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-4, Part III, column 1, line 69. If you are not an approved CTC do not complete line 2.

Line 3--For hospitals that have elected to be reimbursed for the services of teaching physicians on the basis of reasonable cost, enter the amount from Worksheet D-5, Part II, column 3, line 20.

Line 4--Enter the sum of lines 1, 2 and 3.

Line 5--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full.

This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

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

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

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

Line 9--Enter the Part A coinsurance.

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

Line 11--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 11 and 12 will be negative.

Line 12--Multiply the amount (including negative amounts) from line 11 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 13--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 11.

Line 14--Enter the sum of lines 10 and 12.

Line 15--Enter the amount from Worksheet E-4, line 49 for the hospital component only.

Line 16--DO NOT USE THIS LINE.

Line 17--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 17.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

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

Line 18.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 18].

Line 19--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 20 the amount on line 5.99.

Line 20--Contractor use only: Report the amount from Worksheet E-1, column 2, line 5.99.

Line 21--Enter line 18 minus the sum of lines 18.01, 19 and 20. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 22--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

4033.2 Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS--Use Worksheet E-3, Part II to calculate Medicare reimbursement settlement under IPF PPS for hospitals and subproviders. (See 42 CFR 412, subpart N.)

Use a separate copy of Worksheet E-3, Part II for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part II to indicate the component for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

#### Line Descriptions

Line 1--Enter the net Federal IPF PPS payment. This amount excludes payments for outliers, electroconvulsive therapy (ECT), and the teaching adjustment. Obtain this information from the PS&R and/or your records.

Line 2--Enter the net IPF outlier payment. Obtain this from the PS&R and/or your accounting books records.

Line 3--Enter the net IPF payments for ECT. Obtain this from the PS&R and/or your accounting books and records.

**NOTE:** Complete only line 4 or line 5, but not both.

Line 4--For providers that trained residents in the most recent **cost reporting period filed on or before November 15, 2004** (response on Worksheet S-2, Part I, line 71, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period filed on or before November 15, 2004. See FR, volume 69, No. 219, dated November 4, 2004, page 66922 for a detailed explanation.

Line 4.01--For IPFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment under 42 CFR 412.424(d)(1)(iii)(F)(1) or (2).

Line 5--If the response to Worksheet S-2, Part I, line 71, column 2 is "Y" and your facility did not train residents in the most recent cost report filed before November 15, 2004, but qualifies to receive a cap adjustment under 42 CFR 412.424(d)(1)(iii)(D) enter the new program cap adjustment on this line. Do not complete this line until the new program growth period has ended using the method described in 42 CFR 413.79(e)(1)(i) and (ii). If your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the cap adjustment accordingly.

Line 6--Enter the current year unweighted FTE resident count excluding **FTEs** in the new program growth period. FTEs in the new program growth period are reported on line 7. If your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly.

Line 7--Enter the current year unweighted FTE count for residents in the new program growth period. Complete this line only during the new program growth period of the first new program's existence. If your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly.

Line 8--For providers that completed line 4, enter the lower of the FTE count on line 6 or the sum of the cap amounts on lines 4 and 4.01.

For providers that qualify to receive a cap adjustment under 42 CFR 412.424(d)(1)(iii)(D) during the new program growth period of the first new program's existence, enter the FTE count from line 7.

Beginning with the program year following the new program growth period of the first new program's existence, enter the lower of the FTE count on line 6 or the FTE count on line 5. Add to this count the FTEs on line 7 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program.

Line 9--Enter the total IPF patient days divided by the number of days in the cost reporting period (Worksheet S-3, Part I, column 8, line 1 (independent/freestanding) or 16 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 10--Enter the teaching adjustment factor by adding 1 to the ratio of line 8 to line 9. Raise that result to the power of .5150. Subtract 1 from this amount to calculate the teaching adjustment factor. This is expressed mathematically as  $\{(1 + (\text{line 8} / \text{line 9})) \text{ to the } .5150 \text{ power} - 1\}$ .

Line 11--Enter the teaching adjustment by multiplying line 1 by line 10.

Line 12--Enter the adjusted net IPF PPS payments by entering the sum of lines 1, 2, 3, and 11.

Line 13--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable. Only complete this line if your facility is a freestanding/independent non-IPPS hospital that does not complete Worksheet E, Part A.

Line 14--DO NOT USE THIS LINE.

Line 15--For IPFs or IPF subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of reasonable cost, enter the amount from Worksheet D-5, Part II, column 3, line 20.

Line 16--Enter the sum of lines 12, 13, 14 and 15.

Line 17--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

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

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

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

Do not enter on line 17 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 18--Enter line 16 minus line 17.

Line 19--Enter the Part A deductibles.

Line 20--Enter line 18 minus line 19.

Line 21--Enter the Part A coinsurance.

Line 22--Enter the result of subtracting line 21 from line 20.

Line 23--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 23 and 24 will be negative.

Line 24--Multiply the amount (including negative amounts) from line 23 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 25--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 23.

Line 26--Enter the sum of lines 22 and 24.

Line 27--Enter the amount from Worksheet E-4, line 49 for the hospital component (freestanding IPF) only. Do not complete this line for an IPF unit.

Line 28--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility or line 40 for the IPF subprovider. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 29--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 30--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc., enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 30.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 31--Enter the sum of lines 26 through 28 plus or minus lines 29 and 30.

Line 31.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 31].

Line 32--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 33 the amount on line 5.99.

Line 34--Enter line 31 minus the sum of lines 31.01, 32 and 33. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 35--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-1, chapter 1, §115.2.) Attach a schedule showing the details and computations.

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

Line 50--Enter the original outlier amount from Worksheet E-3, Part II, line 2.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 3, §190.7.2.3 - §190.7.2.5.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, chapter 3, §190.7.2.3 - §190.7.2.5.)

Line 53--Enter the time value of money.

**NOTE:** If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

4033.3 Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS--Use Worksheet E-3, Part III to calculate Medicare reimbursement settlement under IRF PPS for hospitals and subproviders. (See 42 CFR 412, subpart P.)

Use a separate copy of Worksheet E-3, Part III for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part III to indicate the component for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

#### Line Descriptions

Line 1--Enter the net federal IRF PPS payment. The federal payment includes short stay outlier amounts. Exclude low income patient (LIP) and outlier payments. Obtain this information from the PS&R and/or your records.

*In accordance with the FR, Vol. 78, No. 151, dated August 6, 2013, page 47869, effective for IRF discharges rendered on or after October 1, 2013, the IRF LIP adjustment factor is updated. Subscript column 1 for lines 1 and 3 for cost reporting periods that overlap October 1, 2013. Enter the net federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2013 in column 1 and the net federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2013 in column 1.01 to facilitate the calculation of the LIP adjustment on line 3, columns 1 and 1.01, respectively. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013.*

Line 2--Enter the Medicare SSI ratio from your contractor as applicable for a freestanding IRF (IRF hospital or facility) or a hospital based IRF (subprovider or subunit).

Line 3--*Effective for cost reporting periods ending prior to October 1, 2013, enter the* IRF LIP payment *as* the result of  $\{(1 + (\text{line } 2) + (L1/L2)) \text{ to the } .4613 \text{ power} - 1\}$  times (line 1). L1 = IRF Medicaid Days from Worksheet S-2, Part I, columns 1 through 6, line 25. L2 = IRF total days from Worksheet S-3, Part I, column 8, lines 1 or 17 as applicable plus employee discount days (S-3, Part I, column 8, line 30 (line 31 for IRF subproviders)).

*For cost reporting periods that overlap October 1, 2013, subscript column 1. To calculate the IRF LIP payment for discharges prior to October 1, 2013, enter in column 1 the result of  $\{(1 + (\text{line } 2) + (L1/L2)) \text{ to the } .4613 \text{ power} - 1\}$  times (line 1, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2013, enter in column 1.01 the result of  $\{(1 + (\text{line } 2) + (L1/L2)) \text{ to the } .3177 \text{ power} - 1\}$  times (line 1, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013. To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2013, enter in column 1 the result of  $\{(1 + (\text{line } 2) + (L1/L2)) \text{ to the } .3177 \text{ power} - 1\}$  times line 1.*

Line 4--Enter the IRF outlier payment. Obtain this from the PS&R and/or your records.

**NOTE:** Complete only line 5 or line 6, but not both.

Line 5--For providers that trained residents in the most recent **cost reporting period ending on or before November 15, 2004** (response to Worksheet S-2, Part I, line 76, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period ending on or before November 15, 2004.

Line 5.01--For IRFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment in accordance with FR, volume 76, No. 151, dated August 5, 2011, page 47846.

Line 6--If the response to Worksheet S-2, Part I, line 76, column 2 is "Y" and your facility did not train residents in the most recent cost reporting period ending on or before November 15, 2004, and qualifies to receive a cap adjustment (see FR Vol. 70, No. 156, page 47929, dated August 15, 2005) enter the new cap adjustment on this line. Do not complete this line until the new program growth period has ended using the method described in 42 CFR 413.79(e)(1)(i) and (ii). If your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the cap adjustment accordingly.

Line 7--Enter the current year unweighted FTE resident count excluding FTEs in the new program growth period. FTEs in the new program growth period are reported on line 8. If your fiscal year end does not correspond to the program year end and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly.

Line 8--Enter the current year unweighted FTE count for residents in the new program growth period. Complete this line only during the new program growth period of the first new program's existence. If your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program, then prorate the FTE count accordingly.

Line 9--For providers that completed line 5, enter the lower of the FTE count on line 7 or the sum of the cap amounts on lines 5 and 5.01.

For providers that qualify to receive a cap adjustment (see FR Vol. 70, No. 156, page 47929, dated August 15, 2005), during the new program growth period of the first new program's existence enter the FTE count from line 8.

Beginning with the program year following the new program growth period of the first new program's existence, enter the lower of the FTE count on line 7 or the FTE count on line 6. Add to this count the FTEs on line 8 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the program year following the new program growth period of the first new program.

Line 10--Enter the total IRF patient days divided by the number of days in the cost reporting period (Worksheet S-3, column 8, line 1 (independent/freestanding) or 17 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

**NOTE:** *For cost reporting periods overlapping October 1, 2013, subscript column 1 (add column 1.01) for lines 11 and 12. For cost reporting periods beginning on or after October 1, 2013, do not script column 1.*

Line 11--*For cost reporting periods ending prior to October 1, 2013, calculate in column 1 the teaching adjustment factor by adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the teaching adjustment factor. This is expressed mathematically as  $\{(1 + (\text{line 9} / \text{line 10})) \text{ to the } .6876 \text{ power} - 1\}$ .*

*In accordance with the FR, Vol. 78, No. 151, dated August 6, 2013, page 47869, effective for IRF discharges rendered on or after October 1, 2013, the teaching adjustment factor is updated. For cost reporting periods that overlap October 1, 2013, subscript column 1.*

*To calculate the teaching adjustment factor for discharges prior to October 1, 2013, enter in column 1 the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of .6876 and then subtract 1 from this amount. This is expressed mathematically as  $\{(1 + (\text{line } 9 / \text{line } 10)) \text{ to the } .6876 \text{ power} - 1\}$ . To calculate the teaching adjustment factor for discharges on or after October 1, 2013, enter in column 1.01 the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of 1.0163 and then subtract 1 from this amount. This is expressed mathematically as  $\{(1 + (\text{line } 9 / \text{line } 10)) \text{ to the } 1.0163 \text{ power} - 1\}$ . Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013.*

*To calculate the teaching adjustment factor for cost reporting periods beginning on or after October 1, 2013, enter in column 1 the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of 1.0163 and then subtract 1 from this amount. This is expressed mathematically as  $\{(1 + (\text{line } 9 / \text{line } 10)) \text{ to the } 1.0163 \text{ power} - 1\}$ .*

*Line 12--For cost reporting periods ending prior to October 1, 2013, calculate the teaching adjustment by multiplying line 1, by line 11. For cost reporting periods that overlap October 1, 2013, subscript column 1. Calculate the teaching adjustment for discharges prior to October 1, 2013 in column 1 by multiplying line 1, column 1 by line 11, column 1. Calculate the teaching adjustment for discharges on or after October 1, 2013, in column 1.01 by multiplying line 1, column 1.01 by line 11, column 1.01. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013. For cost reporting periods beginning on or after October 1, 2013, calculate the teaching adjustment by multiplying line 1, by line 11.*

*Line 13--Enter the sum of line 1, columns 1 and 1.01; line 3, columns 1 and 1.01; line 4 and line 12, columns 1 and 1.01.*

*Line 14--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable. Only complete this line if your facility is a freestanding/independent non-IPPS hospital that does not complete Worksheet E, Part A.*

*Line 15--DO NOT USE THIS LINE.*

*Line 16--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter the amount from Worksheet D-5, Part II, column 3, line 20.*

*Line 17--Enter the sum of lines 13, 14, 15 and 16.*

*Line 18--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:*

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 18. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 18 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 18 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 19--Enter line 17 minus line 18.

Line 20--Enter the Part A deductibles.

Line 21--Enter line 19 less line 20.

Line 22--Enter the Part A coinsurance.

Line 23--Enter the result of subtracting line 22 from line 21.

Line 24--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 24 and 25 will be negative.

Line 25--Multiply the amount (including negative amounts) from line 24 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 26--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 24.

Line 27--Enter the sum of lines 23 and 25.

Line 28--Enter the amount from Worksheet E-4, line 49 for the hospital component (freestanding IRF) only. Do not complete this line for an IRF unit.

Line 29--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility or line 41 for IRF the subproviders. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 30--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 31--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 31.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 32--Enter the sum of lines 27, 28, and 29 plus or minus lines 30 and 31.

Line 32.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 32].

Line 33--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 34 the amount on line 5.99.

Line 35--Enter line 32 minus the sum of lines 32.01, 33 and 34. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 36--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

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

Line 50--Enter the original outlier amount from Worksheet E-3, Part III, line 4.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 3, §140.2.8 - §140.2.10.

Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §140.2.8 - §140.2.10)

Line 53--Enter the time value of money.

**NOTE:** If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

**This page is reserved for future use.**

4033.4 Part IV - Calculation of Medicare Reimbursement Settlement Under LTCH PPS--Use Worksheet E-3, Part IV to calculate Medicare reimbursement settlement under LTCH PPS for hospitals. (See 42 CFR 412, subpart O.)

Line Descriptions

Line 1--Enter the net federal LTCH PPS payment including short stay outlier payments. Obtain this information from the PS&R and/or your records.

Line 2--Enter the high cost outlier payments. Obtain this from the PS&R and/or your records.

Line 3--Enter the sum of lines 1 and 2.

Line 4--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable.

Line 5--DO NOT USE THIS LINE.

Line 6--For hospitals that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter the amount from Worksheet D-5, Part II, column 3, line 20.

Line 7--Enter the sum of lines 3, 4, 5 and 6.

Line 8--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 8. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

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

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 8 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 8 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 9--Enter line 7 minus line 8.

Line 10--Enter the Part A deductibles.

Line 11--Enter line 9 less line 10.

Line 12--Enter the Part A coinsurance.

Line 13--Enter the result of subtracting line 12 from line 11.

Line 14--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 14 and 15 will be negative.

Line 15--Multiply the amount (including negative amounts) from line 14 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 16--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 14.

Line 17--Enter the sum of lines 13 and 15.

Line 18--Enter the amount from Worksheet E-4, line 49 for the hospital.

Line 19--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 20--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 21--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 21.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 22--Enter the sum of lines 17, 18, and 19 plus or minus lines 20 and 21.

Line 22.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 22].

Line 23--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 24 the amount on line 5.99.

Line 25--Enter line 22 minus the sum of lines 22.01, 23 and 24. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 26--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

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

Line 50--Enter the original outlier amount from Worksheet E-3, Part IV, line 2.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 3, §150.26 - §150.28.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, chapter 3, §150.26 - §150.28)

Line 53--Enter the time value of money.

**NOTE:** If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

4033.5 Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement (CAHs)--Use Worksheet E-3, Part V, to calculate reimbursement settlement for Medicare Part A services furnished by critical access hospitals under cost reimbursement (i.e., neither PPS nor TEFRA).

### Line Descriptions

Line 1--Enter the appropriate inpatient operating costs:

Hospital (CAH) - Worksheet D-1, Part II, line 49

Line 2--Enter the amount of Nursing and Allied Health Managed Care payments, if applicable. Only complete this line if your facility is a CAH that does not complete Worksheet E, Part A.

Line 3--If you are approved as a CTC, enter the cost of organ acquisition from Worksheet D-4, Part III, column 1, line 69 when this worksheet is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 3 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full.

This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but not in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system. However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

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

Line 6--CAHs enter on this line 101 percent of the amount on line 4, minus line 5.

Computation of Lesser of Reasonable Cost or Customary Charges--**CAHs are not subject to this provision for inpatient services.**

Line Descriptions

**NOTE: Do not complete lines 7 through 16.**

Lines 7 - 16--These lines provide for the accumulation of charges which relate to the reasonable cost on line 6.

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

Line 7--Enter the program inpatient routine service charges from your records for the applicable component. Include charges for both routine and special care units. The amounts entered include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 8--Enter the total charges for inpatient ancillary services from Worksheet D-3, column 2, sum of lines 50 through 98.

Line 9--If you are an approved CTC, enter the organ acquisition charges from Worksheet D-4, Part III, column 3, line 69 when Worksheet E-3, Part V is completed for the hospital or the hospital component of a health care complex.

Line 10--Enter the sum of lines 7 through 9.

Lines 11 - 14--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or when you fail to make reasonable efforts to collect such charges from those patients. If line 13 is greater than zero, multiply line 10 by line 13, and enter the result on line 14. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 11 through 13. Enter on line 14 the amount from line 10. In no instance may the customary charges on line 14 exceed the actual charges on line 10. (See 42 CFR 413.13(e).)

Line 15--Enter the excess of the customary charges on line 14 over the reasonable cost on line 6.

Line 16--Enter the excess of reasonable cost on line 6 over the customary charges on line 14. Transfer line 16 to line 21.

Line 17--For hospitals that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter amounts from Worksheet D-5, Part II, column 3, line 20.

Computation of Reimbursement Settlement

Line 18--Do not complete this line.

Line 19--Enter the sum of lines 6 and 17.

Line 20--Enter the Part A deductibles billed to Medicare beneficiaries.

Line 21--Do not complete this line.

Line 22--Enter line 19 minus line 20.

Line 23--Enter from PS&R or your records the coinsurance billed to Medicare beneficiaries.

Line 24--Enter line 22 minus line 23.

Line 25--Enter from your records program allowable bad debts net of recoveries. If recoveries exceed the current year's bad debts, lines 25 and 26 will be negative.

Line 26--No reduction is required for critical access hospitals for cost reporting periods beginning prior to October 1, 2012, enter the amount from line 25.

Multiply the amount from line 25 (including negative amounts) by 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 27--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 25.

Line 28--Enter the sum of lines 24 and 26.

Line 29--Enter any other adjustments. For example, if you change the recording of vacation pay from cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 29.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 30--Enter line 28, plus or minus line 29.

Line 30.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 30].

Line 31--Enter interim payments from Worksheet E-1, column 2, line 4. For contractor final settlement, report on line 32 the amount from line 5.99.

Line 33--Enter line 30 minus the sum of lines 30.01, 31 and 32. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 34--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

4033.6 Part VI - Calculation of Reimbursement Settlement - All Other Health Services for Title XVIII Part A PPS SNF Services-- For title XVIII SNFs reimbursed under PPS, complete this part for settlement of Part A services. For Part B services, all SNFs complete Worksheet E, Part B.

When this part is completed for a component, show both the hospital and component numbers.

### Computation of Net Costs of Covered Services

#### Line Descriptions

#### Prospective Payment Amount

Line 1--Compute the sum of the following amounts obtained your books and records or from the PS&R:

- The Resource Utilization Group (RUG) payments made for PPS discharges during the cost reporting period, and
- The RUG payments made for PPS transfers during the cost reporting period.

Line 2--Enter the amount from Worksheet D, Part III, column 9, line 44.

Line 3--Enter the amount from Worksheet D, Part IV, column 11, line 200.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Do not use this line as vaccine costs are included on line 1 of Worksheet E, Part B. Line 5 is shaded on Worksheet E-3, Part VI.

Line 6--Enter any deductible amounts imposed.

Line 7--Enter any coinsurance amounts.

Line 8--Enter from your records program allowable bad debts for deductibles and coinsurance net of bad debt recoveries. If recoveries exceed the current year's bad debts, lines 8 and 9 will be negative.

Line 9--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount must also be reported on line 8. This amount is reported for statistical purposes only for cost reporting periods beginning prior to October 1, 2012.

Line 10--DRA 2005 SNF Bad Debt--Calculate this line as follows for cost reporting periods beginning prior to October 1, 2012:  $[(\text{line 8} - \text{line 9}) * 70 \text{ percent}] + \text{line 9}$ . This is the adjusted SNF reimbursable bad debt in accordance with DRA 2005, section 5004.

In accordance with DRA 2005 SNF Bad Debt as amended by section 3201(b) of the Middle Class Tax Relief and Job Creation Act of 2012, calculate this line as follows: for cost reporting periods beginning on or after October 1, 2012, calculate this line as follows:  $[(\text{line 8} - \text{line 9}) * 65 \text{ percent}] + (\text{line 9} * 88 \text{ percent})$ . For cost reporting periods beginning on or after October 1, 2013, calculate this line as follows:  $[(\text{line 8} - \text{line 9}) * 65 \text{ percent}] + (\text{line 9} * 76 \text{ percent})$ . For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 8 by 65 percent.

Line 11--Enter the title XVIII reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include on this line the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, Part III, line 85.

Line 12--Enter the result of line 4 plus line 5 minus the sum of lines 6 and 7 plus lines 10 and 11.

Line 13--Enter the amounts paid or payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer for inpatient services. Enter only the primary payer amounts applicable to Part A routine and ancillary services.

Line 14--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc., enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 14.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 15--Enter the result of line 12, plus or minus 14, minus line 13.

Line 15.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows:  $[(2 \text{ percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)}) \text{ times line 15}]$ .

Line 16--For title XVIII, enter the total interim payments from Worksheet E-1, column 2, line 4.

Line 17--For contractor final settlement, report the amount from Worksheet E-1, column 2, line 5.99.

Line 18--Enter line 15 minus the sum of the amounts on lines 15.01, 16 and 17. Transfer this amount to Worksheet S, Part III, line as appropriate.

Line 19--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

4033.7 Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services--This worksheet calculates reimbursement for titles V or XIX services for hospitals, subproviders, other nursing facilities and ICF/MRs.

Use a separate copy of this part for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of this part to indicate the component and program for which it is used. When this part is completed for a component, show both the hospital and component numbers. Enter check marks in the appropriate spaces to indicate the applicable reimbursement method for inpatient services (e.g., TEFRA, OTHER).

### Computation of Net Costs of Covered Services

#### Line Descriptions

Line 1--Enter the appropriate inpatient operating costs.

#### Cost Reimbursement

Hospital/CAH or Subprovider - Worksheet D-1, Part II, line 49  
Skilled Nursing Facility, Other Nursing Facility, ICF/MR - Worksheet D-1, Part III, line 86.  
If Worksheet S-2, line 92 is answered "yes", and multiple Worksheets D-1 are prepared, add the multiple Worksheets D-1 and enter the result.

#### TEFRA

Hospital or Subprovider - Worksheet D-1, Part II, line 63

**NOTE:** If you are a new provider reimbursed under TEFRA, use Worksheet D-1, Part II, line 49.

Line 2--Enter the cost of outpatient services for titles V or XIX which is the sum of Worksheet D, Part V, columns 6 and 7 and subscripts where applicable.

Line 3--For titles V and XIX, enter in column 1 the amount paid or payable by the State program for organ acquisition.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Enter in column 1 the amounts paid or payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer for inpatient services for titles V and XIX.

Line 6--Enter in column 2 the primary payer amounts applicable to outpatient services for titles V and XIX.

Line 7--Enter line 4 minus the sum of lines 5 and 6.

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

#### Line Descriptions

Lines 8 - 11--These lines provide for the accumulation of charges which relate to the reasonable cost on line 4.

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

Line 8--Enter in column 1 the program inpatient routine service charges from your records for the applicable component for titles V and XIX. This includes charges for both routine and special care units.

The amounts entered on line 8 include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 9--For titles V and XIX, enter the sum of the appropriate program ancillary charges from Worksheet D, Part V, columns 3 and/or 4 plus subscripts as applicable, line 202 in column 2. Enter charges from Worksheet D-3, column 2, line 202 in column 1.

Line 10--Enter in column 1 for titles V and XIX the organ acquisition charges from line 3.

Line 11--Enter in column 1 for titles V and XIX the amount of the incentive resulting from the target amount computation on Worksheet D-1, Part II, line 58, if applicable.

Line 12--Enter the sum of the amounts recorded on lines 8 through 11.

Lines 13 - 16--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or fail to make reasonable efforts to collect such charges from those patients. If line 15 is greater than zero, multiply line 12 by line 15, and enter the result on line 16. If you do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 13 through 15. Enter on line 16 the amount from line 12. In no instance may the customary charges on line 16 exceed the actual charges on line 12.

Line 17--Enter the excess of the customary charges over the reasonable cost. If the amount on line 16 is greater than the amount on line 4, enter the excess.

Line 18--Enter the excess of total reasonable cost over the total customary charges. If the amount on line 4 exceeds the amount on line 16, enter the excess.

Line 19--Enter for titles V or XIX, columns 1 and 2, the cost of services rendered by interns and residents as follows from Worksheet D-2:

	<u>Col. 1</u>	<u>Col. 2</u>	<u>Col. 1</u>	<u>Col. 2</u>
	<u>Title V</u>	<u>Title V</u>	<u>Title XIX</u>	<u>Title XIX</u>
Hospital	Part I, col. 8, line 9	Part I, col. 8, line 27	Part I, col. 10, line 9	Part I, col. 10, line 27
Subprovider	Part I, col. 8, lines 10-12 as applicable		Part I, col. 10, lines 10-12 as applicable	
Nursing Facility, ICF/MR	Part I, col. 8, line 14		Part I, col. 10, line 14	

Line 20--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter the amounts from Worksheet D-5, Part II, column 3.

<u>Col. 1</u>	<u>Col. 2</u>	<u>Col. 1</u>	<u>Col. 2</u>
<u>Title V</u>	<u>Title V</u>	<u>Title XIX</u>	<u>Title XIX</u>
Line 18	Line 19	Line 22	Line 23

Line 21--Enter the lesser of line 4 or line 16. If this is a CAH or otherwise exempt from lower of cost or charges, transfer the amount from line 4.

#### Prospective Payment Amount

NOTE: Lines 22 through 26 must only be completed for PPS providers.

Line 22--Input the total IPPS payments for titles V and/or XIX, as applicable, in column 1. Enter the total OPSS payments for titles V and/or XIX, as applicable, in column 2. Obtain this from your books and records.

Line 23--Enter the amount of outlier payments made for IPPS discharges during the period, in column 1. Enter the outlier payment for OPSS in column 2.

Line 24--Enter in column 1 the payment for inpatient program capital costs from Worksheet L, Part I, line 12; or Part II, line 5, as applicable.

Line 25--Enter in column 1 the result of Worksheet L, Part III, line 13 less Worksheet L, Part III, line 17. If this amount is negative, enter zero on this line.

Line 26--Enter the routine and ancillary service other pass through costs, respectively, from Worksheet D, Part III, column 9, line 200 and from Worksheet D, Part IV, column 11, line 200, in column 1. Enter the amount from Worksheet D, Part IV, column 13, line 200, in column 2.

Line 27--Enter the sum of lines 22 through 26, in columns 1 and 2 respectively.

Line 28--For titles V and XIX only, enter the customary charges for IPPS in column 1 and OPSS in column 2.

Line 29--For titles V and XIX, enter the sum of lines 21 and 27, in columns 1 and 2, respectively.

#### Computation of Reimbursement Settlement

Line 30--Enter the amount, if any, from line 18, in columns 1 and 2, respectively.

Line 31--Enter the sum of lines 19 and 20 plus line 29 minus lines 5 and 6, in columns 1 and 2 respectively.

Line 32--Enter any deductible amounts imposed in columns 1 and 2 respectively.

Line 33--Enter any coinsurance amounts imposed in columns 1 and 2 respectively.

Line 34--Enter from your records reimbursable bad debts for deductibles and coinsurance net of bad debt recoveries in columns 1 and 2 respectively.

Line 35--Enter in column 1 the reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include the amount on this line in the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, Part III, line 85.

Line 36--Enter the sum of lines 31, 34, and 35 minus the sum of lines 32 and 33 in columns 1 and 2, respectively.

Line 37--Enter any other adjustments in columns 1 and 2, respectively. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Line 38--Enter the result of line 36 plus or minus line 37 in columns 1 and 2, respectively.

Line 39--Enter the amount from Worksheet E-4, line 31 in column 1.

Line 40--Enter the sum of lines 38 and 39 in columns 1 and 2, respectively.

Line 41--For titles V and XIX, obtain interim payments from your records and enter in columns 1 and 2, respectively.

Line 42--Enter the result of line 40 minus line 41, in columns 1 and 2, respectively. Transfer the sum of columns 1 and 2 to Worksheet S, Part III, column 1 (Title V) or column 5 (Title XIX), line as appropriate.

Line 43--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations.

**4034. WORKSHEET E-4 - DIRECT GRADUATE MEDICAL EDUCATION (GME) AND ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**

Use this worksheet to calculate each program's payment (i.e., titles XVIII, V, and XIX) for direct graduate medical education (GME) costs as determined under 42 CFR 413.75 through 413.83. This worksheet applies to the direct graduate medical education cost applicable to interns and residents in approved teaching programs in hospitals and hospital-based providers. Complete this worksheet if the response to line 56 of Worksheet S-2, Part I is yes. The direct medical education costs of the nursing school and paramedical education programs continue to be paid on a reasonable cost basis as determined under 42 CFR 413.85. However, the nursing school and paramedical education costs, formerly paid through the ESRD composite rate as an exception, are paid on this worksheet on the basis of reasonable cost under 42 CFR 413.85. Effective for cost reporting periods beginning on or after October 1, 1997 the unweighted direct graduate medical education FTE is limited to the hospital's FTE count for the most recent cost reporting period ending on or before December 31, 1996. This limit applies to allopathic and osteopathic residents but excludes dentistry and podiatry. The GME payment is also based on the inclusion of Medicare HMO patients treated in the hospital. This worksheet will also calculate payment for direct GME as determined under 42 CFR 413.79(c)(3) and (4) and IME as determined under 42 CFR 412.105(f)(1)(iv)(B) and (C) for hospitals that received an adjustment (reduction or increase) to their FTE resident caps for direct GME and/or IME under section 422 of Public Law 108-173.

**NOTE:** Do not complete this worksheet for a cost reporting period prior to the base period used for calculating the per resident amount (PRA) in situations where the hospital did not train residents in approved residency training programs or did not participate in the Medicare program during the base period but either condition changed in a cost reporting period beginning on or after July 1, 1985. 42 CFR 413.77(e)(1) specified that in this situation, any GME costs for the cost reporting period prior to the base period are reimbursed on a reasonable cost basis.

Also, do not complete this worksheet for residents training in the general acute care part of a CAH since the associated costs are reimbursed on a reasonable cost basis.

Complete this worksheet if this is the first month in which residents were on duty during the first month of the cost reporting period or if residents were on duty during the entire prior cost reporting period. (See 42 CFR 413.77(e)(1).)

This worksheet consists of five sections:

1. Computation of Total Direct GME Amount
2. Computation of Program Patient Load
3. Direct Medical Education Costs for ESRD Composite Rate - Title XVIII only
4. Apportionment of Medicare Reasonable Cost (title XVIII only)
5. Allocation of Medicare Direct GME Costs Between Part A and Part B

Computation of Total Direct GME Amount--This section computes the total approved amount.

#### Line Descriptions

Line 1--Enter the unweighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. If this cost report is less than a full 12 months, contact your contractor. (42 CFR 413.79(c)(2)) Also include here the 30 percent increase to the count for qualified rural hospitals (42 CFR 413.79(c)(2)(i)), and the increase due to primary care residents that were on approved leaves of absence (42 CFR 413.79(i)). Temporarily reduce the cap of a hospital that closed a program(s), if the regulations at 42 CFR 413.79(h)(3)(ii) are applicable. (Effective 10/1/2001.)

Line 2--Enter the unweighted resident FTE count for allopathic and osteopathic programs that meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1) or (e)(3), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995, but before October 1, 2012. For hospitals that began training residents in a new program for the first time on or after October 1, 2012, the cap is effective beginning with the sixth program year (see 77 FR August 31, 2012, 53417). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited or begun on or after January 1, 1995, and before August 6, 1997 is reported on this line and is effective in the fourth program year of each of those new programs (see 66 FR August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 1. Do not report new program FTEs during the time frame prior to the effective date of the hospital's FTE cap on this line. New program FTEs during the time frame prior to the effective date of the hospital's FTE cap are reported on line 15. For urban hospitals that already have an FTE cap on line 1 but start a rural track program in accordance with 42 CFR 413.75(k), enter the unweighted allopathic or osteopathic FTE count for residents in all years of the rural track program that meet the criteria for an add-on to the cap under 42 CFR 413.79(k). If the rural track program is a new program under 42 CFR 413.79(l) and the urban hospital qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (e)(3), do not report FTE residents in the rural track program on this line during the time frame prior to the effective date of the hospital's FTE cap.

Line 3--Enter the section 422 reduction amount to the direct GME cap as specified under 42 CFR 413.79(c)(3).

Line 3.01--Enter the section 5503 reduction amount to the direct GME cap as specified under 42 CFR 413.79(m). If this cost report straddles July 1, 2011, then calculate the prorated section 5503 reduction amount off the cost report and enter the result on this line. (Prorate the cap reduction amount by multiplying it by the ratio of the number of days from July 1, 2011, to the end of the cost reporting period to the total number of days in the cost reporting period). Otherwise enter the full cap reduction amount.

Line 4--Enter the adjustment (increase or decrease) for the unweighted resident FTE count for allopathic or osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(f), and (63 FR 26 336 May 12, 1998), and (67 FR 50069 August 1, 2002).

Line 4.01--Enter, as applicable, all or a portion of the amount of the FTE cap slots the hospital was awarded under section 5503 of ACA. The amount of the section 5503 award that is reported on this line is the amount of the section 5503 award that is being "used" in this cost reporting period. In the 5-year evaluation period following implementation of section 5503 (that is, July 1, 2011 through June 30, 2016), at least 75 percent of the slots are to be "used" for additional primary care and/or general surgery residents, while 25 percent of the amount that is reported may be (but need not be) "used" for other purposes. During the 5-year evaluation period, failure to meet the requirements at 42 CFR 413.79(n)(2) of the regulations means loss of a hospital's section 5503 slots. Therefore, do not automatically report the full amount of the section 5503 slots; only enter the amount of the section 5503 award that equates to at least 75 percent of the FTEs being "used" for additional primary care and/or general surgery FTEs, and no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting period. If the amount reported on Worksheet S-2, Part I, line 61.02, column 3, is less than the amount on line 61.01, column 3, then report 0 on this line.

Line 4.02--Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. Further subscript this line (lines 4.03 through 4.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to

determine the effective date of the cap increase. If the section 5506 award is phased in over more than one effective date, only report the portions of the section 5506 award as they become effective. If the effective date of the cap increase is not the same as your fiscal year begin date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period.)

Line 5--Enter the result of line 1 plus line 2 minus line 3 minus line 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus subscripts as applicable. However, if the resulting cap is less than zero, enter zero on this line.

Line 6--Enter the unweighted resident FTE count for allopathic or osteopathic programs for the current year from your records, other than those in the initial years of the program, i.e., the program has not yet completed one cycle of the program (the "period of years" or the minimum accredited length of the program. The residents in programs within the "period of years" are exempt from the rolling average rules. (42 CFR 413.79(d)(5) and (e).) Contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or greater than 3 years. Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)).

Line 7--Enter the lesser of lines 5 or 6.

Line 8--Enter in column 1, the weighted FTE count for primary care physicians and OB/GYN residents in an allopathic or osteopathic program for the current year other than those in the period of years of the program that meet the criteria for an exception to the rolling average rules. Enter in column 2, the weighted FTE count for all other physicians in an allopathic or osteopathic program for the current year other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules. (42 CFR 413.79(d)(5) and (e)). Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)). Enter in column 3 the sum of columns 1 and 2.

Line 9--If line 6 is less than or equal to line 5, enter the amounts from line 8, columns 1 and 2, in columns 1 and 2 of this line. Otherwise, multiply the amount in each column of line 8 by (line 5/line 6). Enter in column 3 the sum of columns 1 and 2. (42 CFR 413.79(c)(2)(iii).)

Line 10--Enter in column 2 the weighted dental and podiatric resident FTE count for the current year.

Line 11--Enter in column 1, the amount from column 1, line 9. Enter in column 2, the sum of the amounts in column 2, lines 9 and 10.

Line 12--Enter in column 1, the weighted FTE count for primary care residents for the prior year, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific primary care program included in Form 2552-96, Worksheet E-3, Part IV, line 3.22 or Form 2552-10, Worksheet E-4, sum of lines 15 and 16 of the prior year's cost report. If subject to the cap in the prior year Form 2552-96 cost report, report the result of Worksheet E-3, Part IV, line 3.07 times (line 3.04/line 3.05). If subject to the cap in the prior year Form 2552-10 cost report, report the result of Worksheet E-4, column 1, line 8 times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the prior year, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that

specific nonprimary care program included in Form 2552-96, Worksheet E-3, Part IV, line 3.16 or Form 2552-10, Worksheet E-4, sum of lines 15 and 16 of the prior year's cost report. If subject to the cap in the prior year Form 2552-96 cost report, report the result of Worksheet E-3, Part IV, line 3.08 times (line 3.04/line 3.05) plus line 3.11. If subject to the cap in the prior year Form 2552-10 cost report, report the result of Worksheet E-4, column 2, line 8 times (line 5/line 6) plus line 10.

Line 13--Enter in column 1, the weighted FTE count for primary care residents for the cost reporting year before last, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific primary care program included in Form 2552-96, line 3.22 or for 2552-10, sum of lines 15 and 16 of that year's cost report. If subject to the cap in the year before last Form 2552-96 cost report, report the result of line 3.07 times (line 3.04/line 3.05). If subject to the cap in that year Form 2552-10 cost report, report the result of column 1, line 8 times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the cost reporting year before last, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific nonprimary care program included in Form 2552-96, line 3.16 or Form 2552-10, sum of lines 15 and 16 of that year's cost report. If subject to the cap in the cost reporting year before last, Form 2552-96 cost report, report the result of line 3.08 times (line 3.04/line 3.05) plus line 3.11. If subject to the cap in that year Form 2552-10 cost report, report the result of column 2, line 8 times (line 5/line 6) plus line 10.

Line 14--Enter the rolling average FTE count in each column, by adding lines 11 through 13 and dividing by 3.

Line 15--Enter the weighted number of FTE residents in the initial years of a program that meets the exception to the rolling average rules in column 1 for primary care and in column 2 for nonprimary care FTEs.

Line 16--Enter the temporary weighted FTE residents that were displaced by program or a hospital closure in column 1 for primary care and in column 2 for nonprimary care FTEs, which you would not be able to count without a temporary cap adjustment. (42 CFR 413.79(h).)

Line 17--Enter the sum of lines 14 through 16.

Line 18-- Enter in column 1, the primary care and OB/GYN per resident amount. Enter in column 2, the nonprimary care per resident amount.

Line 19--Enter the result of multiplying lines 17 times line 18. Enter in column 3, the sum of columns 1 and 2.

Line 20--Section 422 Direct GME FTE Cap--Enter the number of unweighted allopathic and osteopathic direct GME FTE resident cap slots the hospital received under 42 CFR §413.79(c)(4).

Line 21--Direct GME FTE Resident Unweighted Count Over/Under the Cap--Subtract line 7 from line 6 and enter the result here. If the result is zero or negative, the hospital does not need to use the direct GME section 422 additional cap and lines 22 through 24 will not be completed.

Line 22--Section 422 Allowable Direct GME FTE Resident Count--If the count on line 21 is less than or equal to the count on line 20, then divide line 8 by line 6, and multiply the resulting ratio by the amount on line 21. If the count on line 21 is greater than the count on line 20, then divide line 8 by line 6, and multiply the resulting ratio by the amount on line 20.

Line 23--Enter the locality adjusted national average per resident amount as specified at 42 CFR section 413.77(g), inflated to the hospital's cost reporting period.

Line 24--Enter the product of lines 22 and 23. This is the allowable section 422 GME cost.

Line 25--Enter the sum of lines 19 and 24. This is the total Part A direct GME cost.

Computation of Program Patient Load--This section computes the ratio of program inpatient days to the total inpatient days. For this calculation, total inpatient days include inpatient days of the hospital along with its subproviders, including distinct part units excluded from the prospective payment system. Record hospital inpatient days of Medicare beneficiaries whose stays are paid by risk basis HMOs and organ acquisition days as non-Medicare days. Do not count inpatient days applicable to nursery, hospital-based SNFs and other nursing facilities, and other non-hospital level of care units for the purpose of determining the Medicare patient load.

#### Line Descriptions

Line 26--*Effective for cost reporting periods beginning prior to October 1, 2013, enter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 8 through 12, and 16 through 18, and subscripts, as applicable. Effective for cost reporting periods beginning on or after October 1, 2013, enter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1; 8 through 12 and subscripts; 16 through 18 and subscripts; and 32.* For titles V or XIX, enter the amounts from columns 5 or 7, respectively, sum of lines 1, 8 through 12, and 16 through 18, and subscripts, as applicable *plus column 7, line 32 for title XIX.*

For title XVIII, enter in column 2, Medicare managed care days from Worksheet S-3, Part I, column 6, lines 2, 3 and 4. For title XIX, enter in column 2, Medicaid managed care days from Worksheet S-3, Part I, column 7, lines 2, 3 and 4.

Line 27--*Effective for cost reporting periods beginning prior to October 1, 2013, transfer to columns 1 and 2, respectively, the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, and 16 through 18 and subscripts, as applicable.*

*Effective for cost reporting periods beginning on or after October 1, 2013, transfer to columns 1 and 2, the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, and 16 through 18 and subscripts, as applicable, plus line 32.*

Line 28--In each column, divide line 26 by line 27 and enter the result (expressed as a decimal). Column 1 is the title XVIII Part A inpatient utilization and column 2 is the Medicare managed care inpatient utilization.

Line 29--Multiply the amount on line 25, column 1, by the amount reported in each column of line 28.

Line 30--In column 2, enter the amount on line 29, column 2 multiplied by the reduction factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. This is the reduction for direct GME payments for *Medicare Advantage*.

Line 31--Enter the sum of columns 1 and 2, line 29, less the amount in column 2, line 30.

Direct Medical Education Costs for ESRD Composite Rate Title XVIII Only--This section computes the title XVIII nursing school and paramedical education costs applicable to the ESRD composite rate. These costs are reimbursable based on the reasonable cost principles under 42 CFR 413.85 separate from the ESRD composite rate.

#### Line Descriptions

Line 32--Enter the amount from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94.

Line 33--Enter the amount from Worksheet C, Part I, column 8, sum of lines 74 and 94. This amount represents the total charges for renal and home dialysis.

Line 34--Divide line 32 by line 33, and enter the result. This amount represents the ratio of ESRD direct medical education costs to total ESRD charges.

Line 35--Enter from your records the Medicare outpatient ESRD charges.

Line 36--Enter the result of multiplying line 34 by line 35. This represents the Medicare outpatient ESRD costs. Transfer this amount to Worksheet E, Part B, line 29.

Apportionment of Medicare Reasonable Cost of GME--This section determines the ratio of Medicare reasonable costs applicable to Part A and Part B. The allowable costs of GME on which the per resident amounts are established include GME costs attributable to the entire hospital complex (including non-hospital portions of a health care complex). Therefore, the reasonable costs used in the apportionment between Part A and Part B include the hospital, hospital-based providers, and distinct part units. Do not complete this section for titles V and XIX.

#### Line Descriptions

Line 37--Include the Part A reasonable cost for the entire hospital complex computed by adding the following amounts:

- Hospital and Subprovider(s) - Sum of each Worksheet D-1, Part II, line 49;
- Hospital-Based HHAs - Worksheet H-4, Part I, column 1, line 1;
- Swing Bed-SNF - Worksheet E-2, line 1, column 1;
- Hospital-Based PPS SNF - Sum of Worksheet D-1, Part III, line 74 and Worksheet E-3, Part VI, column 1, line 4.

Line 38--Enter the organ acquisition costs from Worksheet(s) D-4, Part III, column 1, line 69.

Line 39--Enter the cost of teaching physicians from Worksheet(s) D-5, Part II, column 3, line 20.

Line 40--Enter the total Medicare Part A primary payer amounts for the hospital complex from the applicable worksheets.

- PPS hospital and/or subproviders - Worksheet E, Part A, line 60;
- TEFRA hospital and/or subproviders - Worksheet E-3, Part I, line 5;
- IPF PPS hospital and/or subproviders - Worksheet E-3, Part II, line 17;
- IRF PPS hospital and/or subproviders - Worksheet E-3, Part III, line 18;

- LTC PPS hospital - Worksheet E-3, Part IV, line 8;
- Cost reimbursed hospital and/or subproviders - Worksheet E-3, Part V, line 5;
- Hospital-based HHAs - Each Worksheet H-4, Part I, column 1, line 9;
- Swing Bed SNF and/or NF - Worksheet E-2, column 1, line 9; and
- Hospital-based PPS SNF - Worksheet E-3, Part VI, column 1, line 13.

Line 41--Enter the sum of lines 37 through 39 minus line 40.

Line 42--Enter the Part B Medicare reasonable cost. Enter the sum of the amounts on each title XVIII Worksheet E, Part B, columns 1 and 1.01, sum of lines 1, 2, 9, 10, 22, and 23; Worksheet E-2, column 2, line 8; Worksheet H-4, Part I, sum of columns 2 and 3, line 1; Worksheet J-3, column 1, line 1; and Worksheet M-3, line 16.

Line 43--Enter the Part B primary payer amounts. Enter the sum of the amounts on each Worksheet E, Part B, line 31; Worksheet E-2, column 2, line 9; Worksheet H-4, Part I, sum of columns 2 and 3, line 9; Worksheet J-3, line 4; Worksheet M-3, sum of columns 1 and 2, line 17.

Line 44--Enter line 42 minus line 43

Line 45--Enter the sum of lines 41 and 44.

Line 46--Divide line 41 by line 45, and enter the result.

Line 47--Divide line 44 by line 45, and enter the result.

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

#### Line Descriptions

Line 48--Enter the amount from line 31.

Line 49--Complete for title XVIII only. Multiply line 46 by line 48, and enter the result. If you are a hospital subject to IPPS, transfer this amount to Worksheet E, Part A, line 52. Although this amount includes the Part A GME payments for subproviders, for ease of computation, transfer this amount to the primary hospital component worksheet only. If you are freestanding facility subject to TEFRA, transfer this amount to Worksheet E-3, Part I, line 15. If you are a freestanding IPF PPS, transfer this amount to Worksheet E-3, Part II, line 27. If you are a freestanding IRF PPS, transfer this amount to Worksheet E-3, Part III, line 28. If you are a freestanding LTCH PPS, transfer this amount to Worksheet E-3, Part IV, line 18.

Line 50--Complete for title XVIII only. Multiply line 47 by line 48, and enter the result. Transfer this amount to Worksheet E, Part B, line 28. Although this amount includes the Part B GME payments for subproviders, for ease of computation, transfer this amount to the hospital component only.

**SECTIONS 4035 THROUGH 4039 ARE RESERVED FOR FUTURE USE.**