

3630.2 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. OPD PPS services furnished on or after 8/1/2000 is only applicable for hospital title XVIII providers. (See BBRA §202) For services rendered on or after August 1, 2000, for purposes of prospective payment for outpatient services, if the cost reporting periods overlap any of the effective dates, complete subscribed column 1.01 for lines 1.01 through 1.06 only and make a separate transitional corridor or geographic reclassification (urban to rural only) (42 CFR 412.103 and 412.230) payment calculation for the appropriate periods. This may result in multiple subscribed columns. Order the subscribed columns chronologically as the transition dates or geographic reclassification relate to your fiscal year. The dates should also agree with the format on Worksheet D, Part V, columns 9, 9.01, 9.02 and 9.03, etcetera

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 104, columns 9, 9.02 and 11, for hospitals and enter in column 1. Add to the amount reported in column 1 the amount from Worksheet D, VI, line 3 (and/or 3.01 as applicable) for services rendered through March 31, 2001 and on or after January 1, 2003. For SNFs transfer the amount from Worksheet D, Part V, column 9 plus Worksheet D, Part VI, lines 3. For RPCH/CAH providers electing the all-inclusive method of payment for outpatient services prior to October 1, 1997 (see Worksheet S-2, lines 30 through 30.02), obtain this amount from Worksheet C, Part V, column 7, line 108.

CAHs are not subject to transitional corridor payments, therefore lines 1.01 through 1.07 do not apply to CAHs. Transfer Worksheet D, Part V, column 9, line 104 and Worksheet D, Part VI, lines 3 and 3.01.

Line 1.01--Enter the medical and other health services for services rendered on or after August 1, 2000, from Worksheet D, Part V, column 9.01, line 104 added to the amount reported on Worksheet D, Part VI, line 3.01; line 3 for cost reporting periods beginning on or after April 1, 2001. Subtract from this amount outpatient pass through costs reported on Worksheet D, Part IV, line 101, columns 9 and subscripts as applicable.

Line 1.02--Enter the gross PPS payments received including payment for drugs, device pass through payments, and outliers.

Contractors only, add or subtract as applicable to the gross PPS payments the total outlier reconciliation amount from line 54.

Line 1.03--Enter the hospital specific payment to cost ratio provided by your intermediary. 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)

Line 1.04--Line 1.01 times line 1.03.

If line 1.02 is < line 1.04 complete lines 1.05 and 1.06. Otherwise do not complete lines 1.05 and 1.06.

Line 1.05--Line 1.02 divided by line 1.04.

Line 1.06--Enter the transitional corridor payment amount calculated based on the following: For purposes of determining the bed count for small rural hospitals see 42 CFR §412.105(b).

For cost services rendered from January 1, 2006 through December 31, 2008, calculate this line when the response to Worksheet S-2, line 21.06 is "Y".

For services rendered August 1, 2000, through December 31, 2001:

- a. Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y", and Worksheet E, Part A, line 3 is ≤ 100 , enter the difference of line 1.04 minus line 1.02; or
- b. Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the difference of line 1.04 minus line 1.02.

For all other hospitals enter one of the following:

- b. If line 1.05 is ≥ 90 percent but < 100 percent, enter 80 percent of (line 1.04 minus line 1.02).
- c. If line 1.05 is ≥ 80 percent but < 90 percent, enter the result of 71 percent of (line 1.04 minus 70 percent of (line 1.02)).
- d. If line 1.05 is ≥ 70 percent but < 80 percent, enter the result of 63 percent of (line 1.04 minus 60 percent of (line 1.02)).
- e. If line 1.05 is < 70 percent, enter 21 percent of line 1.04.

For services rendered January 1, 2002, through December 31, 2002:

- a. If line 1.02 is $<$ line 1.04, Worksheet S-2, line 21 response is 2 (rural hospital) or if 21.02 equals "Y", and Worksheet E, Part A, line 3 is ≤ 100 , enter the result of line 1.04 minus line 1.02; or
- b. If line 1.02 is $<$ line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the difference of line 1.04 minus line 1.02.

For all other hospitals enter one of the following:

- c. If line 1.05 is ≥ 90 percent but < 100 percent, enter 70 percent of the result of line 1.04 minus line 1.02.
- d. If line 1.05 is ≥ 80 percent but < 90 percent, enter the result of 61 percent of (line 1.04 minus 60 percent of (line 1.02)).
- e. If line 1.05 is < 80 percent, enter 13 percent of line 1.04 .

For services rendered January 1, 2003, through December 31, 2003:

- a. If line 1.02 is $<$ line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y" and Worksheet E, Part A, line 3 is ≤ 100 enter the result of line 1.04 minus line 1.02; or
- b. If line 1.02 is $<$ line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the result of line 1.04 minus line 1.02.

For all other hospital enter one of the following:

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

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

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

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

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

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

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

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

In accordance with DRA 2005, section 5105, as amended by *MIPPA 2008, section 147*, for services rendered January 1, 2006, through *December 31, 2009*, rural hospitals with 100 or fewer beds that are not SCHs are entitled to hold harmless TOPs:

- a. For services rendered January 1, 2006, through December 31, 2006, if Worksheet S-2, line 21.06, is "Y", enter 95 percent of (line 1.04 minus line 1.02).
- b. For services rendered January 1, 2007, through December 31, 2007, if Worksheet S-2, line 21.06, is "Y", enter 90 percent of (line 1.04 minus line 1.02).
- c. For services rendered January 1, 2008, through *December 31, 2009*, if Worksheet S-2, line 21.06, is "Y", enter 85 percent of (line 1.04 minus line 1.02).

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

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

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

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

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

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

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

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

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

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

Line Descriptions

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

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

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

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

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

NOTE: If the amounts on Worksheet D, Part V include charges for professional services, eliminate the amount of the professional component from the charges entered on line 6. Submit a schedule showing these computations with the cost report.

Line 7--Enter zero (0) on this line because the hospital/component cannot bill separate charges for services of residents (in unapproved or approved programs) which are reimbursed under Part B.

Line 8--When Worksheet E is completed for a CTC hospital component for title XVIII, enter the organ acquisition charges from Worksheet D-6, Part III, column 4, line 61.

Line 9-- Enter zero (0) on this line because the hospital/component cannot bill separate charges for the direct patient care services rendered by physicians in teaching hospitals under the election described in 42 CFR 415.160.

Line 10--Enter the sum of lines 6 through 9.

Lines 11 through 14--These lines provide for the reduction of program charges when you do not actually impose such charges in the case of most 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 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 over the reasonable cost. If line 14 exceeds *the sum of lines 1 and 3*, enter the difference.

Line 16--Enter the excess of reasonable cost over the customary charges. If *the sum of lines 1 and 3*, exceeds line 14, enter the difference.

Line 17-- Enter *the amount from line 5, less any amount on reported on line 16 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, lines 47-51), enter the reasonable costs from line 5.

For CAHs with cost reporting periods beginning on or after January 1, 2004, enter on this line 101 percent of line 5. (1/1/2004b)

Line 17.01--Enter the sum of lines 1.02, 1.06, and 1.07, all columns.

Line 18--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 18.01--Enter the deductible and coinsurance relating to the amounts reported on line 17.01.

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, lines 47-51, columns 1-5, as applicable), enter the Part B deductibles billed to program beneficiaries only. Do not enter any Part B coinsurance. For CAHs with cost reporting periods beginning on or after 7/1/2002, enter the deductibles on line 18 and the coinsurance on line 18.01.

Line 19--Subtract line 18 and 18.01 from line 17 and 17.01 respectively.

NOTE: If these services are exempt from LCC, line 17 minus line 18 times 80 percent. Add to that result line 17.01 minus line 18.01.

For critical access hospitals (*CAHs*), with cost reporting periods beginning before July 1, 2002, exempt from LCC, multiply 80 percent times the result of line 17 minus (sum of line 18 plus Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus Worksheet D, Part VI, line 3). Add back Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus Worksheet D, Part VI, line 3. Prorate on a days to days basis lab services for cost reporting periods overlapping 11/29/99. For cost reporting periods beginning on or after 11/29/2004 no prorating is required.

For CAHs with cost reporting periods beginning on or after July 1, 2002, and before January 1, 2004, enter the lesser of (line 17 minus the sum of lines 18 and 18.01) or 80 percent times the result of (line 17 minus line 18 minus lab cost (Worksheet D, Part V, column 9, lines 44, 45, and subscripts) minus vaccine cost (Worksheet D, Part VI, line 3)). Add back the aforementioned lab and vaccine cost).

For CAHs with cost reporting periods beginning on or after January 1, 2004, enter the lesser of (line 17 minus the sum of lines 18 and 18.01) or 80 percent times the result of (line 17 minus line 18 minus 101% of lab cost (Worksheet D, Part V, column 9, lines 44, 45, and subscripts) minus 101% of vaccine cost (Worksheet D, Part VI, line 3)). Add back the aforementioned lab and vaccine cost). (1/1/2004b)

Line 20--This line is used to combine the amounts for medical and other health services, outpatient ambulatory services, outpatient radiology services, and other outpatient diagnostic procedures, for services rendered prior to August 1, 2000. Enter in column 1 only the sum of the amounts from Worksheet E, Part C, columns 1 plus 1.01, line 21; Part D, columns 1 plus 1.01, line 21; and Part E columns 1 plus 1.01, line 21. For services after August 1, 2000, make no entry.

Line 21--Enter in column 1 the amount from Worksheet E-3, Part IV, line 25. Complete this line for the hospital component only.

Line 22--Enter in column 1 the amount from Worksheet E-3, Part IV, line 11. Complete this line for the hospital component only.

Line 23--Enter in column 1 the sum of columns 1 and 1.01, lines 19 through 22.

Line 24--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:

- o Workmens' compensation,
- o No fault coverage,
- o General liability coverage,
- o Working aged provisions,
- o Disability provisions, and
- o 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 26. 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 26 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 26.

Line 25--Enter line 23 minus line 24.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 50--Enter the original outlier amount from line 4 sum of all columns of this worksheet.

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

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

Line 53-- Enter the time value of money by multiplying line 51 times line 52.

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

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

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

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

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

Line Descriptions

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

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