

Line 26--Enter the sum of lines 24 and 25 or 25.01 (hospitals and subproviders only).

Line 27--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 28--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-I, §2146.4.) Specify the adjustment in the space provided.

For SNFs only, include the title XVIII portion of the amount of the State's bill for determining the validity of nurse aide training and testing under §4211(b)(5) of P.L. 100-203. This adjustment includes the State's cost of deeming individuals to have completed training and testing requirements and the State's cost of determining the competency of individuals trained by or in a facility based program.

Line 29--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.)

Line 30--Enter line 26, plus or minus lines 28 and 29, minus line 27.

Line 31--Enter the sequestration adjustment amount, if applicable.

Line 32--Enter interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlement, report on line 32.01 the amount from line 5.99.

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

Line 34--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.

3633.3 Part III - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services and Part A Services for Title XVIII PPS SNFs.--Worksheet E-3 calculates reimbursement for titles V or XIX services for hospitals, subproviders, other nursing facilities and ICF/MRs. For titles V and XIX, complete column 1. For title XVIII SNFs reimbursed under PPS, complete this part for settlement of Part A services using column 2. For Part B services, all SNFs complete Worksheet E, Part B.

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., PPS, TEFRA, OTHER).

If the State program is under PPS for inpatient hospital services, do not complete line 1. Complete lines 24 through 32 for services covered by PPS. Complete lines 2 through 8, 9 through 15, and 16 through 23 only for services not covered by PPS. If the State program follows TEFRA for inpatient hospital services, do not complete lines 24 through 29. If the State program follows cost reimbursement, do not complete lines 15 and 24 through 29.

Computation of Net Costs of Covered ServicesLine 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 82. If Worksheet S-2, line 38.03 is answered yes, and multiple Worksheets D-1 are prepared, add the multiple Worksheets D-1 and enter the result. For cost reporting periods beginning on or after July 1, 1998 make no entry.
 RPCH - Worksheet C, Part IV, line 6

TEFRA

Hospital or Subprovider - Worksheet D-1, Part II, line 59

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

Line 2--Enter in column 1 the cost of outpatient services for titles V or XIX which is the sum of Worksheet D, Part V, column 9 and subscripts where applicable (SNFs only) (hospitals use column 9 and subscripts where applicable), line 104 and Worksheet D, Part VI, line 3 and subscripts where applicable. For RPCHs, enter the sum of Worksheet C, Part V, lines 107 or 109, and Worksheet D, Part VI, line 3. For title XVIII, enter in column 2 the amount from Worksheet D-4, column 3, line 101. For SNFs participating in the demonstration, enter the amount from Worksheet E-3, Part V, line 5. For cost reporting periods beginning on or after July 1, 1998 make no entry for Title XVIII.

Line 3--Enter in column 1 for titles V or XIX the cost of services rendered by interns and residents as follows from Worksheet D-2

| | <u>Title V</u> | <u>Title XIX</u> |
|--------------------------|--|---|
| Hospital | Part I, col. 8, line 9 plus line 24 | Part I, col. 10, line 9 plus line 24 |
| Subprovider | Part I, col. 8, line 10 | Part I, col. 10, line 10 |
| Nursing Facility, ICF/MR | Part I, col. 8, line 13 | Part I, col. 10, line 13 |

Line 4--For titles V and XIX, enter in column 1 the amount paid or payable by the State program for organ acquisition.

Line 5--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter in column 1 amounts from Worksheet D-9, Part II, column 3.

| <u>Title V</u> | <u>Title XIX</u> |
|---------------------------|---------------------------|
| Sum of lines 14 and 15 | Sum of lines 18 and 19 |

Line 6--Enter the sum of lines 1 through 5.

Line 7--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. For title XVIII SNFs reimbursed under PPS, enter in column 2 only the primary payer amounts applicable to Part A routine and ancillary services

Line 8--Enter in column 1 the primary payer amounts applicable to outpatient services for titles V and XIX.

Line 9--Enter line 6 minus the sum of lines 7 and 8.

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 as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e). RPCH components must follow State instructions regarding the application of LCC to determine the applicability of this provision. This section is not required for SNFs with cost reporting periods beginning on or after July 1, 1998.

Line Descriptions

Lines 10 through 15--These lines provide for the accumulation of charges which relate to the reasonable cost on line 9.

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) your charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §§2570-2577.

Line 10--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 10 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 11--For titles V and XIX, enter in column 1 the sum of the appropriate program ancillary charges from Worksheet D, Part V, column 5 plus subscripts as applicable, line 104; Worksheet D, Part VI, line 2; and Worksheet D-4, column 2, line 103.

For title XVIII SNFs reimbursed under PPS (less than 1500 days), for cost reporting periods beginning prior to July 1, 1998, enter in column 2 the amount from Worksheet D-4, column 2, line 103; otherwise make no entry.

Line 12--Enter in column 1 (for titles V or XIX) the total billed charges from your records for services of interns and residents furnished to program beneficiaries.

Line 13--Enter in column 1 (for titles V and XIX) the organ acquisition charges from line 4.

Line 14--Enter in column 1 (for titles V or XIX) your charges for the services for which the cost is entered on line 5.

Line 15--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 16--Enter the sum of the amounts recorded on lines 10 through 15.

Lines 17 through 20--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 19 is greater than zero, multiply line 16 by line 19, and enter the result on line 20. 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 17 through 19. Enter on line 20 the amount from line 16. In no instance may the customary charges on line 20 exceed the actual charges on line 16. For title XVIII SNFs reimbursed under PPS, lines 18 through 20 apply to Part A ancillary services only. For SNFs for cost reporting periods beginning on or after July 1, 1998, no entry is required.

Line 21--Enter the excess of the customary charges over the reasonable cost. If the amount on line 20 is greater than the amount on line 9, enter the excess.

Line 22--Enter the excess of total reasonable cost over the total customary charges. If the amount on line 9 exceeds the amount on line 20, enter the excess. Transfer this amount to line 34.

Line 23--Enter in columns 1 and 2 the amount from line 9.

Prospective Payment Amount

Line 24--Compute in column 1 the sum of the following amounts supplied by the intermediary:

- o The DRG payments made for PPS discharges during the cost reporting period, and
- o The DRG payments made for PPS transfers during the cost reporting period.

For Title XVIII SNFs reimbursed under PPS (less than 1500 days), multiply the number of Medicare days by the prospective payment rate, and enter the result in column 2. If the SNF is participating in the demonstration, transfer the amount reported on Worksheet E-3, Part V, line 25. For cost reporting periods beginning on or after July 1, 1998, transfer the amount from Worksheet S-7, column 5, line 46. SNFs electing 100 percent Federal rate for cost reporting periods beginning on or after July 1, 2001, providers are required to input the total RUG payments. Obtain this from your books and records or the PS&R.

Line 25--Enter in column 1 the amount of outlier payments made for PPS discharges during the period. See CMS Pub. 15-I, chapter 28 for a discussion of these outlier payments.

Line 26--Enter in column 1 the payment for inpatient program capital costs from Worksheet L, Part I, line 6; Part II, line 10; or Part III, line 5, as applicable.

Line 27--Enter the amount from Worksheet L, Part IV, line 13, as applicable for cost reporting periods beginning before October 1, 2001. For cost reporting periods beginning on and after October 1, 2001, enter the result of Worksheet L, Part IV, line 13 less Worksheet L, Part IV, line 17. If this amount is negative, enter zero on this line.

Line 28--Enter the routine service other pass through costs from Worksheet D, Part III, column 8, lines 25 through 30 and 33 for hospital or from line 31 for the subprovider. For cost reporting periods beginning on or after July 1, 1998, for title XVIII SNFs, enter in column 2 the amount from Worksheet D, Part III, column 8, line 34.

Line 29--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101. For cost reporting periods beginning on or after July 1, 1998, for title XVIII SNFs, enter the amount from Worksheet D, Part IV, column 7, line 101.

Line 30--Enter the sum of lines 23 through 29.

Line 31--For titles V and XIX only, enter the customary charges for PPS.

Line 32--For titles V and XIX PPS, enter the lesser of lines 30 or 31. For non PPS, enter the amount from line 30. For title XVIII, enter the amount from line 30.

Line 33--Enter any deductible amounts imposed.

Computation of Reimbursement Settlement

Line 34--Enter the amount, if any, from line 22. For SNFs with cost reporting periods beginning on or after July 1, 1998, do not complete this line.

Line 35--Enter line 32 less the sum of lines 33 and 34.

Line 36--Enter any coinsurance amounts.

Line 37--For titles V and XIX, enter in column 1 the sum of the amounts from line 19 of Worksheet E, Parts C, D, and E. Do not complete this line for title XVIII.

Line 38--Enter from your records program reimbursable bad debts for deductibles and coinsurance net of bad debt recoveries. If recoveries exceed the current year's bad debts, lines 38 (Title XVIII SNFPSS, V or XIX) and 38.01 (Title V or XIX) will be negative. Reimbursable bad debts for hospital-based PPS SNFs under title XVIII are paid at 100 percent for cost reporting periods beginning prior to October 1, 2005.

Line 38.01, column 1--Applies to hospitals and subproviders only if Title V or XIX follow Medicare principles--Multiply the amount (including negative amounts) on line 38 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999; 70 percent for October 1, 2000 and all subsequent periods.

Line 38.02--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 38. (4/1/2004b)

Line 38.03--DRA 2005 SNF Bad Debt--For cost reporting periods beginning on or after October 1, 2005 calculate this line as follows: $[(\text{line 38} - \text{line 38.02}) * .7] + \text{line 38.02}$. This is the adjusted SNF allowable bad debt in accordance with DRA 2005, section 5004. (10/1/2005b)

Line 39--Enter the title XVIII 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, line 81.

Line 40--For cost reporting periods beginning prior to October 1, 2005, enter the sum of lines 35, 37, 38 (Title XVIII, column 2) or 38.01 (Title V or XIX, column 1) and 39, minus line 36. For cost reporting periods beginning on or after October 1, 2005, enter the sum of lines 35, 37, 38.01 (Title V or XIX, column 1) or 38.03 (Title XVIII, column 2) and 39, minus line 36.

Lines 41 through 48--Do not complete these lines.

Line 49--Enter in column 1, for titles V and XIX, and in column 2, for title XVIII SNFs reimbursed under PPS, the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination of a decrease in program utilization.

NOTE: For titles V or XIX PPS providers for whom capital is included in PPS, the prior periods are only those paid under reasonable cost or the hold harmless methodology under capital PPS.

Line 50--Enter any other adjustments. 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-I, §2146.4.) Specify the adjustment in the space provided.

Line 51--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. Enter the amount of any excess depreciation taken as a negative amount.

NOTE: For titles V or XIX PPS providers for whom capital is included in the PPS, the prior periods are only those paid under reasonable cost or the hold harmless methodology under capital PPS.

Line 52--Enter the result of line 40, plus or minus lines 50 and 51, minus line 49.

Line 53--For provider components subject to PPS under titles V and XIX only, enter the amount of the additional payment amounts relating to indirect medical education.

Line 54--Enter the amount from Worksheet E-3, Part IV, line 23 or line 23.01

Line 55--Enter the sum of lines 52, 53, and 54.

Line 56--Enter the sequestration adjustment amount, if applicable.

Line 57--For titles V and XIX, obtain interim payments from your records. For title XVIII, enter the total interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlement, report on line 57.01 the amount from line 5.99.

Line 58--Enter line 55 minus the sum of the amounts on lines 56 and 57. Transfer this amount to Worksheet S, Part II, line as appropriate.

Line 59--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.

3633.4 Part IV - Direct Graduate Medical Education 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 413.83. 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 25.01 of Worksheet S-2 is "Y". 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 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 beginning for services rendered on or after January 1, 1998. The percent of Medicare HMO patient days that is included is limited to 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent by 2002. For cost reporting periods beginning before October 1, 1997, complete lines 1 through 3. For cost reporting periods beginning on or after October 1, 1997 skip lines 1 through 3 and begin with line 3.01.

NOTE: Do not complete this worksheet for GME if residents were on duty only after the first month of the cost reporting period. These costs are reimbursed as a reasonable cost and as such are not reimbursed through this worksheet. (See 42 CFR 413.86(e)(4).)

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