

3659. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED
OUTPATIENT REHABILITATION PROVIDER FOR SERVICES RENDERED TO
PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your fiscal intermediary.

Line Descriptions

Line 1--Enter the total program interim payments paid to the outpatient rehabilitation provider. The amount entered reflects 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 includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable.

Line 2--Enter the total program interim payments 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. It does not include payments reported on line 1.

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

Line 4--Transfer the total interim payments to the title XVIII Worksheet J-3, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due from the provider to the program, 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 the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet J-3, line 26.

3660. WORKSHEET L - CALCULATION OF CAPITAL PAYMENT

Worksheet L, Parts I through IV, calculate program settlement for PPS inpatient hospital capital-related costs in accordance with the final rule for payment of capital-related costs on a prospective payment system pursuant to 42 CFR 412, Subpart M. (See the August 30, 1991 **Federal Register**.) Only provider components paid under PPS complete this worksheet.

Worksheet L consists of the following four parts:

- Part I - Fully Prospective Method
- Part II - Hold Harmless Method
- Part III Payment Under Reasonable Cost
- Part IV Computation of Exception Payments

COMPLETE ONLY PART I, II, OR III.

At the top of the worksheet, indicate by checking the applicable boxes the health care program, provider component, and the PPS capital payment method for which the worksheet is prepared.

3660.1 Part I - Fully Prospective Method--This part computes settlement under the fully prospective method only, as defined in 42 CFR 412.340. Use the fully prospective method for PPS capital settlement when the hospital's base year hospital-specific rate is below the adjusted Federal rate.

Line Descriptions

Line 1--Enter the amount of the hospital-specific rate portion of capital payments for discharges during the period. Do not complete this line for cost reporting periods beginning on and after October 1, 2001 for hospitals paid 100 percent of the Federal rate.

Line 2--Enter the amount of the Federal rate portion of the capital DRG payments for other than outlier during the period. Subscript column 1 as indicated in the general instructions for lines 4.02 through 4.03.

Line 3--Enter the amount of the Federal rate portion of the capital outlier payments made for PPS discharges during the period. (See 42 CFR 412.312(c).) Subscript this line to report outlier payments received for services rendered before October 1, 1997, and on or after October 1, 1997.

Line 4--Enter the result of dividing the sum of total patient days (Worksheet S-3, Part I, column 6, lines 12 and 28) by the number of days in the cost reporting period (365 or 366 in case of leap year). Do not include statistics associated with an excluded unit (subprovider).

NOTE: Reduce total patient days by nursery days (Worksheet S-3, Part I, column 6, line 11), and swing bed days (Worksheet S-3, Part I, column 6, lines 3 and 4).

Line 4.01--Enter the number of interns and residents from Worksheet S-3, Part I, column 9, line 12. For cost reporting periods beginning on or after October 1, 1997 obtain the intern and resident amount from Worksheet E, Part A, line 3.17. In addition, for cost reporting periods beginning on or after July 1, 2005, if the hospital received additional IME FTE resident cap slots under 42 CFR §413.79(c)(4) (Worksheet S-2, line 25.06, column 2, is "Y") add the amount reported on Worksheet E-3, Part VI, line 18). For cost reporting periods that overlap July 1, 2005, multiply the FTE count from Worksheet E-3, Part VI, line 18 by line 1 in order to prorate the number of days in the cost reporting period occurring after July 1, 2005.

Lines 4.02 through 4.03--IME Adjustment Factor Phase Out--In accordance with 42 CFR 412.322(c) and (d), the IME adjustment factor is eliminated for discharges occurring on or after 10/1/2009. Consequently, for line 2 (above) and lines 4.02 through 4.03, column 1 must be subscripted to accommodate the corresponding portion of the provider's cost reporting period when the provider's cost reporting period overlaps 10/1/2009. For cost reporting periods beginning on or after 10/1/2009, do not subscript column 1.

Line 4.02--Enter the result of the following calculation: $\{e^{.2822 \times \text{line 4.01}/\text{line 4}}\}-1$ where $e = 2.71828$. (See 42 CFR 412.322(a)(3) for limitation of the percentage of I&Rs to average daily census. Line 4.01 divided by line 4 cannot exceed 1.5. *The capital IME adjustment factor is not applicable beginning 10/1/2009, therefore enter -0- on this line for discharges occurring on or after 10/1/2009.*

Line 4.03--Multiply line 4.02 by the sum of lines 2 and 3. Do not include line 3.01.

Lines 5 - 5.04

NOTE: Enter the amount of the Federal rate portion of the additional capital payment amounts relating to the disproportionate share adjustment. Complete these lines if you answered yes to line 36.01 on Worksheet S-2. (See 42 CFR 412.312(b)(3).) For hospitals qualifying for disproportionate share in accordance with 42 CFR 412.106(c)(2) (Pickle amendment hospitals), do not complete lines 5 through 5.02, and enter 11.89 percent on line 5.03.

Line 5--Enter the percentage of SSI recipient patient days (from your intermediary or your records) to Medicare Part A patient days. This amount agrees with the amount reported on Worksheet E, Part A, line 4.

Line 5.01--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12, plus line 2, minus the sum of lines 3 and 4) divided by total days reported on Worksheet S-3, column 6, line 12, minus the sum of lines 3 and 4. Increase total patient days by any employee discount days reported on Worksheet S-3, Part I, line 28.

For cost reporting periods beginning on or after October 1, 2004, enter the percentage resulting from the calculation of the total Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, minus the sum of lines 3 and 4, plus column 5.01, line 26) to total days reported on Worksheet S-3, column 6, line 12, minus the sum of lines 3 and 4, plus column 6.01, line 26. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

Line 5.02--Add lines 5 and 5.01, and enter the result.

Line 5.03--Enter the percentage that results from the following calculation: $(e^{.2025 \times \text{line 5.02}})-1$ where e equals 2.71828.

Line 5.04--Multiply line 5.03 by the sum of lines 2 and 3 (do not include line 3.01), and enter the result.

Line 6--Enter the sum of lines 1, 2 (and subscripted columns), 3, 3.01, 4.03 (and subscripted columns), and 5.04. For title XVIII, transfer the amount on line 6 to Worksheet E, Part A, line 9. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, column 1, line 26.

3660.2 Part II - Hold Harmless Method.--This part computes settlement under the hold harmless method only as defined in 42 CFR 412.344. Use the hold harmless method for PPS capital settlement when the hospital's base year hospital-specific rate exceeds the established Federal rate. Do not complete this part for cost reporting periods beginning on and after October 1, 2001, except for new providers certified prior to October 1, 1999, that are paid in accordance with 42 CFR 412.324(b)(3). Formerly hold harmless providers (other than new providers) should consider themselves fully prospective and complete Part I of the Worksheet.

This part (Worksheet L, Part II) is no longer applicable for cost reporting periods beginning on or after October 1, 2008.

NOTE: If you have elected payments at 100 percent of the Federal rate (as indicated on Worksheet S-2, line 37.01), complete only lines 5 and 10 of this part.

Line Descriptions

Line 1--Enter the amount of program inpatient new capital costs. This amount is the sum of the program inpatient routine service new capital costs from the appropriate Worksheet D, Part I, column 12, sum of lines 25 through 30 and 33 for the hospital and line 31 for the subproviders and program inpatient ancillary service new capital costs from Worksheet D, Part II, column 8, line 101.

Line 2--Enter the amount of program inpatient old capital costs. This amount is the sum of the program inpatient routine service old capital costs from the appropriate Worksheet D, Part I, column 10, sum of lines 25 through 30 and 33 for the hospital and line 31 for the subproviders and program inpatient ancillary service old capital costs from Worksheet D, Part II, column 6, line 101.

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

Line 4--Enter the ratio of new capital costs on line 1 to the total capital cost on line 3. Carry the ratio to six decimal places.

Line 5--Enter the amount of payments that would have been made for inpatient program capital costs if the provider were paid at 100 percent of the Federal rate throughout the cost reporting period. This amount is provided by the fiscal intermediary. Compute this amount by grossing up the Federal payments made for new capital by multiplying each part of the capital Federal payment (capital DRG, capital outlier, capital DSH, and capital IME) by a ratio. The numerator of the ratio is 100 and the denominator is the new capital ratio used for interim payment during the period. When there has been any change to the new capital ratio during the period, make a separate computation for each period for which there was a separate new capital ratio. For example, if a 15 percent ratio was used for the first three months and a 20 percent ratio was used for the last nine months, divide the four components of the capital Federal rate data for the first three months by .15 and divide the four components of the capital Federal rate data for the last nine months by .20. Use the interim payment new capital ratio since grossed up payments made during the period were based on the interim ratio payment.

NOTE: If it is necessary to make a year end adjustment to the DSH or IME amounts on Worksheet E, Part A, lines 3 and 4, respectively, to reflect more current data than was used for payment purposes, then also make these adjustments to the data on this line.

Line 6--Hospitals that did not qualify as sole community providers during the cost reporting period enter a reduction factor of 85 percent. SCHs enter 100 percent. If you were an SCH during a portion of the cost reporting period, compute the hold harmless old capital cost reduction percentage by dividing the number of days in your cost reporting period for which you were not a sole community hospital (reduction factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 15 percent, and subtract the amount from 100. Enter the resulting hold harmless old capital cost reduction percentage as a percentage.

Line 7--Multiply line 2 by line 6.

Line 8--Multiply line 5 by line 4.

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

Line 10--Enter the greater of line 5 or line 9. If the provider has elected payment based on 100 percent of the Federal rate (see Worksheet S-2, line 37.01), enter the amount from line 5. For title XVIII, transfer this amount to Worksheet E, Part A, line 9. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, column 1, line 26.

3660.3 Part III - Payment Under Reasonable Cost--This part computes capital settlement under reasonable cost principles subject to the reduction pursuant to 42 CFR 412.324(b). Use the reasonable cost method for capital settlement determinations for new providers *under* 42 CFR 412.324(b) *for the first two years* or for titles V or XIX determinations, if applicable. *This part may also be completed for cost reporting periods beginning on or after October 1, 2002, for the first two years* for new providers *under* 42 CFR 412.304(c)(2)(i) (response to Worksheet S-2, line 33, column 1 is "Y" and column 2 is "N").

Line Descriptions

Line 1--Enter the amount of program inpatient routine service capital costs. This amount is the sum of the program inpatient routine capital costs from the appropriate Worksheet D, Part I, sum of columns 10 and 12, sum of the amounts on lines 25 through 30 and 33 for the hospital (line 31 for the subprovider).

Line 2--Enter the amount of program inpatient ancillary capital costs. This amount is the sum of the amounts of program inpatient ancillary capital costs from the appropriate Worksheet D, Part II, columns 6 and 8, line 101.

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

Line 4--Enter a reduction factor of 85 percent.

Line 5--Multiply line 3 by line 4. For title XVIII, transfer the amount to Worksheet E, Part A, line 9. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, column 1, line 26.

3660.4 Part IV - Computation of Exception Payments--This part computes minimum payment levels by class of provider with an additional payment exception for extraordinary circumstances for hospitals paid under either the fully prospective method or the hold harmless method pursuant to 42 CFR 412.348. Complete this part only if the provider component completed Parts I or II of this worksheet. For cost reporting periods beginning on or after October 1, 2001, complete this part only if the provider qualifies for an additional payment for extraordinary circumstances pursuant to 42 CFR 412.348(e) (the facility indicates "Y" to question 52 on worksheet S-2) or the special exceptions payment pursuant to 42 CFR 412.348(g) (the facility indicates "Y" to question 52.01 on worksheet S-2).

Line 1--Enter the amount of program inpatient routine service and ancillary service capital costs. This amount is the sum of the program inpatient routine service capital costs from the appropriate Worksheet D, Part I, sum of columns 10 and 12, sum of lines 25 through 30 and 33 for the hospital, line 31 for the subprovider, and program inpatient ancillary service capital costs from Worksheet D, Part II, sum of columns 6 and 8, line 101.

Line 2--Enter program inpatient capital costs for extraordinary circumstances as provided by 42 CFR 412.348(e), if applicable, from Worksheet L-1, sum of Part II, column 7, sum of lines 25 through 30 and 33 for the hospital, line 31 for the subproviders, and Part III, column 5, line 101.

Line 3--Enter line 1 less line 2.

Line 4--Enter the appropriate minimum payment level percentage. The minimum payment levels for portions of cost reporting periods beginning on or after October 1, 2001 are:

- o SCHs (located in either an urban or a rural area) - 90 percent;
- o Urban hospitals with at least 100 beds and a disproportionate patient percentage of at least 20.2 percent - 80 percent; and
- o All other hospitals - 70 percent.

For providers that qualify for the special exceptions payment pursuant to 42 CFR 412.348(g) the appropriate minimum payment level is 70 percent.

The minimum payment levels in subsequent transition years will be revised, if necessary, to keep total payments under the exceptions process at no more than 10 percent of capital prospective payments.

If you were an SCH during a portion of the cost reporting period, compute the minimum payment level percentage by dividing the number of days in your cost reporting period for which you were not an SCH (70 percent factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 70 percent. Divide the number of days in your cost reporting period for which you were an SCH (90 percent factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 90 percent. Add the amounts from steps 1 and 2 to compute the capital cost minimum payment level percentage. Display exception percentage in decimal format, e.g., 70 percent is displayed as .70 or 0.70.

Line 5--Enter the product of line 3 multiplied by line 4.

Line 6--Hospitals that did not qualify as sole community providers during the cost reporting period enter a reduction factor of 85 percent. SCHs enter 100 percent. If you were a sole community hospital during a portion of the cost reporting period, compute the capital cost reduction percentage by dividing the number of days in your cost reporting period for which you were not a sole

community hospital (reduction factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 15 percent and subtract the amount from 100. Enter the resulting extraordinary circumstance percentage adjustment in decimal format, e.g., 85 percent is displayed as .85 or 0.85.

Line 7--Enter the product of line 2 multiplied by line 6.

Line 8--Enter the sum of lines 5 and 7.

Line 9--Enter the amount from Part I, line 6 or Part II, line 10, as applicable.

Line 10--Enter line 8 less line 9.

Lines 11 through 14--A hospital is entitled to an additional payment if its capital payments for the cost reporting period is less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive. This additional payment amount is reduced for any amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels. For cost reporting period beginning on or after October 1, 2001, the offsetting amounts will be determined based on the amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels in the lesser of the preceding 10-year period or the period of time under which the hospital is subject to the prospective payment system for capital related costs.

A positive amount on line 10 represents the amount of capital payments under the minimum payment level in the current year. This amount must be offset for the amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels in prior years, as reported on line 11. If the net amount on line 12 remains a positive amount, this amount represents the current year's additional payment for capital payments under the minimum payment level. Report this amount on line 13. If the net amount on line 12 is a negative amount, this amount represents the reduced amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. In this case, no additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the following cost reporting period.

A negative amount on line 10 represents the amount of capital payments over the minimum payment level in the current year. Add any carry forward of prior years' amounts of the hospital's cumulative payments in excess of cumulative minimum payment levels, as reported on line 11, to the current year excess on line 12. The net amount on line 12 represents the total amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. No additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the following cost reporting period.

Line 11--For cost reporting periods beginning prior to October 1, 2001, if applicable, enter the amount from the prior year's Worksheet L, Part IV, line 14.

For cost reporting periods beginning on or after October 1, 2001, the offsetting amounts will be determined based on the amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels in the lesser of the preceding 10-year period or the period of time under which the hospital is subject to the prospective payment system for capital related costs. Enter the appropriate offset amount as computed pursuant to 42 CFR 412.312(e)(3).

Line 12--Enter the sum of lines 10 and 11.

Line 13--If the amount on line 12 is positive, enter the amount on this line.

Line 14--If the amount on line 12 is negative, enter the amount on this line.

For cost reporting periods beginning on and after October 1, 2001, complete lines 15 through 17 only when line 12 is a positive amount.

Line 15--Enter the current years allowable operating and capital payments calculated from Worksheet E, Part A, line 6, plus the capital payments reported on line 9 above, minus 75 percent of the current year's operating disproportionate share payment amount reported on Worksheet E, Part A, line 4.04.

Line 16--Current years operating and capital costs from worksheet D-1, line 49 minus the sum of D, Part III, lines 25 through 30, column 8 (PPS subproviders use line 31, column 8), and D, Part IV, column 7, line 101.

Line 17--Enter on this line the current year's exception offset amount. This is computed as line 15 minus line 16. If this amount is negative, enter zero on this line. If the amount on line 13 is greater than line 17, transfer the amount on line 13, less any reported amount on line 17, to Worksheet E, Part A, line 10.

3661. WORKSHEET L-1 - ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

This worksheet provides for the determination of direct and indirect capital-related costs associated with capital expenditures for extraordinary circumstances, allocated to inpatient operating costs. Only complete this worksheet for providers that qualify for an additional payment for extraordinary circumstances under 42 CFR 412.348(e).

3661.1 Part I - Allocation of Allowable Capital Costs for Extraordinary Circumstances--Use this part in conjunction with Worksheet B-1. The format and allocation process employed is similar to that used on Worksheets B, Part I and B-1. Any cost center subscripted lines and/or columns added to Worksheet B, Part I, are also added to this worksheet in the same sequence.

Column 0--Assign capital expenditures relating to extraordinary costs to specific cost centers on this worksheet, column 0. Enter on the appropriate lines those capital-related expenditure amounts relating to extraordinary costs which were directly assigned on Worksheet B, Part III. Enter on lines 3 and 4, as applicable, the remaining capital expenditure amounts relating to extraordinary costs which have not been directly assigned.

NOTE: Recognize capital expenditures relating to extraordinary costs as new capital-related costs.

Columns 1 through 24--Transfer amounts on the top lines of columns 3 and 4 from column 0, line as applicable. For example, transfer line 3, column 0 to line 3, column 3. For all other columns, the top line represents the cross total amount.

For each column, enter on line 104 of this worksheet, Part I, the total statistics of the cost center being allocated. Obtain this amount from Worksheet B-1 from the same column and line number used to allocate cost on this worksheet. (For example, obtain the amount of new capital-related costs - buildings and fixtures from Worksheet B-1, column 3, line 3.)

Divide the amount entered on line 104 by the total capital expenses entered in the same column on the first line. Enter the resulting unit cost multiplier on line 105. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services rendered. Report applicable cost center statistics on Worksheet B-1. Enter the result of each computation on this worksheet in the corresponding column and line. (See §3600.1 for rounding standards.)