

Line 27--Subtract the amount on line 26 from the amount on line 21. This amount represents the general inpatient routine service cost net of swing bed-SNF type and NF type inpatient costs.

Lines 28 through 36--All providers must complete lines 28 through 36. PPS providers complete these lines for data purposes only. However, if line 3 equals line 2 above you are not to complete these lines.

Line 28--Enter the total charges for general inpatient routine services, excluding charges for swing bed-SNF type and NF type inpatient services (from your records).

Line 29--Enter the total charges for private room accommodations, excluding charges for private room accommodations for swing bed-SNF type and NF type inpatient services (from your records).

Line 30--Enter the total charges for semi-private room and ward accommodations, excluding semi-private room accommodation charges for swing bed-SNF type and NF type services (from your records).

Line 31--Enter the general inpatient routine cost to charge ratio (rounded to six decimal places) by dividing the total inpatient general routine service costs (line 27) by the total inpatient general routine service charges (line 28).

Line 32--Enter the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the amount on line 29 by the days on line 3.

Line 33--Enter the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the amount on line 30 by the days on line 4.

Line 34--Subtract the average per diem charge for all semi-private accommodations (line 33) from the average per diem charge for all private room accommodations (line 32) to determine the average per diem private room charge differential. If a negative amount results from this computation, enter zero on line 34.

Line 35--Multiply the average per diem private room charge differential (line 34) by the inpatient general routine cost to charge ratio (line 31) to determine the average per diem private room cost differential (rounded to two decimal places).

Line 36--Multiply the average per diem private room cost differential (line 35) by the private room accommodation days (excluding private room accommodation days applicable to swing bed-SNF type and NF type services) (line 3) to determine the total private room accommodation cost differential adjustment.

Line 37--Subtract the private room cost differential adjustment (line 36) from the general inpatient routine service cost net of swing bed-SNF type and NF type costs (line 27) to determine the adjusted general inpatient routine service cost net of swing bed-SNF type service costs, NF type service costs, and the private room accommodation cost differential adjustment. If line 3 equals line 2, enter the amount from line 27 above.

3622.2 Part II - Hospital and Subproviders Only--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX and the calculation of program excludable cost for all hospitals and subproviders. For hospitals reimbursed under TEFRA, it provides for the application of a ceiling on the rate of cost increase for the hospital and subproviders. When the worksheet is completed for a component, show both the hospital and component numbers.

NOTE: This is not completed for RPCH providers. (See Worksheet S-2, line 31ff.) RPCH providers complete Worksheet C, Part IV, in lieu of this part. For cost reporting periods beginning after October 1, 1997 CAHs will complete this worksheet.

Line Descriptions

Line 38--For non-PPS providers (includes IRFs and LTCHs during the TEFRA/PPS blend), divide the adjusted general inpatient routine service cost (line 37) by the total general inpatient routine service days including private room (excluding swing bed and newborn) days (line 2) to determine the general inpatient routine service average cost per diem (rounded to two decimal places). For PPS providers (includes IRFs and LTCHs under 100 percent PPS), divide the sum of lines 36 and 37 by the inpatient days reported on line 2. For CAHs the per diem, unless there is an adjustment for private room differential, should be equal to the per diem calculated in the formula on line 26. If this is a CAH and there is a private room differential, process as a non PPS provider,

Line 39--Multiply the total program inpatient days including private room (excluding swing bed and newborn) days (line 9) by the adjusted general inpatient routine service average cost per diem (line 38) to determine the general inpatient service cost applicable to the program.

Line 40--Multiply the medically necessary private room (excluding swing bed) days applicable to the program (line 14) by the average per diem private room cost differential (line 35) to determine the reimbursable medically necessary private room cost applicable to the program. PPS providers including IRF, IPF and LTCH, reimbursed at 100 percent Federal rate enter zero.

Line 41--Add lines 39 and 40 to determine the total general inpatient routine service cost applicable to the program.

Line 42--This line is for titles V and XIX only and provides for the apportionment of your inpatient routine service cost of the nursery, as appropriate.

Column 1--Enter the total inpatient cost applicable to the nursery from Worksheet C, Part I, line 33.

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|---------------------------------|----------|
| TEFRA, COST, or OTHER Inpatient | Column 3 |
| PPS Inpatient | Column 5 |

Column 2--Enter the total inpatient days applicable to the nursery from line 15.

Column 3--Divide the total inpatient cost in column 1 by the total inpatient days in column 2 (rounded to two decimal places).

Column 4--Enter the program nursery days from line 16.

Column 5--Multiply the average per diem cost in column 3 by the program nursery days in column 4.

Lines 43 through 47--These lines provide for the apportionment of the hospital inpatient routine service cost of intensive care type inpatient hospital units (excluding nursery) to the program.

Column 1--Enter on the appropriate line the total inpatient routine cost applicable to each of the indicated intensive care type inpatient hospital units from Worksheet C, Part I, lines 26 through 30, as appropriate.

| | |
|---------------------------------|----------|
| TEFRA, COST, or OTHER Inpatient | Column 3 |
| PPS Inpatient | Column 5 |

Column 2--Enter on the appropriate line the total inpatient days applicable to each of the indicated intensive care type inpatient units. Transfer these inpatient days from Worksheet S-3, Part I, column 6, lines 6 through 10, as appropriate.

Column 3--For each line, divide the total inpatient cost in column 1 by the total inpatient days in column 2 (rounded to two decimal places).

Column 4--Enter on the appropriate line the program days applicable to each of the indicated intensive care type inpatient hospital units. Transfer these inpatient days from Worksheet S-3, Part I, columns 3, 4, or 5, as appropriate, lines 6 through 10.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type unit days for the purpose of computing the intensive care type unit per diem. The days are included in column 2. However, count the program days as general routine days in computing program reimbursement. Enter the program days on line 9 and not in column 4, lines 43 through 47, as applicable. (See CMS Pub. 15-I, §2217.)

Column 5--Multiply the average cost per diem in column 3 by the program days in column 4.

Line 48--Enter the total program inpatient ancillary service cost from the appropriate Worksheet D-4, column 3, line 101.

Line 49--Enter the sum of the amounts on lines 41 through 48. When this worksheet is completed for components, neither subject to prospective payment, nor subject to the target rate of increase ceiling (i.e., "Other" box is checked), transfer this amount to Worksheet E-3, Part II, line 1 or Part III, column 1, line 1, as appropriate. Do not complete lines 50-59. For all inclusive rate providers (Method E) apply the percentage to the sum of the aforementioned lines based on the provider type designated on Worksheet S-2, line 19 (see PRM 15-I, section 2208).

Lines 50-53--These lines compute total program inpatient operating cost less program capital-related, nonphysician anesthetists, and approved medical education costs. Complete these lines for all provider components.

Line 50--Enter on the appropriate worksheet the total pass through costs including capital-related costs applicable to program inpatient routine services. Transfer capital-related inpatient routine cost from Worksheet D, Part I, columns 10 and 12, sum of lines 25 through 30 and line 33 for the hospital, and line 31 for the subprovider. Add that amount to the other pass through costs from Worksheet D, Part III, column 8, sum of lines 25 through 30 and line 33 for the hospital, and line 31 for the subprovider.

Line 51--Enter the total pass through costs including capital-related costs applicable to program inpatient ancillary services. Transfer capital-related inpatient ancillary costs from Worksheet D, Part II, sum of columns 6 and 8, line 101. Add that amount to the other pass through costs from Worksheet D, Part IV, column 7, line 101.

Line 52--Enter the sum of lines 50 and 51.

Line 53--Enter total program inpatient operating cost (line 49) less program capital-related, nonphysician anesthetists (if appropriate), and approved medical education costs (line 52).

Lines 54 through 59--Except for those hospitals specified below, all hospitals (and distinct part hospital units) excluded from prospective payment are reimbursed under cost reimbursement principles and are subject to the ceiling on the rate of hospital cost increases (TEFRA). (See 42 CFR 413.40.) The following hospitals are reimbursed under special provisions and, therefore, are not generally subject to TEFRA or prospective payment:

- o Hospitals reimbursed under approved State cost control systems (see 42 CFR 403.205 through 403.258);

- o Hospitals reimbursed in accordance with demonstration projects authorized under §402(a) of the Social Security Amendments of 1967 or §222(a) of the Social Security Amendments of 1972; and
- o Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

For your components subject to the prospective payment system or not otherwise subject to the rate of increase ceiling as specified above, make no entries on lines 54 through 59.

NOTE: A new non-PPS hospital or subprovider (Lines 34 and/or 35 of Worksheet S-2 with a “Y” response) is cost reimbursed for all cost reporting periods through the end of its first 12 month cost reporting period. The 12 month cost reporting period also becomes the TEFRA base period unless an exemption under 42 CFR 413.40 (f) is granted. If such an exemption is granted, cost reimbursement continues through the end of the exemption period. The last 12 month period of the exemption is the TEFRA base period. For cost reporting periods beginning on or after October 1, 1997, new providers will be paid the lower of their inpatient operating costs per case or 110 percent of the national median of the target amounts for similar provider types.

Line 54--Enter the number of program discharges including deaths (excluding newborn and DOAs) for the component from Worksheet S-3, Part I, columns 12 through 14 (as appropriate), lines 12 and 14 (as appropriate). A patient discharge, including death, is a formal release of a patient.

Line 55--Enter the target amount per discharge as obtained from your intermediary. The target amount establishes a limitation on allowable rates of increase for hospital inpatient operating cost. The rate of increase ceiling limits the amount by which your inpatient operating cost may increase from one cost reporting period to the next. (See 42 CFR 413.40.)

Line 56--Multiply the number of discharges on line 54 by the target amount per discharge on line 55 to determine the rate of increase ceiling.

Line 57--Subtract line 53 from line 56 to determine the difference between adjusted inpatient operating cost and the target amount.

Line 58 through 58.04--This line provides incentive payments when your cost per discharge for the cost reporting period subject to the ceiling is less than the applicable target amount per discharge. In addition, for cost reporting periods beginning on or after October 1, 1997, bonus payments are provided for hospitals who have received PPS exempt payments for three or more previous cost reporting periods and whose operating costs are less than the target amount, expected costs (lesser of actual costs or the target amount for the previous year), or trended costs (lesser of actual operating costs or the target amount in 1996; or for hospitals where its third full cost reporting period was after 1996 the inpatient operating cost per discharge), updated and compounded by the market basket. It also provides for an adjustment when the cost per discharge exceeds the applicable target amount per discharge. If line 57 is zero, enter zero on lines 58 through 58.04. New providers skip lines 58 through 58.04 and go to line 59.

Line 58--If line 57 is a positive amount (actual inpatient operating cost is less than the target amount), enter on line 58 the lesser of 50 percent of line 57 or 5 percent of line 56. For cost reporting periods beginning on or after October 1, 1997, the respective percentages are 15 percent and 2 percent. However, the respective percentages are 15 percent and 3 percent for psychiatric hospital/subprovider for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, (see BIPA §306 and 42CFR 413.40(d)(2)). If line 57 is a negative amount (actual inpatient operating cost is greater than the target amount) for cost reporting periods beginning prior to October 1, 1997, enter on line 58, the lesser of 50 percent of the absolute value of line 57 or 10 percent of line 56. For cost reporting periods beginning on or after October 1, 1997, do not complete line 58 (leave blank) and complete line 58.04 for calculation of any adjustments to the operating costs when line 57 is negative.

Line 58.01--Starting with the first full cost reporting period and counting forward, enter from the third full cost reporting period the lesser of the hospital's inpatient operating cost per discharge (line 53/line 54) or line 55, updated and compounded by the market basket for each year through the current reporting year. If the third full cost reporting period ended during or before the Federal fiscal year 1996 use the amounts from fiscal year 1996. For hospitals where its third full cost reporting period ended in the Federal fiscal year 1997 or subsequent fiscal period enter the inpatient operating cost per discharge updated and compounded by the market basket for each year through the current reporting year.

Line 58.02--Enter from the prior year cost report, the lesser of the hospital's inpatient operating cost per discharge (line 53/line 54) or line 55, updated by the market basket.

Line 58.03--For cost reporting periods beginning on or after October 1, 1997, if (line 53/line 54) is less than the lower of lines 55, 58.01 or 58.02, enter the lesser of 50 percent of the amount by which operating costs (line 53) are less than expected costs (line 54 times line 58.02), or 1 percent of the target amount (line 56); otherwise enter zero. *See 42 CFR 413.40(d)(4)(i).*

For long-term care hospitals and psychiatric hospitals or psychiatric subproviders the 1 percent limitation is increased to 1.5 percent for cost reporting periods beginning on and after October 1, 2000 and before October 1, 2001 and to 2 percent for cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002. For cost reporting periods beginning on or after 10/1/2002, the instructions in the above paragraph are again applicable.

Line 58.04--If line 57 is a negative amount (actual inpatient operating cost is greater than the target amount) and line 53 is greater than 110 percent of line 56, enter on this line the lesser of (1) or (2): (1) 50 percent of the result of (line 53 minus 110 percent of line 56) or (2) 10 percent of line 56; otherwise enter zero. *See 42 CFR 413.40(d)(3).*

Line 59--For cost reporting periods beginning prior to October 1, 1997, enter the sum of lines 52 and 58 plus the lesser of line 53 or line 56. For cost reporting periods beginning on or after October 1, 1997, if line 57 is a positive amount, enter the sum of lines 52, 53, 58 and 58.03 (if applicable). If line 57 is a negative amount enter the sum of lines 52, 56, and 58.04. If line 57 is zero, enter the sum of lines 52 and 56. New providers enter the lesser of lines 53 or 56 plus line 52. TEFRA providers (42 CFR §413.40(j)), except cancer and children's hospitals, for services rendered on and after October 1, 1997 and on or before September 30, 2002, are required to reduce capital to 85 percent of reported costs. To recalculate line 52, for cost reporting periods that overlap the October 1, 1997 effective date, multiply the capital pass through costs included on lines 50 and 51 of Worksheet D-1, which are obtained from Worksheet D, Parts I and II, by the ratio of days on and after October 1, 1997, to total days for the period. Multiply that result by 85 percent and add to that 100 percent of the ratio of days prior to October 1, 1997, to total days applied to the capital pass through amount. For cost reporting periods beginning on or after October 1, 1997, multiply the capital amount reported on lines 50 and 51 by 85 percent. Add the result of the 85 percent of capital to the non capital pass through costs included on lines 50 and 51 (10/1/97s). To recalculate line 52, for cost reporting periods that overlap the September 30, 2002 expiration date, multiply the capital pass through costs included on lines 50 and 51 of Worksheet D-1, which are obtained from Worksheet D, Parts I and II, by the ratio of days on and before September 30, 2002, to total days for the period applied to the capital pass through amount. Multiply that result by 85 percent and add to that 100 percent of the ratio of days after September 30, 2002, to total days for the period. For cost reporting periods beginning on or after October 1, 2002, multiply the capital amount reported on lines 50 and 51 by 100 percent. Add the result of the 100 percent of capital to the non capital pass through costs included on lines 50 and 51 as the capital reduction is no longer applicable (9/30/02s).

Lines 59.01 through 59.08--Lines 59.01 through 59.08 will be completed for long-term care providers with cost reporting periods beginning on or after October 1, 2002 and before October 1, 2006, that have not elected to be reimbursed at 100 percent of the Federal rate.

Line 59.01--Enter the allowable inpatient cost per discharge, computed as line 59 divided by line 54.

Line 59.02--Enter the number of program discharges occurring from the beginning of the cost reporting period through June 30. For full year cost reporting periods ending June 30, this amount will agree with the discharges entered on line 54.

Line 59.03--Enter the number of program discharges occurring from July 1 through the end of the cost reporting period.

NOTE: Subscripted line 59.04 and 59.07 will be required for cost reporting periods greater than 12 months that overlap two July 1 dates.

Line 59.05 through 59.07--Compute the reduced inpatient cost per discharge for each period by applying the appropriate budget neutrality factor to the allowable inpatient cost per discharge reported on line 59.01. Budget neutrality factors have been identified in the Federal Register dated August 30, 2002, page 56034; June 6, 2003, page 34153; May 7, 2004, page 25703; *May 6, 2005, page 24202; May 12, 2006, page 27841; and May 11, 2007, page 26900* and are reflected as follows:

- 93.40 percent for discharges occurring from 10/1/2002 through 6/30/2003.
- 94.00 percent for discharges occurring from 7/1/2003 through 6/30/2004.
- 99.50 percent for discharges occurring from 7/1/2004 through 6/30/2005.
- 1.000 (a 0.0 percent reduction) for discharges occurring from 7/1/2005 through 6/30/2006.
- 1.000 (a 0.0 percent reduction) for discharges occurring from 7/1/2006 through 6/30/2007.
- *The budget neutrality factor is not computed for discharges occurring on or after 7/1/2007.*

Line 59.08--Enter the sum lines 59.02 times 59.05, 59.03 times 59.06, and 59.04 times 59.07 (if applicable). Transfer this amount to Worksheet E-3, Part I, line 1 for long-term care hospital providers with cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, that have not elected to be reimbursed at 100 percent of the Federal rate.

Line 60--Enter the amount of Medicare swing bed-SNF type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-SNF type inpatient days on line 10 by the rate used on line 17. For CAH multiply line 10 times the per diem calculated on line 38 (12/21/00b).

Line 61--Enter the amount of Medicare swing bed-SNF type inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-SNF type inpatient days on line 11 by the rate used on line 18. For CAH multiply line 11 times the per diem calculated on line 38 (12/21/00b).

Line 62--Enter the sum of lines 60 and 61. Transfer this amount to the appropriate Worksheet E-2, column 1, line 1 for cost reporting periods beginning prior to July 1, 2002. However, CAHs continue to transfer this amount to worksheet E-2.

Line 63--Enter the amount of titles V or XIX swing bed-NF type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-NF type inpatient days on line 12 by the rate used on line 19.

Line 64--Enter the amount of titles V or XIX swing bed-NF type inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-NF type inpatient days on line 13 by the rate used on line 20.

Line 65--Enter the sum of lines 63 and 64. Transfer this amount to the appropriate Worksheet E-2, column 1, line 2. If your state recognizes only one level of care obtain the amount from line 62.