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 *1.02* 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.*

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.

Line 3--Line 1 minus line 2.

Line 4--Enter 80 percent of line 3 in column 1. For column 1.01 do not complete this line.

Line 5--This amount is the ASC portion of the blended amount. The ASC portion of the blended amount is 58 percent of the amount on line 4 of column 1 and line 1 of column 1.01.

Line 6--Enter the amount of the outpatient ASC cost from Worksheet D, Part V, columns 6 and 6.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

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 for the same services for outpatient ambulatory surgical procedures only if that amount is lower than the blended ASC amount. 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).

If you bill an all-inclusive rate or bill gross departmental charges and reflect a discount on the bill, you must, when billing Medicare, show gross departmental charges for each service on the bill. Identify the difference between the sum of these gross charges and the net amount you wish to collect. Also maintain a memorandum record when you bill an all-inclusive charge to non-Medicare patients. Always use the gross departmental charges for cost apportionment purposes. Show the discount amount in the customary charge computations, as appropriate.

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

Line 7--Enter the total charges which relate to reasonable cost on line 6 from Worksheet D, Part V, columns 2 and 2.01 (if applicable), line 104, in columns 1 (if applicable) and 1.01 respectively.

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 7. Submit a schedule showing these computations with the cost report.

Lines 8 through 11--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 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. 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 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of the customary charges over the reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 13--Enter the excess of reasonable cost over the customary charges. If line 6 exceeds line 11, enter the difference.

Line 14--Enter the lesser of the reasonable cost on line 6 or the customary charges on line 11.

NOTE: If these services are exempt from LCC, enter the reasonable cost from line 6.

Line 15--Enter in column 1 the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries for outpatient ambulatory surgical procedures. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for the service or procedure, coinsurance entered on this line reflects coinsurance based on 20 percent of full charges, not discounted charges. Make no entry for column 1.01.

NOTE: If these services are exempt from LCC, enter the Part B deductibles from line 2. Exclude Part B coinsurance.

Line 16--Subtract line 15 from line 14 for column 1 and enter the amount on line 14 for column 1.01.

NOTE: If these services are exempt from LCC, subtract the deductibles reported on line 15 from line 14, and multiply the result by 80 percent for column 1 only.

Line 17--Enter 42 percent of line 16.

Line 18--Enter the sum of lines 5 and 17.

Line 19--Enter the lesser of lines 16 or 18 in columns 1 and 1.01.

Line 20--Enter the Part B deductibles and coinsurance in column 1.01 only.

Line 21--In column 1, enter the amount reported on line 19. In column 1.01, subtract line 20 from line 19. If these services are exempt from LCC, subtract the deductibles reported on line 20 from line 19, and multiply the result by 80 percent. Transfer the sum of columns 1 and 1.01 for title XVIII to Worksheet E, Part B, line 20; titles V and XIX to Worksheet E-3, Part III, column 1, line 37.

3630.4 Part D - Outpatient Radiology Services.--Use this worksheet to calculate reimbursement settlement for outpatient radiology services for the hospital and/or subprovider for titles V, XVIII, and XIX, for services rendered prior to August 1, 2000; otherwise do not complete this form.

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)(2)(E) and 1833(n) of the Act, a payment methodology is imposed for radiology services performed on an outpatient basis by hospitals. Aggregate payment for radiology services performed in a hospital on an outpatient basis is based on the lower of (1) the hospital's reasonable cost or customary charges (in the aggregate) net of cost sharing, or (2) a blend of the hospital's outpatient radiology costs or its charges (whichever are less) net of (a) deductibles and coinsurance and (b) 62 percent of the physicians' fee schedule net of cost sharing as if the services were performed in a physician's office in the same locality. The blend consists of 42 percent hospital-specific cost and 58 percent fee schedule. For cost reporting periods that end on or after October 1, 1997, and on or 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.