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

period. (See 42 CFR 413.86(e)(4).)

This worksheet consists of five sections:

1. Computation of Total Direct GME Amount
2. Computation of Program Patient Load
3. Direct Medical Education Costs for ESRD Composite Rate - Title XVIII only
4. Apportionment of Medicare Reasonable Cost (title XVIII only)
5. Allocation of Medicare Direct GME Costs Between Part A and Part B

Computation of Total Direct GME Amount.--This section computes the total approved amount.

Line Descriptions

Lines 1 and 1.01--Enter the total number of FTE residents. Compute this amount in accordance with 42 CFR 413.86(f), (g), and (h).

NOTE: If this is a short period cost report, FTEs are prorated by the ratio of the number of days in the cost reporting period to the number of days in the calendar year.

Lines 2 and 2.01--Enter the updated per resident amount obtained from the intermediary in conformance with the subscripting on line 1.

In accordance with 42 CFR 413.86(e), if this is the first cost reporting period in which residents were on duty during the first month of the cost reporting period, enter the per resident amount based on the lower of:

- The sum of Worksheet B, Part I, columns 22 and 23, line 103 divided by the number of FTEs reported on line 1; or

- The weighted mean value of per resident amounts of hospitals located in the same geographic wage area for cost reporting periods beginning in the same fiscal year. Obtain this amount from your fiscal intermediary.

Line 3--Multiply the number of FTE residents on lines 1 and 1.01 by the updated amount on lines 2 and 2.01, and enter the result in the aggregate on line 3. Round to the whole number during each phase of this computation.

FTE residents subject to the cap for cost reporting periods beginning on or after October 1, 1997:

Line 3.01--Enter the unweighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. If this cost report is less than a full 12 months, contact your intermediary.(42 CFR 413.86(g)(4). Also include here the 30 percent increase to the count for qualified rural hospitals (42 CFR 413.86(g)(4)(i)), and the increase due to primary care residents that were on approved leaves of absence (42 CFR 413.86(g)(9).(4/01) Effective for cost reporting periods beginning on or after October 1, 2001, temporarily reduce the FTE count of a hospital that closed a program(s), if the regulations at 42 CFR 413.86(g)(9)(iii)(B) are applicable.

Line 3.02--Enter the unweighted resident FTE count for allopathic and osteopathic programs which meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.86(g)(6). For hospitals qualifying for a cap adjustment under 42 CFR 413.86(g)(6)(i), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995. For hospitals qualifying for a cap adjustment under 42 CFR 413.86(g)(6)(ii), the cap for each new program accredited or begun on or after January 1, 1995 and

before August 6, 1997, is effective in the fourth program year of each of those new programs (see 66 FR August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 3.01. Also enter the unweighted allopathic or osteopathic FTE count for residents in all years of the rural track program that meet the criteria for an add-on to the cap under 42 CFR 413.79(j). If the rural track program is a new program under 42 CFR 413.79(l) and qualifies for a cap adjustment under 413.79(e)(1) or (e)(3), do not report FTE residents in the rural track program on this line until the fourth program year of the rural track program. Report these FTEs on line 3.16 or line 3.22 (04/01). Also include here any temporary adjustment to the cap due to a hospital closing effective for cost reporting periods beginning before October 1, 2001.

Line 3.03--Enter the adjustment (increase or decrease) for the unweighted resident FTE count for allopathic or osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), and (63 FR 26 336 May 12, 1998).

Line 3.04--Enter the sum of lines 3.01 through 3.03, which is the FTE adjusted cap. For cost reporting periods ending on of after July 1, 2005, if worksheet S-2, line 25.05, column 1 is "N", enter the sum of lines 3.01 through 3.03. If this hospital's FTE cap is reduced under 42 CFR §413.79(c)(3) due to unused resident slots, (Worksheet S-2, line 25.05, column 1 is "Y"), effective for cost reporting periods ending on or after July 1, 2005, enter the sum of line 3.03 and line 4 from Worksheet E-3, Part VI.

Line 3.05--Enter the unweighted resident FTE count for allopathic or osteopathic programs for the current year from your records, other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules. (42 CFR 413.79(d) and/or (e).

Line 3.06--Enter the lesser of lines 3.04 or 3.05.

Line 3.07--Enter the weighted FTE count for primary care physicians and OB/GYN residents in an allopathic or osteopathic program for the current year other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero. (42 CFR 413.79(d) and/or (e)).

Line 3.08--Enter the weighted FTE count for all other physicians in an allopathic or osteopathic program for the current year other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero. (42 CFR 413.79(d) and/or (e) (10/97)).

Line 3.09--Enter the sum of lines 3.07 and 3.08.

Line 3.10--For cost reporting periods beginning prior to October 1, 2001, if line 3.05 is less than or equal to line 3.04, enter the amount from line 3.09, otherwise multiply line 3.09 by (3.04/line 3.05). (10/97) For cost reporting periods beginning on or after October 1, 2001, if line 3.05 is less than or equal to line 3.04, enter the amount from line 3.09, otherwise multiply line 3.07 by (line 3.04/line 3.05) and multiply line 3.08 by (line 3.04/line 3.05) and add the results. (42 CFR 413.79(c)(2)(iii)).

Line 3.11--Enter the weighted dental and podiatric resident FTE count for the current year. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero (10/97).

Line 3.12--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.10 and 3.11 for column 1 or column 0, if applicable. For cost reporting periods beginning on or after October 1, 2001, if the amount from line 3.09 is reported on line 3.10 enter the sum of lines 3.11 and 3.08. Otherwise, enter the sum of line 3.11 and (3.08 times (line 3.04/line 3.05)).

Line 3.13--For cost reporting periods beginning prior to October 1, 2001, enter the total weighted FTE resident count for the prior cost reporting year (if subject to the cap in the prior year, report the sum of lines 3.10 and 3.11 of the prior year), other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules. If a zero is entered on this line, enter in column zero a 1 if the hospital did not report FTEs this period, but did have an approved program. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE count for nonprimary care residents for the prior year (if subject to the cap in the prior year, report the result of line 3.08 times (line 3.04/line 3.05) plus line 3.11, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific nonprimary program included in line 3.16 of the prior year's cost report.

Line 3.14--For cost reporting periods beginning on or after October 1, 1998, but prior to October 1, 2001, enter the total weighted FTE resident count for the cost reporting year before last (if subject to the cap in the year before last, report the sum of lines 3.10 and 3.11of the year before last) other than those in the initial years of the program that meet the exception to the averaging rules. If zero is entered on this line, enter in column zero a 1 if the hospital did not report FTEs but did have an approved program. For cost reporting periods beginning on or after October 1, 2001, enter the total weighted FTE resident count for nonprimary care residents for the cost reporting year before last (if subject to the cap in the year before last, report the result of line 3.08 times (line 3.04/line 3.05) plus line 3.11 other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific nonprimary program from line 3.16 of the penultimate year's cost report.

Line 3.15--For cost reporting periods ending prior to June 30, 2006, enter the rolling average FTE count by adding lines 3.12 through 3.14 and divide by the number of lines greater than zero (see 42 CFR 413.79(d)(5)) unless column zero is completed for any of these lines. For cost reporting periods ending on or after June 30, 2006, enter the rolling average FTE count by adding lines 3.12 through 3.14 and divide by 3.

Line 3.16--For cost reporting periods beginning prior to October 1, 2001, enter the weighted number of FTE residents in the initial years of a primary care and OB/GYN program that meets the exception to the rolling average rules. For cost reporting periods beginning on or after October 1, 2001, enter the sum of line 3.15 and the weighted number of nonprimary care FTE residents in the initial years of new allopathic and osteopathic programs (42 CFR 413.79(d)(5) and/or 413.79(e). Effective for cost reporting periods beginning on or after October 1, 2001, also add the temporary weighted adjustments for nonprimary care FTE residents that were displaced by program or hospital closure. (42 CFR 413.79(h)).

For cost reporting periods ending on or after June 30, 2006, enter in column zero the weighted number of nonprimary care FTE residents in the initial years of new allopathic and osteopathic programs (42 CFR 413.79(d)(5) and/or 413.79(e)) and add the temporary weighted adjustments for nonprimary care FTE residents that were displaced by program or hospital closure. Enter in column 1 the sum of lines 3.15 and the number reported in column zero of this line.

Line 3.17--For cost reporting periods beginning prior to October 1, 2001, enter the weighted number of FTE residents in the initial years of all other programs that meet the rolling average exception criteria in 42 CFR 413.79(d). For cost reporting periods beginning on or after October 1, 2001 enter the nonprimary care per resident amount.

Line 3.18--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.15 through 3.17. For cost reporting periods beginning on or after October 1, 2001, enter the result of multiplying lines 3.16 times line 3.17.

Line 3.19--For cost reporting periods beginning prior to October 1, 2001, enter the primary care and OB/GYN physician per resident amount. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE resident count for primary care and OB/GYN residents for the prior year cost report (if subject to the cap in the prior year, report the result of line 3.07 times (line 3.04/line 3.05)) other than those in the initial years of the program that meet the criteria for an exception to the averaging rules 42 CFR 413.79(d)(5). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific primary program included in line 3.22 of the prior year's cost report.

Line 3.20--For cost reporting periods beginning prior to October 1, 2001, enter the all other program per resident amount. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE resident count for primary care and OB/GYN residents in the cost reporting year before last (if subject to the cap in the year before last, report the product of line 3.07 times (line 3.04/line 3.05) from the year before last), other than those in the initial years of the program that meet the criteria for the rolling average exception. 42 CFR 413.79(d)(5). However, if the period of years during which the FTE residents in any year of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific primary program included in line 3.22 of the penultimate year's cost report.

For cost reporting periods beginning prior to October 1, 2001, in order to generate a weighted payment amount for lines 3.21 and 3.22, if lines 3.07 and/or 3.08 of column 1 are zero substitute the count for lines 3.07 and/or 3.08 for the current period with the counts entered in column zero for those lines. (10/01) For cost reporting periods beginning on or after October 1, 2001 this instruction no longer applies (10/01).

Line 3.21--For cost reporting periods beginning prior to October 1, 2001, enter the primary care unadjusted approved amount by multiplying the sum of lines 3.07 and 3.16 by line 3.19. For cost reporting periods beginning on or after October 1, 2001, if the amount from line 3.09 was reported on line 3.10, enter the rolling average primary care and OB/GYN count by adding the sum of (lines 3.07, 3.19 and 3.20)/3), otherwise, calculate the rolling average for primary care and OB/GYN FTE count as follows (line 3.07 times (line 3.04/line 3.05)), plus line 3.19, and 3.20) and divide the result by 3.

Line 3.22--For cost reporting periods beginning prior to October 1, 2001, enter the other unadjusted approved amount by multiplying line 3.20 by the sum of lines 3.08, 3.11, and 3.17. For cost reporting periods beginning on or after October 1, 2001 enter the sum of line 3.21 and the weighted number of primary care and OB/GYN FTE residents in the initial years of new allopathic and osteopathic programs 42 CFR 413.79(d)(5) and/or 413.79(e). Effective for cost reporting periods beginning on or after October 1, 2001, also add any temporary weighted adjustments for primary care and OB/GYN FTE residents that were displaced by program or hospital closure. 42 CFR 413.79(h).

For cost reporting periods ending on or after June 30, 2006, enter in column zero the weighted number of primary care OB/GYN FTE residents in the initial years of new allopathic and osteopathic programs (42 CFR 413.79(d)(5) and/or 413.79(e)) and add the temporary weighted adjustments for primary care and OB/GYN FTE residents that were displaced by program or hospital closure. Enter in column 1 the sum of lines 3.21 and the number reported in column zero of this line.

Line 3.23--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.21 and 3.22. For cost reporting periods beginning on or after October 1, 2001 enter the primary care and OB/GYN per resident amount.

Line 3.24--For cost reporting periods beginning prior to October 1, 2001, divide line 3.23 by the sum of lines 3.07, 3.08, 3.11, 3.16, and 3.17. For cost reporting periods beginning on or after October 1, 2001 multiply line 3.23 by 3.22 and enter the result.

Line 3.25--For cost reporting periods beginning prior to October 1, 2001, enter the total approved amount for resident costs, line 3.24 times line 3.18. For cost reporting periods beginning on or after October 1, 2001 enter the sum of lines 3.18 and 3.24.

Computation of Program Patient Load - Non Managed Care.--This section computes the ratio of program inpatient days to the total inpatient days. For this calculation, total inpatient days include inpatient days of the hospital along with its subproviders, including distinct part units excluded from the prospective payment system. Record hospital inpatient days of Medicare beneficiaries whose stays are paid by risk basis HMOs and organ acquisition days as non-Medicare days. Do not count inpatient days applicable to nursery, hospital-based SNFs and other nursing facilities, and other non-hospital level of care units for the purpose of determining the Medicare patient load.

Line Descriptions

Line 4--For title XVIII, enter the sum of the days reported on Worksheet S-3, Part I, column 4, lines 1, 6 through 10, and 14. For titles V or XIX, enter the amounts from columns 3 or 5, respectively, sum of lines 1, 6 through 10, and 14.

Line 5--Enter the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 6 through 10, and 14 and subscripts as applicable.

Line 6--Divide line 4 by line 5 and enter the result (expressed as a decimal).

Lines 6.01 through 6.08 are completed for cost reports that end on or after January 1, 1998.

Line 6.01--Enter the total GME payment for non-managed care days. For 12 month cost reporting periods which end between January 1, 1998 and September 29, 1998, multiply line 6 times line 3. Otherwise multiply line 6 times line 3.25. (Including a short period cost report which begins on or after October 1, 1997 and ends prior to January 1, 1998.) For cost reporting periods that end on or after July 1, 2005, multiply line 6 times line 3.25 and to this amount, add the hospital's section 422 direct GME payment for non-managed care, from line 11 from Worksheet E-3, Part VI.

Computation of Program Patient Load - Managed Care Days.--Effective January 1, 1998, hospitals will report managed care days to allow for a Medicare plus Choice direct GME payment 42 CFR 413.76(c).

Line 6.02--Enter Medicare managed care days occurring on or after January 1 of this cost reporting period. These days are included in the days reported on Worksheet S-3, Part I, column 4, line 2. The balance of the days prior to January 1 are entered on line 6.06. (4/30/03) Effective for cost reporting periods ending on after June 30, 2006, enter all Medicare managed care days on line 6.02.

Line 6.03--Enter total inpatient days from line 5 above.

Line 6.04--Enter the appropriate percentage for inclusion of the managed care days, beginning January 1 of each year, i.e. 20 percent for 1998, 40 percent for 1999, 60 percent for 2000, 80 percent for 2001, and 100 percent for 2002 and after.

Line 6.05--Calculate the Graduate Medical Education payment for managed care days on or after January 1 through the end of the cost reporting period, {(line 6.02/line 6.03) times (line 6.04)} times line 3, for cost reporting periods beginning before October 1, 1997, otherwise times line 3.25. For services rendered on or after January 1, 2000, and before January 1, 2001, reduce the amount by the factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. Future updates will be published by CMS for services rendered on and after January 1, 2001.

Line 6.06--Enter the Medicare managed care days occurring before January 1 of this cost reporting period. Make no entry prior to January 1, 1998. This line equals Worksheet S-3, Part I, column 4, line 2 minus line 6.02 above. Do not complete this line for cost reporting periods ending on or after June 30, 2006.

Line 6.07--Enter the percentage using the criteria identified on line 6.04 above. For years prior to January 1, 2003, the percentage is always 20 percent less than the amount reported on line 6.04.

Line 6.08--Calculate the Graduate Medical Education payment for managed care days prior to January 1 of this cost reporting period: {(line 6.06/line 6.03) times line 6.07) times line 3.25}. For services rendered on or after January 1, 2000, and prior to January 1, 2001, reduce the amount by the factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. For services on or after January 1, 2001, updates will be published by CMS. After reducing this amount by the Nursing and Allied Health Medicare Advantage (formerly Medicare + Choice) factor, for fiscal years ending on or after July 1, 2005, add to this amount the hospital's section 422 direct GME payment for managed care, if applicable, from line 12 of W/S E-3, Part VI. For cost reporting periods ending on or after June 30, 2006, this line will only reflect the hospital's section 422 direct GME payment for managed care, if applicable, from line 12 of W/S E-3, Part VI.

Direct Medical Education Costs for ESRD Composite Rate Title XVIII Only.--This section computes the title XVIII nursing school and paramedical education costs applicable to the ESRD composite rate. These costs are reimbursable based on the reasonable cost principles under 42 CFR 413.85 separate from the ESRD composite rate.

Line Descriptions

Line 7--Enter the amount from Worksheet B, Part I, sum of columns 21 and 24, lines 57 and 64.

Line 8--Enter the amount from Worksheet C, Part I, column 8, sum of lines 57 and 64. This amount represents the total charges for renal and home dialysis.

Line 9--Divide line 7 by line 8, and enter the result. This amount represents the ratio of ESRD direct medical education costs to total ESRD charges.

Line 10--Enter from your records the Medicare outpatient ESRD charges.

Line 11--Enter the result of multiplying line 9 by line 10. This represents the Medicare outpatient ESRD costs. Transfer this amount to Worksheet E, Part B, line 22.

Apportionment of Medicare Reasonable Cost of GME.--This section determines the ratio of Medicare reasonable costs applicable to Part A and Part B. The allowable costs of GME on which the per resident amounts are established include GME costs attributable to the entire hospital complex (including non-hospital portions of a health care complex). Therefore, the reasonable costs used in the apportionment between Part A and Part B include the hospital, hospital-based providers, and distinct part units. Do not complete this section for titles V and XIX.

Line Descriptions

Line 12--Include the Part A reasonable cost for the entire hospital complex computed by adding the following amounts:

- Hospital and Subprovider(s) - Sum of each Worksheet D-1, line 49;
- Hospital-Based HHAs - Worksheet H-7, Part I, column 1, line 1;
- Swing Bed-SNF - Worksheet D-1, line 62 (for cost reporting periods beginning prior to July 1, 2002) swing Bed-SNF - Worksheet E-2, line 1, column 1 (for cost reporting periods beginning on or after July 1, 2002);
- Hospital-Based Non-PPS SNF - Worksheet D-1, line 82; and
- Hospital-Based PPS SNF - Sum of Worksheet D-1, line 70 and Worksheet E-3, Part III, column 2, line 6.

Line 13--Enter the organ acquisition costs from Worksheet(s) D-6, Part III, column 1, line 61.

Line 14--Enter the cost of teaching physicians from Worksheet(s) D-9, Part II, column 3, line 16.

Line 15--Enter the total Medicare Part A primary payer amounts for the hospital complex from the applicable worksheets.

- PPS hospital and/or subproviders - Worksheet E, Part A, line 17;
- TEFRA hospital and/or subproviders - Worksheet E-3, Part I, line 5;
- Cost reimbursed hospital and/or subproviders and Non-PPS SNFs - Worksheet E-3, Part II, line 5;
- Hospital-based HHAs - Each Worksheet H-7, Part I, column 1, line 9;
- Swing Bed SNF and/or NF - Worksheet E-2, column 1, line 9; and
- Hospital-based PPS SNF - Worksheet E-3, Part III, column 2, line 7.

Line 16--Enter the sum of lines 12 through 14 minus line 15.

Line 17--Enter the Part B Medicare reasonable cost. Enter the sum of the amounts on each title XVIII Worksheet E, Part B, columns 1 and 1.01,sum of lines 1,1.01, 1.07, 2 through 4; Worksheet E, Parts C, D, and E, columns 1 and 1.01 line 6; Worksheet E-2, column 2, line 8; Worksheet H-7, Part I, sum of columns 2 and 3, line 1; Worksheet J-3, columns 1 and 1.01 if applicable, lines 1 and 1.01, and Worksheet M-3, line 16.

Line 18--Enter the Part B primary payer amounts. Enter the sum of the amounts on each Worksheet E, Part B, line 24; Worksheet E-2, column 2, line 9; Worksheet H-7, Part I, sum of columns 2 and 3, line 9; and Worksheet J-3, line 2, columns 1 and 1.01 if applicable.

Line 19--Enter line 17 minus line 18

Line 20--Enter the sum of lines 16 and 19.

Line 21--Divide line 16 by line 20, and enter the result.

Line 22--Divide line 19 by line 20, and enter the result.

Allocation of Medicare Direct GME Costs Between Part A and Part B.--Use this section to compute the GME payments for title XVIII, Part A and Part B, and to compute the total GME payments applicable to titles V and XIX.

Line Descriptions

Line 23--For cost reporting periods ending prior to January 1, 1998, multiply line 3 by line 6, and enter the result. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, line 54. Do not compute lines 24 and 25.

Line 23.01--For cost reporting periods that end on or after January 1, 1998, enter the sum of lines 6.01, 6.05, and 6.08. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, line 54. Do not compute lines 24 and 25.

Line 24--Complete for title XVIII only. Multiply line 23 or 23.01 by line 21, and enter the result. If you are a hospital subject to PPS, transfer this amount to Worksheet E, Part A, line 11. Although this amount includes the Part A GME payments for subproviders, for ease of computation, transfer this amount to the primary hospital component worksheet only. If you are freestanding facility subject to TEFRA, an LTCH PPS, IPF PPS, or IRF PPS, transfer this amount to Worksheet E-3, Part I, line 13. If you are subject to cost reimbursement, i.e., CAH, transfer this amount to Worksheet E-3, Part II, line 18.

Line 25--Complete for title XVIII only. Multiply line 23 or 23.01 by line 22, and enter the result. Transfer this amount to Worksheet E, Part B, line 21. Although this amount includes the Part B GME payments for subproviders, for ease of computation, transfer this amount to the hospital component only.

3633.5 Part V - Calculation of NHCMQ Demonstration Reimbursement Settlement for Medicare Part A Services.--Use this part to calculate reimbursement if you are a part of the NHCMQ demonstration project for cost reporting periods beginning before July 1, 1998.

Part A - Inpatient Services: Provider Computation of Reimbursement.--Use this part to calculate payment for title XVIII services furnished by NHCMQ Demonstration participants. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ Demonstration.

Line Descriptions

Line 1--Enter the number of total title XVIII inpatient days. Obtain this figure from Worksheet S-3, Part I, column 4, line 15.