

4034. WORKSHEET E-4 - DIRECT GRADUATE MEDICAL EDUCATION (GME) 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 GME costs as determined under 42 CFR 413.75 through 413.83. This worksheet applies to the direct GME cost applicable to interns and residents in approved teaching programs in hospitals, hospitals with excluded units, and CAH-based excluded units. Do not complete this worksheet for interns and residents training in the general acute care part of a CAH; those CAH costs are reimbursed on a reasonable cost basis on Worksheet E-3, Part V. The direct medical education costs of the nursing programs and paramedical education programs continue to be paid on a reasonable cost basis as determined under 42 CFR 413.85. However, the nursing program 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 GME 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. This worksheet will also calculate payment for direct GME as determined under 42 CFR 413.79(c)(3) and (4) and IME as determined under 42 CFR 412.105(f)(1)(iv)(B) and (C) for hospitals that received an adjustment (reduction or increase) to their FTE resident caps for direct GME and/or IME under section 422 of Public Law 108-173.

**NOTE:** For cost reporting periods beginning prior to December 27, 2020, do not complete this worksheet for a cost reporting period prior to the base period used for calculating the per resident amount (PRA) in situations where the hospital did not train residents in approved residency training programs or did not participate in the Medicare program during the base period but either condition changed in a cost reporting period beginning on or after July 1, 1985. 42 CFR 413.77(e)(1) specified that in this situation, any GME costs for the cost reporting period prior to the base period are reimbursed on a reasonable cost basis.

For cost reporting periods beginning prior to December 27, 2020, 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 413.77(e)(1).) For cost reporting periods beginning on or after December 27, 2020, this exception at 42 CFR 413.77(e)(1) for reasonable cost payment for direct GME no longer applies. Complete Worksheet E-4 in accordance with 42 CFR 413.78(b)(2) if the answer to Worksheet S-2, Part I, line 56, column 1, is "Y".

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.

For IPPS hospitals participating in the PARHM demonstration during this cost reporting period and (1) the hospital participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete this worksheet; or (2) the hospital participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet E-4 for the portion of the cost reporting period included in the demonstration. Select the "Hospital" box and complete a separate Worksheet E-4, for the portion of the cost reporting period not included in the demonstration.

Line Descriptions

Line 1--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 contractor. (42 CFR 413.79(c)(2)) Also include here the 30 percent increase to the count for qualified rural hospitals (42 CFR 413.79(c)(2)(i)), and the increase due to primary care residents that were on approved leaves of absence (42 CFR 413.79(i)). Temporarily reduce the cap of a hospital that closed a program(s), if the regulations at 42 CFR 413.79(h)(3)(ii) are applicable. (Effective October 1, 2001.)

Line 1.01--Enter the FTE cap adjustment if your hospital qualifies under section 131 of the CAA 2021 for a reset to your FTE cap, and this cost report is after the cap-building window has closed for the qualifying new program(s). During the new program cap-building window, report the FTEs on line 15. See 86 FR 73418 (December 27, 2021).

Line 2--Enter the unweighted resident FTE count for allopathic and osteopathic programs that meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1) or (e)(3), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995, but before October 1, 2012. For urban hospitals that participate in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), the cap is effective beginning with the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)). For rural hospitals that participate in training residents in a new program on or after October 1, 2012 under 42 CFR 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on each new program. Therefore, the rural hospital's FTE resident cap is adjusted for each new program effective with the hospital's cost reporting period that coincides with or follows the start of the sixth program year of each new program started (see 79 FR 50110 (August 22, 2014)). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited or begun on or after January 1, 1995, and before August 6, 1997, is reported on this line and 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 1. Do not report new program FTEs during the time frame prior to the effective date of the hospital's FTE cap on this line. New program FTEs during the time frame prior to the effective date of the hospital's FTE cap are reported on line 15.

**RURAL TRACK PROGRAMS IN EFFECT PRIOR TO §127 OF THE CAA 2021:** For urban hospitals that already have an FTE cap on line 1 but start a rural track program in accordance with 42 CFR 413.75(k), 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(k). (If the rural track program is a new program under 42 CFR 413.79(l) and the hospital qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (e)(3), do not report FTE residents in the rural track program on this line during the time frame prior to the effective date of the hospital's FTE cap). Only enter rural track cap adjustments in effect in a cost reporting period beginning prior to October 1, 2022.

Line 2.26--**RURAL TRACK PROGRAMS IN EFFECT UNDER §127 OF THE CAA 2021:** For rural track program FTE cap limitation adjustments effective for cost reporting periods beginning on or after October 1, 2022, for both urban and rural hospitals that participate in a rural track program (defined at 42 CFR 413.75(b), under section 127 of the CAA 2021, enter the rural track program FTE cap limitation adjustment after the cap-building window has closed for the particular

rural track program (see 86 FR 73418 (December 27, 2021)). During the cap-building window, report the FTEs on line 15. Further subscript this line through line 2.49 for each additional rural track program FTE limitation at either the urban hospital or rural hospital.

Line 3--Enter the section 422 reduction amount to the direct GME cap as specified under 42 CFR 413.79(c)(3).

Line 3.01--Enter the section 5503 reduction amount to the direct GME cap as specified under 42 CFR 413.79(m). If this cost report straddles July 1, 2011, then calculate the prorated section 5503 reduction amount off the cost report and enter the result on this line. (Prorate the cap reduction amount by multiplying it by the ratio of the number of days from July 1, 2011, to the end of the cost reporting period to the total number of days in the cost reporting period). Otherwise enter the full cap reduction amount.

Line 3.02--Enter the adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) from line 2 for rural track programs with a rural track Medicare GME affiliation agreement, in accordance with 87 FR 49075 (August 10, 2022).

Line 4--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(f), and (63 FR 26336 (May 12, 1998), and 67 FR 50069 (August 1, 2002)). Note: Affiliation adjustments on this line must not include FTEs from rural track programs on lines 2 through 2.49.

Line 4.01--Enter, as applicable, all or a portion of the amount of the FTE cap slots the hospital was awarded under section 5503 of ACA. The amount of the section 5503 award that is reported on this line is the amount of the section 5503 award that is being "used" in this cost reporting period. In the 5-year evaluation period following implementation of section 5503 (that is, July 1, 2011, through June 30, 2016), at least 75 percent of the slots are to be "used" for additional primary care and/or general surgery residents, while 25 percent of the amount that is reported may be (but need not be) "used" for other purposes. During the 5-year evaluation period, failure to meet the requirements at 42 CFR 413.79(n)(2) of the regulations means loss of a hospital's section 5503 slots. Therefore, for portions of cost reporting periods occurring during the 5-year evaluation period (July 1, 2011, and before July 1, 2016), do not automatically report the full amount of the section 5503 slots; only enter the amount of the section 5503 award that equates to at least 75 percent of the FTEs being "used" for additional primary care and/or general surgery FTEs, and no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting period. For portions of cost reporting periods occurring during the 5-year evaluation period (July 1, 2011, and before July 1, 2016), if the amount reported on Worksheet S-2, Part I, line 61.02, column 3, is less than the amount on line 61.01, column 3, then report zero on this line.

Line 4.02--Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. Further subscript this line (lines 4.03 through 4.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to determine the effective date of the cap increase. If the section 5506 award is phased in over more than one effective date, only report the portions of the section 5506 award as they become effective. If the effective date of the cap increase is not the same as your fiscal year beginning date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period.)

Line 4.21--Enter the amount of increase if the hospital was awarded FTE cap slots under section 126 of the CAA 2021, effective beginning July 1, 2023. If this cost report straddles July 1, calculate a prorated cap increase by multiplying the increase by the ratio of the number of days

from July 1, to the end of the cost reporting period, to the total number of days in the cost reporting period. Subscript this line (line 4.22 through 4.27) if the hospital receives FTE cap slot awards on more than one occasion under section 126 of the CAA 2021, effective July 1 of a year.

Line 5--Enter the result of line 1 plus line 1.01 plus line 2, plus lines 2.26 through 2.49, minus line 3, minus line 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27. However, if the resulting cap is less than zero, enter zero on this line.

Line 6--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 (i.e., the program has not yet completed one cycle of the program (the "period of years") or the minimum accredited length of the program). The residents in programs within the "period of years" are exempt from the rolling average rules. (42 CFR 413.79(d)(5) and (e).) Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)).

Line 7--Enter the lesser of lines 5 or 6.

Line 8--Enter in column 1, the weighted FTE count for primary care physicians and OB/GYN residents in an allopathic or osteopathic program for the current year. Enter in column 2, the weighted FTE count for all other physicians in an allopathic or osteopathic program for the current year. Exclude FTE residents in the initial period of years of the new program, which for urban or rural hospitals that began training residents in a new program under 42 CFR 413.79(e)(1) or (e)(3), prior to October 1, 2012, means that the program has not yet completed one cycle of the program (i.e., "period of years,") or minimum accredited length of the program. (42 CFR 413.79(d)(5) and (e)). For new programs started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), do not include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (i.e., the initial years) (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program on or after October 1, 2012, under 42 CFR 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on each new program. Therefore, for rural hospitals, do not include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of each individual new program started (see 79 FR 50110 (August 22, 2014)). For both urban and rural hospitals, report FTE residents in the initial years of the new program and/or the new rural track program on line 15. Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)). Enter in column 3, the sum of columns 1 and 2.

Line 9--For cost reporting periods that begin prior to October 1, 2022, and if Worksheet S-2, Part I, line 68, is "N", if line 6 is less than or equal to line 5, enter the amounts from line 8, columns 1 and 2, in columns 1 and 2, respectively, of this line. Otherwise, multiply the amount in each column of line 8 by (line 5/line 6). Enter in column 3, the sum of columns 1 and 2. (See 42 CFR 413.79(c)(2)(iii).)

For cost reporting periods that begin on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", if the total weighted FTE count from line 8, column 3, is less than or equal to the amount on line 5, then enter the amounts from line 8, columns 1 and 2, in columns 1 and 2, respectively, of this line. Otherwise, if the total weighted FTE count from line 8, column 3, is greater than the FTE cap on line 5, then enter in column 1 the result of line 8, column 1 (primary care & OB/GYN weighted FTEs), divided by line 8, column 3 (total weighted FTEs), times the FTE cap on line 5. Enter in column 2 the result of line 8, column 2 (other weighted FTEs), divided by line 8, column 3 (total weighted FTEs), times the FTE cap on line 5. Enter in column 3 the sum of columns 1 and 2. See 87 FR 49066 (August 10, 2022) and 42 CFR 413.79(c)(2)(iii).

Line 10--Enter in column 2, the weighted dental and podiatric resident FTE count for the current year.

Line 10.01--Enter in column 2, the unweighted dental and podiatric resident FTE count for the current year. This amount is used for informational purposes only and does not impact the calculations on this worksheet.

Line 11--Enter in column 1, the amount from column 1, line 9. Enter in column 2, the sum of the amounts in column 2, lines 9 and 10.

Line 12--For cost reporting periods that begin prior to October 1, 2022, and if Worksheet S-2, Part I, line 68, is "N", enter in column 1, the weighted FTE count for primary care residents for the prior year, 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 has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific primary care (or OB/GYN) program included in Form CMS-2552-96, Worksheet E-3, Part IV, line 3.22, or Form CMS-2552-10, Worksheet E-4, from line 15 of the prior year's cost report. If subject to the cap in the prior year Form CMS-2552-96 cost report, report the result of Worksheet E-3, Part IV, line 3.07, times (line 3.04/line 3.05). If subject to the cap in the prior year Form CMS-2552-10 cost report, report the result of Worksheet E-4, column 1, line 8, times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the prior year, 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 has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific nonprimary care program included in Form CMS-2552-96, Worksheet E-3, Part IV, line 3.16, or Form CMS-2552-10, Worksheet E-4, from line 15 of the prior year's cost report. If subject to the cap in the prior year Form CMS-2552-96 cost report, report the result of Worksheet E-3, Part IV, line 3.08, times (line 3.04/line 3.05), plus line 3.11. If subject to the cap in the prior year Form CMS-2552-10 cost report, report the result of Worksheet E-4, column 2, line 8, times (line 5/line 6), plus line 10.

For cost reporting periods that begin on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", if the prior year total weighted FTE count from line 8, column 3, is less than or equal to line 5 from the prior year, then enter the amount from line 8, column 1, in column 1 of this line; and the sum of lines 8 and 10, column 2, in column 2 of this line. If subject to the cap in the prior year (if the prior year total weighted FTE count from line 8, column 3, is greater than the FTE cap on line 5 from the prior year), then enter in column 1 the result of line 8, column 1 (primary care & OB/GYN weighted FTEs), divided by line 8, column 3 (total weighted FTEs), times the FTE cap on line 5. Enter in column 2 the result of line 8, column 2 (other weighted FTEs), divided by line 8, column 3 (total weighted FTEs), times the FTE cap on line 5, plus the amount on line 10, column 2. See 87 FR 49066 (August 10, 2022). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line, in column 1 or column 2, as applicable, the count of FTE residents in that specific primary care (or OB/GYN) program or non-primary care program included in Form CMS-2552-10, Worksheet E-4, from line 15 of the prior year's cost report.

Line 13--For cost reporting periods that begin prior to October 1, 2022, and if Worksheet S-2, Part I, line 68, is "N", enter in column 1, the weighted FTE count for primary care (or OB/GYN) residents for the cost reporting year before last, 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 has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific primary care (or OB/GYN) program included on

Form CMS-2552-96, line 3.22, or Form CMS-2552-10, from line 15 of that year's cost report. If subject to the cap in the year before last Form CMS-2552-96 cost report, report the result of line 3.07, times (line 3.04/line 3.05). If subject to the cap in that year Form CMS-2552-10 cost report, report the result of column 1, line 8, times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the cost reporting year before last, 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 has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific nonprimary care program included in Form CMS-2552-96, line 3.16, or Form CMS-2552-10, from line 15 of that year's cost report. If subject to the cap in the cost reporting year before last, Form CMS-2552-96 cost report, report the result of line 3.08, times (line 3.04/line 3.05), plus line 3.11. If subject to the cap in that year Form CMS-2552-10 cost report, report the result of column 2, line 8, times (line 5/line 6), plus line 10.

For cost reporting periods that begin on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", if the penultimate year total weighted FTE count from line 8, column 3, is less than or equal to line 5 from the penultimate year, then enter the amount from line 8, column 1, in column 1 of this line; and the sum of lines 8 and 10, column 2, in column 2 of this line. If subject to the cap in the penultimate year, (if the penultimate year total weighted FTE count from line 8, column 3, is greater than the FTE cap on line 5 from the penultimate year) then enter in column 1 the result of line 8, column 1 (primary care & OB/GYN weighted FTEs), divided by line 8, column 3 (total weighted FTEs) times the FTE cap on line 5. Enter in column 2 the result of line 8, column 2 (other weighted FTEs), divided by line 8, column 3 (total weighted FTEs) times the FTE cap on line 5, plus the amount on line 10, column 2. See 87 FR 49066 (August 10, 2022). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line, in column 1 or column 2, as applicable, the count of FTE residents in that specific primary care (or OB/GYN) program or non-primary care program included in Form CMS-2552-10, Worksheet E-4, from line 15 of that year's cost report.

Line 14--Enter the rolling average FTE count in each column, by adding lines 11 through 13, and dividing by 3.

Line 15--Enter the weighted number of FTE residents in the initial years of a program in column 1 for primary care and OB/GYN, and in column 2 for nonprimary care FTEs. For a new program started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012 under 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program(s) on or after October 1, 2012 under 42 CFR 413.79(e)(3), include FTE residents in a particular new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of that new program (see 79 FR 50110 (August 22, 2014)).

For hospitals receiving an adjusted FTE cap for new program(s) under section 131 of the CAA 2021, enter the FTEs on this line prior to the cost reporting period that coincides with or follows the start of the sixth program year of the new program(s) (see 86 FR 73418 (December 27, 2021)).

Effective for cost reporting periods beginning on or after October 1, 2022, for urban and rural hospitals participating in a rural track program(s), enter the FTEs prior to the cost reporting period that coincides with or follows the start of the sixth program year of that rural track program (see 86 FR 73418 (December 27, 2021)).

Line 15.01--Enter the unweighted number of FTE residents in the initial years of a program in column 1 for primary care and OB/GYN, and in column 2 for nonprimary care. Use line 15 instructions to determine the unweighted FTE resident counts for this line. This amount is used for informational purposes only and does not impact the calculations on this worksheet.

Line 16--Enter the temporary weighted FTE residents that were displaced by program or a hospital closure in column 1 for primary care, and in column 2 for nonprimary care, which you would not be able to count without a temporary cap adjustment. (42 CFR 413.79(h).)

Line 16.01--Enter the temporary unweighted FTE residents that were displaced by program or a hospital closure in column 1 for primary care, and in column 2 for nonprimary care, which you would not be able to count without a temporary cap adjustment. (42 CFR 413.79(h).) This amount is used for informational purposes only and does not impact the calculations on this worksheet.

Line 17--Enter the sum of lines 14 through 16.

Line 18--Enter in column 1, the primary care and OB/GYN per resident amount. Enter in column 2, the nonprimary care per resident amount.

Line 18.01--Enter in columns 1 and 2 the same single revised per resident amount received in accordance with section 131 of the CAA 2021.

Line 19--Enter the result of multiplying line 17 by line 18. Enter in column 3, the sum of columns 1 and 2. If this hospital received a PRA in accordance with section 131 of the CAA 2021 on line 18.01, then multiply line 17 by line 18.01 and enter in column 3, the sum of columns 1 and 2.

Line 20--Section 422 Direct GME FTE Cap--Enter the number of unweighted allopathic and osteopathic direct GME FTE resident cap slots the hospital received under 42 CFR §413.79(c)(4).

Line 21--Direct GME FTE Resident Unweighted Count Over/Under the Cap--Subtract line 7 from line 6 and enter the result here. If the result is zero or negative, the hospital does not need to use the direct GME section 422 additional cap and lines 22 through 24 will not be completed.

Line 22--Section 422 Allowable Direct GME FTE Resident Count--For cost reporting periods that begin prior to October 1, 2022, and if Worksheet S-2, Part I, line 68, is "N", if the count on line 21 is less than or equal to the count on line 20, then divide line 8 by line 6, and multiply the resulting ratio by the amount on line 21. If the count on line 21 is greater than the count on line 20, then divide line 8 by line 6, and multiply the resulting ratio by the amount on line 20. For cost reporting periods that begin on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", if the weighted FTE count on line 8 is less than or equal to the adjusted FTE cap on line 5, the hospital entered the weighted FTEs from line 8 on line 9. In this instance, the additional section 422 cap slots are unnecessary; do not complete lines 22 through 24. If the weighted FTE count on line 8 is greater than the adjusted FTE cap on line 5, the hospital entered the adjusted FTE cap on line 9. In this instance, subtract line 9 from line 8. If line 8 minus line 9 equals or exceeds the section 422 DGME FTE cap on line 20, then enter the amount from line 20 on line 22. If line 8 minus line 9 is less than line 20, enter the result line 8 minus line 9 on line 22. See 87 FR 49066 (August 10, 2022).

Line 23--Enter the locality adjusted national average per resident amount as specified at 42 CFR 413.77(g), inflated to the hospital's cost reporting period.

Line 24--Enter the product of lines 22 and 23. This is the allowable section 422 GME cost.

Line 25--Enter the sum of lines 19 and 24. This is the total Part A direct GME cost.

Computation of Program Patient Load--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 PPS. 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.

The BBRA provided that payments that are made to teaching hospitals for costs of direct GME associated with services to MA enrollees will be reduced by an estimated percentage in each CY. Specifically, the law provides that the estimated reductions in MA direct GME payments must equal the estimated total additional MA nursing and allied health education payments. Accordingly, for portions of cost reporting periods occurring in a calendar year, all hospitals that receive MA direct GME payments (including those that do not receive additional nursing and allied health payments under the BIPA provision) will have these payments reduced by the percent reduction in accordance with CR 11642 or subsequent applicable CRs.

Complete lines 26 through 30, columns 2 and 2.01, as applicable. Calendar year providers complete only column 2.

#### Line Descriptions

Line 26--Effective for cost reporting periods beginning prior to October 1, 2013, enter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 8 through 12, 16, and 17, and subscripts as applicable.

Effective for cost reporting periods beginning on or after October 1, 2013, enter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, or column 6.01 (for the PARHM demonstration worksheet), lines 1, 8 through 12, 16, and 17, and subscripts as applicable, and line 32. For title V or XIX, enter the amounts from columns 5 or 7, respectively, sum of lines 1, 8 through 12, 16, and 17, and subscripts, as applicable, plus column 7, line 32, for title XIX.

For title XVIII, if you are a calendar year provider or not impacted by CR 11642, enter in column 2, the Medicare managed care days from Worksheet S-3, Part I, column 6, or column 6.01 (for the PARHM demonstration worksheet), lines 2, 3, and 4. For title XIX, enter in column 2, Medicaid managed care days from Worksheet S-3, Part I, column 7, lines 2, 3, and 4.

If you are impacted by CR 11642 or subsequent CRs, the response to Worksheet S-2, Part I, line 56, column 2, is "Y", for title XVIII, and you are not a calendar year end provider enter in column 2, the portion of the Medicare managed care days reported on Worksheet S-3, Part I, column 6, or column 6.01 (for the PARHM demonstration worksheet), lines 2, 3, and 4, occurring prior to January 1; and enter in column 2.01, the portion of the Medicare managed care days reported on Worksheet S-3, Part I, column 6, or column 6.01 (for the PARHM demonstration worksheet), lines 2, 3, and 4, occurring on or after January 1.

Line 27--Effective for cost reporting periods beginning prior to October 1, 2013, transfer to columns 1, 2, and 2.01, respectively, the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, 16, and 17, and subscripts as applicable.

Effective for cost reporting periods beginning on or after October 1, 2013, transfer to columns 1, 2, and 2.01, the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, 16, 17, and subscripts as applicable, and line 32.



Line 28--In each column, divide line 26 by line 27 and enter the result (expressed as a decimal). Column 1 is the title XVIII Part A inpatient utilization and columns 2 and 2.01 is the Medicare managed care inpatient utilization.

Line 29--Multiply the amount on line 25, column 1, by the amount reported in each column of line 28. Enter in column 3, the sum of columns 1, 2, and 2.01.

Line 29.01--If the response to Worksheet S-2, Part I, line 56, column 2, is "Y", enter in columns 2 and 2.01, the applicable reduction percentage to MA direct GME payments. Enter in column 2, the MA reduction percentage for the portion of the cost reporting period prior to January 1; and enter in column 2.01, the MA reduction percentage for the portion of the cost reporting period on or after January 1. Calendar year providers complete only column 2.

CY	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Percent reduction to MA DGME	9.77	7.85	7.16	6.41	5.86	5.32	4.99	4.44	4.12	4.07	3.73

CY	2021	2022
Percent reduction to MA DGME	3.26	3.27

Line 30--In column 2, enter the amount on line 29, column 2, multiplied by the reduction factor reported in the 65 FR 47038 and 47039 (August 1, 2000). This is the reduction for direct GME payments for Medicare Advantage. If the response to Worksheet S-2, Part I, line 56, column 2, is "Y", enter in column 2 the result of line 29, column 2, multiplied by the reduction factor on line 29.01, column 2, and enter in column 2.01 the result of line 29, column 2.01, multiplied by the reduction factor on line 29.01, column 2.01. Enter in column 3, the sum of columns 2 and 2.01.

Line 31--Enter the sum of columns 1, 2, and 2.01, line 29, less the amount in columns 2 and 2.01, line 30.

Direct Medical Education Costs for ESRD Composite Rate Title XVIII Only--This section computes the title XVIII nursing program 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 32--Enter the amount from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94.

Line 33--Enter the amount from Worksheet C, Part I, column 8, sum of lines 74 and 94. This amount represents the total charges for renal and home dialysis.

Line 34--Divide line 32 by line 33, and enter the result. This amount represents the ratio of ESRD direct medical education costs to total ESRD charges.

Line 35--Enter from your records the Medicare outpatient ESRD charges.

Line 36--Enter the result of multiplying line 34 by line 35. This represents the Medicare outpatient ESRD costs. Transfer this amount to Worksheet E, Part B, line 29.

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 that 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 37--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, Part II, line 49;
- Hospital-Based HHAs - Worksheet H-4, Part I, column 1, line 1;
- Swing-Bed SNF - Worksheet E-2, line 1, column 1;
- Hospital-Based PPS SNF - Sum of Worksheet D-1, Part III, line 74, and Worksheet E-3, Part VI, column 1, line 4.

Line 38--*TEFRA providers enter the organ acquisition costs from Worksheet(s) D-4, Part III, column 1, line 69. All other providers enter the sum of organ acquisition costs from Worksheet(s) D-4, Part III, column 1, line 69, plus HSCT acquisition costs from Worksheet D-6, Part III, line 10, column 1.*

Line 39--Enter the cost of teaching physicians from Worksheet(s) D-5, Part II, column 3, line 20, or D-5, Part IV, column 1, line 20, as applicable.

Line 40--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 60;
- TEFRA hospital and/or subproviders - Worksheet E-3, Part I, line 5;
- IPF PPS hospital and/or subproviders - Worksheet E-3, Part II, line 17;
- IRF PPS hospital and/or subproviders - Worksheet E-3, Part III, line 18;
- LTCH PPS hospital - Worksheet E-3, Part IV, line 8;
- Cost reimbursed hospital and/or subproviders - Worksheet E-3, Part V, line 5;
- Hospital-based HHAs - Each Worksheet H-4, 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 VI, column 1, line 13.

Line 41--Enter the sum of lines 37 through 39 minus line 40.

Line 42--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, 2, 9, 10, 22, and 23; Worksheet E-2, column 2, line 8; Worksheet H-4, Part I, sum of columns 2 and 3, line 1; Worksheet J-3, column 1, line 1; Worksheet M-3, line 16; and Worksheet N-2, sum of columns 11 and 12, line 11.

Line 43--Enter the Part B primary payer amounts. Enter the sum of the amounts on each Worksheet E, Part B, line 31; Worksheet E-2, column 2, line 9; Worksheet H-4, Part I, sum of columns 2 and 3, line 9; Worksheet J-3, line 4; Worksheet M-3, sum of columns 1 and 2, line 17; and Worksheet N-4, line 5.

Line 44--Enter line 42 minus line 43.

Line 45--Enter the sum of lines 41 and 44.

Line 46--Divide line 41 by line 45, and enter the result.

Line 47--Divide line 44 by line 45, 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 48--Enter the amount from line 31.

Line 49--Complete for title XVIII only. Multiply line 46 by line 48, and enter the result. If you are a hospital subject to IPPS, transfer this amount to Worksheet E, Part A, line 52. 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, transfer this amount to Worksheet E-3, Part I, line 15. If you are a freestanding IPF PPS, transfer this amount to Worksheet E-3, Part II, line 27. If you are a freestanding IRF PPS, transfer this amount to Worksheet E-3, Part III, line 28. If you are a freestanding LTCH PPS, transfer this amount to Worksheet E-3, Part IV, line 18.

Line 50--Complete for title XVIII only. Multiply line 47 by line 48, and enter the result. Transfer this amount to Worksheet E, Part B, line 28. Although this amount includes the Part B GME payments for subproviders, for ease of computation, transfer this amount to the hospital component only.