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 and observation bed days (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 4 equals line 2, enter the amount from line 27 above.

4025.2 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.

CAHs are also required to complete this worksheet.

Line Descriptions

Line 38--For non-IPPS providers, (includes CAHs), 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, IPFs, 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 43.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient, or IPF, IRF, and LTCH PPS	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 31 through 35, as appropriate.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient, or IPF, IRF and LTCH PPS	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 8, lines 8 through 12, 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 5, 6, or 7, as appropriate, lines 8 through 12.

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. 15-1, chapter 22, §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-3, column 3, line 200.

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 V, line 1, or Part VII, line 1, as appropriate. Do not complete lines 50 through 63.

For all inclusive rate providers (Method E), apply the percentage to the sum of the aforementioned lines (lines 41 through 48) based on the provider type designated on Worksheet S-2, column 4, line 3 (see CMS Pub. 15-1, chapter 22, §2208).

Lines 50 through 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, column 7, sum of lines 30 through 35 and line 43 for the hospital, and line 40, 41, or 42, as applicable, for the subprovider. Add that amount to the other pass-through costs from Worksheet D, Part III, column 9, sum of lines 30 through 35 and line 43, for the hospital, and line 40, 41, or 42, as applicable, 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, column 5, line 200. Add that amount to the other pass-through costs from Worksheet D, Part IV, column 11, line 200.

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 63--Except for those hospitals specified below, all hospitals (and distinct part hospital units) excluded from prospective payment and *extended neoplastic disease care hospitals* 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.) CAHs do not complete these lines as CAH reimbursement is based on reasonable cost. The following hospitals are reimbursed under special provisions and, therefore, are not generally subject to TEFRA or prospective payment:

- Hospitals reimbursed under approved State cost control systems (see 42 CFR 403.300 through 403.322);
- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

For your components subject to the PPS or not otherwise subject to the rate of increase ceiling as specified above, make no entries on lines 54 through 63.

NOTE: A new non-PPS hospital or subprovider (lines 85 and/or 86 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.

NOTE: For lines 54 through 63: In the FFY *2018* IPPS final rule, (*82* FR *38298* (August *14, 2017*)), CMS *created a new category of IPPS excluded hospitals named "extended neoplastic disease care hospitals" under* subsection (d)(1)(B)*(vi)* of the Act*, for hospitals that were formally classified as "subclause (II) LTCHs*, effective for cost reporting periods beginning on or after *January 1, 2015*, (that is, *calendar year 2015* and subsequent fiscal years). The payment adjustment is determined based on reasonable cost, as described at 42 CFR 412.526(c).

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 14 and 16 through 18 (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 contractor. 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 62--New providers and *extended neoplastic disease care hospitals* do not complete lines 58 through 62. 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, 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 62.

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 15 percent of line 57 or 2 percent of line 56. If line 57 is negative, do not complete line 58 (leave blank); however, complete line 62 for calculation of any adjustments to the operating costs.

Line 59--Enter the inpatient operating cost per discharge updated and compounded by the market basket for each year through the current reporting year.

Line 60--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 61--If (line 53 ÷ line 54) is less than the lower of lines 55, 59, or 60, enter the lesser of 50 percent of the amount by which operating costs (line 53) are less than expected costs (line 54 times line 60), or 1 percent of the target amount (line 56); otherwise enter zero. (See 42 CFR 413.40(d)(4)(i).)

Line 62--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 63--Allowable Cost Plus incentive Payment--If line 57 is a positive amount, enter the sum of lines 52, 53, 58, and 61 (if applicable). If line 57 is a negative amount, enter the sum of lines 52, 56, and 62. If line 57 is zero, enter the sum of lines 52 and 56. New providers and *extended neoplastic disease care hospitals* enter the lesser of lines 53 or 56, plus line 52.

Line 64--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 CAHs multiply line 10, times the per diem calculated on line 38.

Line 65--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 CAHs multiply line 11, times the per diem calculated on line 38.

Line 66--Enter the sum of lines 64 and 65. For CAHs only transfer this amount to Worksheet E-2, column 1, line 1.

Line 67--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 68--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 69--Enter the sum of lines 67 and 68. 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 66.

4025.3 Part III - SNF, NF, and ICF/IID Only--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX. Hospital-based SNFs complete lines 70 through 74 and 83 through 86 for data purposes only as SNFs are reimbursed under SNF PPS for title XVIII. Complete lines 70 through 89 for titles V and XIX. When this worksheet is completed for a component, show both the hospital and component numbers. Any reference to the nursing facility will also apply to the ICF/IID unit.