

3630. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E, Parts A and B, calculate title XVIII settlement for inpatient hospital services under PPS and title XVIII (Part B) settlement for medical and other health services. Worksheet E, Parts C, D, and E, calculate (for titles V, XVIII, and XIX) settlement for outpatient ambulatory surgery, radiology, and other diagnostic procedures. Worksheet E-3 computes title XVIII, Part A settlement for non-PPS hospitals, settlements under titles V and XIX, and settlements for title XVIII SNFs reimbursed under a prospective payment system.

Worksheet E consists of the following five parts:

- Part A - Inpatient Hospital Services Under PPS
- Part B - Medical and Other Health Services
- Part C - Outpatient Ambulatory Surgical Center
- Part D - Outpatient Radiology Services
- Part E - Other Outpatient Diagnostic Procedures

Application of Lesser of Reasonable Cost or Customary Charges.--Worksheet E, Parts B, C, D, and E, allow for the computation of the lesser of reasonable costs or customary charges (LCC) for services covered under Part B. Make a separate computation on each of these worksheets. In addition, make separate computations to determine whether the services on any or all of these worksheets are exempt from LCC. For example, the provider may meet the nominality test for the services on Worksheet E, Parts B and C only and, therefore, be exempt from LCC only for these services.

For those provider Part B services exempt from LCC for this reason, reimbursement for the affected services is based on 80 percent of reasonable cost net of the Part B deductible amounts.

3630.1 Part A - Inpatient Hospital Services Under PPS.--

NOTE: For SCH/MDH status change and/or geographical reclassification (see 42 CFR 412.102/103) subscript column 1 for lines 1-2, 3.21-3.24, 4.03-4.04, and 5-7. (9/30/96)

Enter on lines 1 through 5 in column 1 the applicable payment data for the period applicable to SCH status. Enter on lines 1 through 5 in column 1.01 the payment data for the period in which the provider did not retain SCH status. The data for lines 1 through 5 must be obtained from the provider's records or the PS&R.

For cost reporting periods beginning on or after October 1, 2000, SCH providers must subscript column 1 for lines 1-2, 3.21-3.24, 4.03-4.04, and 5-7, for cost reporting periods overlapping 9/30/2001, 9/30/2002 or 9/30/2003. Enter in column 1 the applicable payment data for the period prior to October 1 and enter in column 1.01, the applicable payment data for the period on or after October 1.

For cost reporting periods overlapping October 1, 2006, small rural MDH providers must subscript column 1 for lines 1-2, 3.21-3.24, 4.03-4.04 and 5-7 (42 CFR (412.106(d)(2)(iv)(D))). Enter in column 1 the applicable payment data for the period prior to October 1, 2006, and enter in column 1.01 the applicable payment data for the period on or after October 1, 2006.

Line Descriptions

Line 1--The amount entered on this line is computed as the sum of the Federal portion (DRG payment) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. Beginning October 1, 1997, the formula for calculating indirect medical education will be modified annually beginning October 1 of each year. (The phrase "through October 1, 2001" was deleted in T15 from the end of previous sentence). To accommodate the change in the formula it is necessary to subscript line 1. On line 1 enter the payments for discharges occurring prior to October 1. (See the asterisks (*) below for any

exceptions to the reporting of these payments.) If you answered yes to question 21.02 on Worksheet S-2, subscript column 1 and report the payments before the reclassification in column 1.01 and on or after the reclassification in column 1. For discharges occurring on or after April 1, 2001 through September 30, 2001 a modification has been made to the IME formula. See lines 1.07 and 1.08 for identifying payments made on or after that date. In addition, for discharges occurring on or after April 1, 2004 through September 30, 2004 a modification has been made to the DSH payment percentages. See lines 1.07 and 1.08 for identifying payments made on or after these dates.

Line 1.01--Enter the payment for discharges occurring on or after October 1 and before January 1.

Line 1.02--Enter the payments for discharges occurring on or after January 1.

The chart provided below is to assist with the placement of DRG amounts in accordance with the instructions for Worksheet E, Part A.

Cost Reports **Without** Dates of Services 4/1/2001 - 9/30/2001 or 4/1/2004 - 9/30/2004

DRG Payments	Line 1	Line 1.01	Line 1.02
Medicare Managed Care Payments	Line 1.03	Line 1.04	Line 1.05
Cost Reporting Period			
1/1 - 12/31	1/1 - 9/30	10/1 - 12/31	
2/1 - 1/31	2/1 - 9/30	10/1 - 12/31	1/1 - 1/31
3/1 - 2/28-29	3/1 - 9/30	10/1 - 12/31	1/1 - 2/28-29
4/1 - 3/31	4/1 - 9/30	10/1 - 12/31	1/1 - 3/31
5/1 - 4/30	5/1 - 9/30	10/1 - 12/31	1/1 - 4/30
6/1 - 5/31	6/1 - 9/30	10/1 - 12/31	1/1 - 5/31
7/1 - 6/30	7/1 - 9/30	10/1 - 12/31	1/1 - 6/30
8/1 - 7/31	8/1 - 9/30	10/1 - 12/31	1/1 - 7/31
9/1 - 8/31	9/1 - 9/30	10/1 - 12/31	1/1 - 8/31
10/1 - 9/30		10/1 - 12/31	1/1 - 9/30
11/1 - 10/31	10/1 - 10/31	11/1 - 12/31	1/1 - 9/30
12/1 - 11/30	10/1 - 11/30	12/1 - 12/31	1/1 - 9/30

Cost Reports **With** Dates of Services 4/1/2001 - 9/30/2001 or 4/1/2004 - 9/30/2004

DRG Payments	Line 1	Line 1.01	Line 1.02	Line 1.07
Medicare Managed Care Payments	Line 1.03	Line 1.04	Line 1.05	Line 1.08
Cost Reporting Period				
1/1 - 12/31	1/1 - 3/31	10/1 - 12/31		4/1 - 9/30
2/1 - 1/31	2/1 - 3/31	10/1 - 12/31	1/1 - 1/31	4/1 - 9/30
3/1 - 2/28-29	3/1 - 3/31	10/1 - 12/31	1/1 - 2/28-29	4/1 - 9/30
4/1 - 3/31		10/1 - 12/31	1/1 - 3/31	4/1 - 9/30
5/1 - 4/30	5/1 - 9/30	10/1 - 12/31	1/1 - 3/31	4/1 - 4/30
6/1 - 5/31	6/1 - 9/30	10/1 - 12/31	1/1 - 3/31	4/1 - 5/31
7/1 - 6/30	7/1 - 9/30	10/1 - 12/31	1/1 - 3/31	4/1 - 6/30
8/1 - 7/31	8/1 - 9/30	10/1 - 12/31	1/1 - 3/31	4/1 - 7/31
9/1 - 8/31	9/1 - 9/30	10/1 - 12/31	1/1 - 3/31	4/1 - 8/31
10/1 - 9/30		10/1 - 12/31	1/1 - 3/31	4/1 - 9/30
11/1 - 10/31	10/1 - 10/31	11/1 - 12/31	1/1 - 3/31	4/1 - 9/30
12/1 - 11/30	10/1 - 11/30	12/1 - 12/31	1/1 - 3/31	4/1 - 9/30

NOTE: Twelve month cost reporting periods that end in October and November or a 13 month cost reporting period which ends on these months must report payments for the ending months of October and November on line 1.

NOTE: A 13 month cost report that ends January 31 must report the payments for the 13th month (January 1- January 31) on line 1.02.

For short period cost reports, base the input of payment as if it was a 12 month cost report from the beginning date. Be sure lines 1 through 1.02, 1.03 through 1.05, and 3.21 through 3.23 reflect the same time period and the appropriate adjustment factor (10/97).

Hospitals receive payments for indirect medical education for managed care patients beginning January 1, 1998. Therefore, further subscripts are required to report the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture in conjunction with the PPS PRICER the simulated payments. Only a specified percentage of the simulated payment is allowed to be included, i.e., 20 percent for January 1, 1998, 40 percent for January 1, 1999, 60 percent for January 1, 2000, 80 percent for January 1, 2001, and 100 percent thereafter. (See the chart and exceptions identified with asterisks (*) (**)) above before reporting these payments on the lines below.)

Line 1.03--Enter the total managed care "simulated payments" from the PS&R prior to March 31 or October 1. Complete line 1.08 for cost reports that overlap April 1, 2001.

Line 1.04--Enter the total managed care "simulated payments" from the PS&R from October 1 and before January 1.

Line 1.05--Enter the total managed care "simulated payments" from the PS&R on or after January 1 but before April 1/October 1.

Complete line 1.08 for cost reports with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004.

Line 1.06--If you answered "yes" to line 55 of Worksheet S-2, and you did not receive the add-on payment during the year, report the additional amount eligible in accordance with CFR 412.107 on line 1.06 by multiplying the sum of lines 1 through 2.01 by .5 percent for services beginning in the government's fiscal year 1998 and .3 percent for 1999. If lines 1 through 2.01 reflect payment and you are no longer eligible, multiply that amount by .995025 for 1998 and .997024 for 1999 and subtract that result from the sum of lines 1 through 2.01 and enter the result as a negative.

Line 1.07--Enter the payment for discharges occurring on or after April 1, 2001 and before October 1, 2001 or April 1, 2004 through September 30, 2004.

Line 1.08--Enter the total managed care "simulated payments" from the PS&R on or after April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004.

Line 2--Enter the amount of outlier payments made for PPS discharges during the period. See 42 CFR 412, Subpart F for a discussion of these items. Report only the outlier payments attributable to discharges occurring prior to October 1, 1997. Report on line 2.01 the outlier payments received for discharges occurring on and after October 1, 1997.

Line 3--Enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 2, line 12) by the number of days in the cost reporting period (365 or 366 in case of leap year). Do not include statistics associated with an excluded unit (subprovider).

NOTE: Reduce the bed days available by nursery days (Worksheet S-3, Part I, column 2, line 11), swing bed days (Worksheet S-3, Part I, column 6, sum of lines 3 and 4), and the number of observation days (Worksheet S-3, Part I, column 6, line 26 for cost reporting periods beginning before October 1, 2004 and beginning on or after October 1, 2009, or Worksheet S-3, Part I, column 6.02, line 26 for cost reporting periods beginning on or after October 1, 2004, and beginning before October 1, 2009).

Indirect Medical Educational Adjustment--Calculate the amount of the additional payment relating to indirect medical education on lines 3 to 3.03. (See 42 CFR 412.105.) Calculate the IME adjustment only if you answered "yes" to line 25.01 on Worksheet S-2. For cost reporting periods ending on or before September 30, 1997, complete lines 3 to 3.03. For cost reporting periods which overlap October 1, 1997, and thereafter, skip lines 3.01 to 3.03 and complete lines 3.04 to 3.24.

Line 3.01--Enter the number of interns and residents from Worksheet S-3, Part I, column 9, line 12. (See 42 CFR 412.105(f) for counting FTE.)

Line 3.02--Enter the indirect medical education percentage ($1.89 \times \{(1 + \text{line } 3.01/\text{line } 3) \text{ to the } .405 \text{ power} - 1\}$).

Line 3.03--Multiply the percentage calculated on line 3.02 by the sum of lines 1 and 2 and subscripts.

Calculation of the adjusted cap in accordance with 42 CFR 412.105(f):

Line 3.04--Enter the FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. 42 CFR 412.105(f)(1)(iv) Effective for discharges occurring on or after April 1, 2000, adjust this count for the 30 percent increase for qualified rural hospitals. For cost reporting periods beginning on or after November 29, 1999, adjust for any increases due to primary care residents that were on approved leaves of absence. (42 CFR 412.105(f)(1)(iv) and (xi) respectively) Effective for discharges occurring 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 412.105(f)(1)(ix) are applicable.

Line 3.05--Enter the 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 413.79(e). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1), 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 413.79(e)(2), 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 FTE's that were already included in the cap on line 3.04. Also enter here the allopathic or osteopathic FTE count for residents in all years of a rural track program that meet the criteria for an add-on to the cap under 42 CFR 412.105(f)(1)(x). (If the rural track program is a new program under 42 CFR 413.79(l) and qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (3), do not report FTE residents in the rural track program on this line until the fourth program year. Report these FTEs on line 3.17). Also include here any temporary adjustment to the cap due to a hospital closing for cost reporting periods beginning before October 1, 2001.

Line 3.06--Enter the adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 **Federal Register**, page 26336, May 12, 1998.

Line 3.07--Enter the sum of lines 3.04 through 3.06 for all cost reporting periods ending prior to July 1, 2005 and for cost reporting periods ending on or after July 1, 2005, only if worksheet S-2, line 25.05 column 2 is "N". If the IME FTE cap was reduced under 42 CFR 412.105(f)(1)(iv)(B) due to unused residency slots, (Worksheet S-2, line 25.05, column 2 is "Y"), for cost reporting periods ending on or after July 1, 2005, enter the sum of the amounts from line 3.06 plus the amount on Worksheet E-3, Part VI, line 15.

Calculation of the allowable current year FTEs:

Line 3.08--Enter the FTE count for allopathic and osteopathic programs in the current year from your records for cost reporting periods beginning on or after October 1, 1997. Residents in new programs who were included in the cap (line 3.04) should be included on lines 3.08, 3.09, 3.11, 3.12, and prior years' counts on lines 3.15 and 3.16. These residents are not included after the rolling average. Do not include residents in the initial years of the new program. (42 CFR 412.105(f)(1)(iv) and/or (f)(1)(v).)

Lines 3.09 through 3.12 apply only to providers with cost reporting periods that overlap the October 1, 1997 effective date. Complete these lines in lieu of line 3.08. Do not include residents in the initial years of the program. **For cost reporting periods beginning on or after October 1, 1997, do not complete these lines.**

Line 3.09--For cost reporting periods beginning before October 1, enter the percentage of discharges to total discharges occurring prior to October 1. (10/97)

Line 3.10--For cost reporting periods beginning before October 1, 1997, enter the percentage of discharges to total discharges occurring on and after October 1. (10/97)

Line 3.11--Enter the FTE count net of dental and podiatry for the period identified in line 3.09. Use the actual count as if counting for the entire year, or what would have been reported on line 3.08. Do not include intern and residents in the initial years of the program 42 CFR 413.79(d).

Line 3.12--Enter the FTE count net of dental and podiatry for the period identified in line 3.10. Use the actual count as if counting for the entire year, or what would have been reported on line 3.08. Do not include intern and residents in the initial years of the program 42 CFR 413.79(d).

Line 3.13--Enter the FTE count for residents in dental and podiatric programs.

Line 3.14--Enter the result of the lesser of lines 3.07 or 3.08 added to line 3.13. If lines 3.09 through 3.12 are completed, enter the sum of (line 3.09 times line 3.11) plus the lesser of (line 3.10 times line 3.12) or (line 3.10 times line 3.07). Add that result to the amount on line 3.13. Calculate the rolling average count for cost reporting periods beginning on or after October 1, 1997.

Line 3.15--Enter the total allowable FTE count from line 3.14 or line 3.01 of the prior year. Do not include residents in the initial years of the program. 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 43 CFR 412.105(f)(i)(v)) expired, enter on this line the allowable FTE count from line 3.14 plus the count of FTE residents in that specific program included in line 3.17 of the prior year's cost report. If you had no approved teaching program make no entry (10/97). See comment for line 3.08. If you did not have any FTE's reported for this period but you did have an approved teaching program, enter a (1) in column 0 (applicable for cost reporting periods ending before 6/30/2006).

Line 3.16--Enter the total allowable FTE count for the penultimate year from line 3.14 if that year ended on or after September 30, 1997. If you had no approved teaching program make no entry. Do not include residents in the initial years of the program (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 43 CFR 412.105(f)(i)(v) expired, enter on this line the allowable FTE count from line 3.14 plus the count of FTE residents in that specific program included in line 3.17 of the penultimate year's cost report. (10/97) See comment for line 3.08. If you did not have any FTE's reported for this period but you did have an approved teaching program, enter a (1) in column 0 (applicable for cost reporting periods ending before 6/30/2006).

Line 3.17--Enter the sum of lines 3.14 through 3.16 and divide by the number of these lines greater than zero, unless a 1 is entered in column zero on lines 3.15 and 3.16 then count those lines. (See 42 CFR 413.79(d).) Add to that result the number of FTE residents in the initial years of the program that meet the rolling average exception in 42 CFR 413.79(d)(5) and (e)(6). Effective for discharges occurring on or after October 1, 2001, add to this amount any temporary adjustments for FTE residents that were displaced by program or hospital closure (42 CFR 412.105(f)(1)(ix)).

For cost reporting periods ending on or after June 30, 2006, enter in column zero the number of FTE residents in the initial years of the program that meet the rolling average exception and temporary adjustments for FTE residents that were displaced by program or hospital closure, (See 42CFR 412.105(f)(1)(v)). Enter in column 1 the sum of lines 3.14 through 3.16 divided by three; add to this count the FTEs reported in column zero.

This change is date sensitive and column zero only applies to cost reporting periods ending on or after June 30, 2006.

Line 3.18--Enter the current year resident to bed ratio. Line 3.17 divided by line 3.

Line 3.19--In general, for cost reporting periods beginning on or after October 1, 1997, enter from the prior year cost report the intern and resident to bed ratio by dividing line 3.14 by line 3. However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e), add to the numerator of the prior year intern and resident to bed ratio the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program (i.e., the period of years is the minimum accredited length of the program). If the provider is participating in a Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap and current year FTE count due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator and the prior year numerator, and b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior year's numerator (see FR Vol. 66, No. 148 dated August 1, 2001, page 39880). Effective for cost reporting periods beginning on or after October 1, 2002, if the current year is the first cost reporting period in which a receiving hospital trains FTE residents displaced by the closure of another hospital or program, then also adjust the numerator of the prior year ratio for the number of current year FTE residents that were displaced by hospital or program closure (42 CFR 412.105(a)(1)(iii)). Also, in the cost reporting period following the last year the receiving hospital's FTE cap is temporarily adjusted for the displaced residents, adjust the numerator of the prior year ratio by subtracting the displaced FTE residents reported on line 3.17 of the prior year's cost report.(42 CFR 412.105 (a)(1)(iv)). If no intern and resident to bed ratio was reported in the prior year, calculate the ratio using the FTE count for residents in the initial years of the new program. For prior year cost reporting periods ending prior to October 1, 1997, compute the ratio by dividing line 3.01 by line 3.

Line 3.20--For cost reporting periods beginning on or after October 1, 1997, enter the lesser of lines 3.18 or 3.19.

IME adjustment calculation for hospitals with cost reporting periods beginning prior to October 1. The multiplier of the adjustment factor defined in 42 CFR 412.105(d) is changed every October 1st for discharges occurring on and after: October 1, 1996 - 1.89; October 1, 1997 - 1.72; October 1, 1998 - 1.6; October 1, 1999 - 1.60; October 1, 2000 – through March 31, 2001 - 1.54, April 1, 2001 through September 30, 2001 – 1.66; and, on or after October 1, 2001 through September 30, 2002 – 1.6; and on or after October 1, 2002 through September 30, 2003 – 1.35; On or after October 1, 2003 through March 31, 2004 – 1.35; On or after April 1, 2004 through September 30, 2004 – 1.47; On or after October 1, 2004 through September 30, 2005 – 1.42; On or after October 1, 2005 through September 30, 2006 – 1.37; On or after October 1, 2006 through September 30, 2007 – 1.32; On or after October 1, 2007 – 1.35.

For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, an additional computation will be required for discharges occurring during these periods. See line 3.24 below and the revised payment chart on page 36-136.1 for completion of line 3.24.

Line 3.21--For payments reported on lines 1 and 1.03, enter the result of the following: The appropriate multiplier of the adjustment factor for the payment period identified on line 1 times $\{(1 + \text{line } 3.14/\text{line } 3^*) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{sum of (the amount on line 1) + (line 1.03 times the appropriate percentage identified in the paragraph prior to line 1.03) + Line 2.}^{**}\}$

Line 3.22--For payments reported on lines 1.01 and 1.04, enter the result of the following: The appropriate adjustment factor for the payment period identified on line 1.01 times $\{(1 + \text{line } 3.14/\text{line } 3^*) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{line } 1.01 + (\text{line } 1.04 \text{ times the appropriate percentage identified in the paragraph prior to line } 1.03)\}$.

Line 3.23--For payments reported on lines 1.02 and 1.05, enter the result of the following: The appropriate multiplier of the adjustment factor for the payment period identified on line 1.02 times $\{(1 + \text{line } 3.14/\text{line } 3^*) \text{ to the } .405 \text{ power} - 1\}$ times $(\text{line } 1.02 + \text{line } 1.05 \text{ times the appropriate percentage identified in the paragraph prior to line } 1.03)$.

* For cost reporting periods beginning on or after October 1, 1997, replace $\{(\text{line } 3.14 \text{ divided by line } 3)(\text{adjust line } 3.14 \text{ by the interns and residents in the initial years of the program})\}$ with the ratio reported on line 3.20. ** For discharges prior to October 1, 1997, only; do not include outliers for purposes of the IME calculation for discharges occurring on and after October 1, 1997.

Line 3.24--Enter the sum of lines 3.21 through 3.23. For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, add to this result, the appropriate multiplier of the adjustment factor for the payment period identified on line 1.07 times $\{(1 + \text{line } 3.14/\text{line } 3^*) \text{ to the } .405 \text{ power} - 1\}$ times $\{\text{the sum of line } 1.07 + (\text{line } 1.08 \text{ times the appropriate percentage identified in the paragraph prior to line } 1.03)\}$. For cost reporting periods ending on or after July 1, 2005, add to this result the amount from Worksheet E-3, Part VI, line 23.

Disproportionate Share Adjustment.--Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on lines 4 through 4.04. Complete this portion only if you answered yes to line 21.01 of Worksheet S-2. For cost reporting periods which overlap January 20, 2000, do not complete lines 4 through 4.03 and enter on line 4.04 the manually calculated DSH payment adjusted by the appropriate reduction. (See intermediary PM A-99-62 for proper determination of DSH adjustment.) For those hospitals experiencing a change in the DSH percentage as a result of the application of the BIPA provisions effective for services on and after April 1, 2001, or as a result

of the application of the MMA provisions effective for discharges on and after April 1, 2004, (i.e., geographic reclassification) subscript column 1 (add column 1.01) for lines 1, 1.01, 1.02, 1.07, 4.03 and 4.04 and apply the appropriate percentage for the DSH payment and reduction in accordance with the payment dates prescribed above. Review the payment chart on page 137 and lines 1, 1.01, 1.02 and 1.07 for proper reporting of payments. Do not subscript the column for lines 4.03 and 4.04, except as applicable for SCH\MDH and geographic reclassification.

Line 4--Enter the percentage of SSI recipient patient days to Medicare Part A patient days. (Obtain the percentage from your intermediary/MAC.)

Line 4.01--For cost reporting periods beginning prior to October 1, 2004, and on or after October 1, 2009, enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, (plus Worksheet S-3, Part I, line 29, column 5 for cost reporting periods beginning on or after October 1, 2009), minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12 (plus Worksheet S-3, Part I, line 29, column 6 for cost reporting periods beginning on or after October 1, 2009) minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

For cost reporting periods beginning on or after October 1, 2004, and beginning before October 1, 2009, enter the percentage resulting from the calculation of the total Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, plus column 5.01, line 26, minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12, plus column 6.01, line 26, minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

Line 4.02--Add lines 4 and 4.01 to equal the hospital's DSH patient percentage.

Line 4.03--Compare the percentage on line 4.02 with the criteria described in 42 CFR 412.106(c) and (d). Enter the percentage identified in the CFR to be applied against PPS payments. Hospitals qualifying for DSH in accordance with 42 CFR 412.106(c)(2) (Pickle Amendment hospitals), if Worksheet S-2, line 21.01, column 2 is "Y" for yes, enter 35.00 percent on line 4.03.

For cost reporting periods with dates of service in the period April 1, 2001, through September 30, 2001, or April 1, 2004, through September 30, 2004, enter in column 0 the percentage to be applied against PPS payment for the period April 1 through September 30. In addition, for MDH providers for cost reporting periods overlapping October 1, 2006, the rural 12 percent DSH payment cap does not apply for discharges occurring on or after October 1, 2006. Enter in column 1 the percentage to be applied for discharges occurring prior to October 1, 2006, and enter in column 1.01 the percentage to be applied for discharges occurring on or after October 1, 2006.

NOTE: For cost reporting periods ending on or after October 1, 2004 and before October 1, 2006, 42 CFR 412.102 provides for a transition to a rural DSH payment amount from a urban payment amount over two years, for hospitals that were considered urban under the MSA definition, but are considered rural under the CBSA definition. Impacted hospitals whose DSH payment adjustment exceeds 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2005 and 1/3 of the difference between the urban and rural operating DSH for FY 2006.

Line 4.04--Multiply line 4.03 by the sum of lines 1, 1.01, 1.02 and 2 and enter the result. For discharges occurring on or after October 1, 1997, multiply line 4.03 by the sum of lines 1, 1.01, and 1.02. For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, add to this amount the product of the payment percentage identified on line 4.03, column 0, applied to the payments identified on line 1.07. Reduce that amount for discharges occurring on or after October 1, 1997, by 1 percent; 2 percent for October 1, 1998, 3 percent for October 1, 1999; 3 percent for October

1, 2000 through March 31, 2001; 1 percent for April 1, 2001 through September 30, 2001; 3 percent for October 1, 2001 through September 30, 2002; and 0 (zero) percent thereafter. Review the payment chart on page 137 for the proper splitting of payments before and on or after October 1 and April 1 for those cost reports that overlap these dates in order to properly calculate the reduction.

High Percentage of ESRD Beneficiary Discharges Adjustment.--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104. When the average weekly cost per dialysis treatment changes within a cost reporting period, create a subscripted column 1.01 for lines 5.01 and 5.05.

Line 5--Enter total Medicare discharges reported on Worksheet S-3, Part I, excluding discharges for DRGs 302, 316, and 317, or effective October 1, 2007, excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages and 48520 and 48447).

Line 5.01--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see Vol. 69, FR 154, dated August 11, 2004, page 49087) excluding DRGs 302, 316, and 317, or effective October 1, 2007, excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48520 and 48447).

Line 5.02--Divide line 5.01, sum of columns 1 and 1.01 by line 5, sum of columns 1 and 1.01. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

Line 5.03--Enter the total Medicare ESRD inpatient days excluding DRGs 302, 316, and 317 or effective October 1, 2007, MS-DRGs 652, 682, 683, 684, and 685, as applicable.

Line 5.04--Enter the average length of stay expressed as a ratio to 7 days. Divide line 5.03 by line 5.01, sum of columns 1 and 1.01, and divide the result by 7 days.

Line 5.05--Enter the average weekly cost per dialysis treatment of \$401.43 (\$133.81 times the average weekly number of treatments (3)). See CR 6216, Transmittal 98, dated December 12, 2008. See CR 6679, Transmittal 113, dated October 30, 2009, for the calendar year 2010 average weekly cost per dialysis treatment of \$405.45 (3 times rate per treatment of \$135.15). This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.

Line 5.06--Enter the ESRD payment adjustment (line 5.04, column 1 times line 5.05, column 1 times line 5.01, column 1 plus, if applicable, line 5.04, column 1 times line 5.05, column 1.01 times line 5.01, column 1.01).

Line 6--Enter the sum of lines 1, 1.01, 1.02, 1.07, 2, 2.01, 3.03 (for cost reporting periods which overlap October 1, 1997, and thereafter, substitute line 3.24 for line 3.03), 4.04 (subscripted columns), and 5.06. For cost reporting periods beginning in the government's fiscal year in 1998 and 1999 and you answered yes to line 55 of Worksheet S-2, add to this sum the amount on line 1.06, if applicable.

Line 7-- Sole community hospitals are paid the highest rate of the Federal payment rate, the hospital-specific rate (HSR) determined based on a Federal fiscal year 1982 base period (see 42 CFR 412.73), or the hospital-specific rate determined based on a Federal fiscal year 1987 base period. (See 42 CFR 412.75.) For discharges occurring on or before October 1, 2006, Medicare dependent hospitals are paid the highest of the Federal payment rate, or the Federal rate plus 50 percent of the amount of the excess over the Federal rate of the higher of either the 1982 base period, or the 1987 base period hospital specific rate. For discharges occurring on or after October 1, 2006, Medicare dependent hospitals are paid the highest of the Federal payment rate, or the Federal rate plus 75 percent of the amount of the excess over the Federal rate of the highest rate for the 1982, 1987 or 2002 base period hospital specific rate. For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments.

For sole community hospitals only, the hospital-specific payment amount entered on this line is supplied by your fiscal intermediary. Calculate it by multiplying the sum of the DRG weights for the period (per the PS&R) by the final per discharge hospital-specific rate for the period. For new hospital providers established after 1987, do not complete this line. Use the higher of the hospital-specific rate based on cost reporting periods beginning in FY 1982 or FY 1987. Use the hospital-specific rate (operating cost per discharge divided by the case mix index for 1982 or 1987, as applicable) updated to the beginning of the cost reporting period and adjusted for budget neutrality, if applicable, in this calculation. For services rendered on or after October 1, 2003, use the hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, or 1996.

Additionally, for sole community hospitals only for cost reporting periods beginning on or after January 1, 2009, use the hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, 1996, or 2006. (See 42 CFR 412.78.)

For MDH discharges occurring on or after October 1, 2006, and before October 1, 2011, an MDH can use a FY 2002 hospital specific rate.

Line 7.01--In addition to the comparison of 1982 and 1987, sole community hospitals can compare the hospital specific rate for cost reporting periods beginning in FY 1996 (CFR 412.77). For SCHs with cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003, enter on this line the hospital-specific payment amount based on the cost reporting period beginning in FY 1996 as supplied by your fiscal intermediary. For services rendered on or after October 1, 2003, do not use this line, but rather use line 7.

Line 8--For SCHs, enter the greater of line 6 or 7. For MDHs (for discharges occurring on or after October 1, 1997, and before October 1, 2006), if line 6 is greater than line 7, enter the amount on line 6. Where line 7 is greater than line 6, enter the amount on line 6, plus 50 percent of the amount that line 7 exceeds line 6. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2011, if line 6 is greater than line 7, enter the amount on line 6. Where line 7 is greater than line 6, enter the amount on line 6, plus 75 percent of the amount that line 7 exceeds line 6. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 6.

For hospitals subscribing column 1 of line 6 due to a change in geographic location, this computation will be computed separately for each column, and the sum of the calculations will be entered in column 1 of this line.

For SCHs with cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003 - The transition into the FY 1996 rate is actually a blend based on discharges for FY 2001 (October 1, 2000 - September 30, 2001) of 75 percent of the higher of the 1982, 1987, or Federal amount and 25 percent of 1996. For FY 2002 (October 1, 2001 - September 30, 2002), the blend is 50/50, and for FY 2003 (October 1, 2002 - September 30, 2003) the blend is 25/75.

If line 7.01 is greater than lines 6 and 7, enter the higher of lines 7 or 6 multiplied by the appropriate blend percentage. Add to this amount, the amount on line 7.01 multiplied by the appropriate FY 1996 HSR blend percentage. (42 CFR 412.92) If line 7.01 is not greater than lines 6 or 7, enter the greater of lines 6 or 7. If line 6 is greater than lines 7 and 7.01, enter that amount on this line.

Line 9--Enter the payment for inpatient program capital costs from Worksheet L, Part I, line 6; Part II, line 10; or Part III, line 5, as applicable.

Line 10--Enter the exception payment for inpatient program capital, if applicable, from Worksheet L, Part IV, line 13 for cost reporting periods beginning before October 1, 2001. For cost reporting periods beginning on and after October 1, 2001, if the provider continues to

qualify for the additional payment for extraordinary circumstances pursuant to 42 CFR 412.348(e) enter the exception payment for inpatient program capital from Worksheet L, Part IV, line 13. If the provider qualifies for the special exceptions payment pursuant to 42 CFR 412.348(g) enter the result of Worksheet L, Part IV, line 13 less Worksheet L, Part IV, line 17. If this amount is negative, enter zero on this line.

Line 11--Enter the amount from Worksheet E-3, Part IV, line 24. Complete this line only for the hospital component.

Obtain the payment amounts for lines 11.01 and 11.02 from your fiscal intermediary.

Line 11.01--Enter the amount of Nursing and Allied Health Managed Care payments if applicable.

Line 11.02--Enter the special add-on payment for new technologies (see change request 2301).

Line 12--Enter the net organ acquisition cost from Worksheet(s) D-6, Part III, column 1, line 61.

Line 13--Enter the cost of teaching physicians from Worksheet D-9, Part II, column 3, line 16.

Line 14--Enter on the appropriate Worksheet E, Part A, the routine service other pass through costs from Worksheet D, Part III, column 8, lines 25 through 30 for the hospital and line 31 for the subproviders.

Line 15--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101.

Line 16--Enter the sum of lines 8 through 15.

Line 17--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, treat the services as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted by you in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 12. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 17 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductible and coinsurance on line 17.

Enter the primary payer amounts applicable to organ transplants. However, do not enter the primary payer amounts applicable to organ acquisitions. Report these amounts on Worksheet D-6, Part III, line 58.

If you are subject to PPS, include the covered days and charges in the program days and charges, and include the total days and charges in the total days and charges for inpatient and pass through cost apportionment. Furthermore, include the DRG amounts applicable to the patient stay on line 1. Enter the primary payer payment on line 17 to the extent that the primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductibles.

Line 19--Enter from the PS&R or your records the deductibles billed to program patients.

Line 20--Enter from the PS&R or your records the coinsurance billed to program patients.

Line 21--Enter the program reimbursable bad debts, reduced by the bad debt recoveries. If recoveries exceed the current year's bad debts, line 21 and 21.01 will be negative.

Line 21.01--Enter line 21 (including negative amounts) times 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999, and 70 percent for October 1, 2000 and thereafter.

Line 21.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 21. (4/1/2004b)

Line 22--Enter the sum of lines 18 and 21.01 minus the sum of lines 19 and 20.

Line 23--Enter the programs share of any recovery of accelerated depreciation applicable to prior periods paid under reasonable cost or the hold harmless methodology under capital PPS resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136 - 136.16.)

Line 24--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Effective for Federal fiscal years 2011 and 2012 (October 1, 2010, through September 30, 2011, and October 1, 2011, through September 30, 2012, respectively), temporary improved/changed payments are mandated by §§3125 and 10314 ACA of 2010, as addressed in 42 CFR 412.101 for discharges occurring during Federal fiscal years 2011 and 2012. For cost reporting periods which begin before May 1, 2010, and overlap October 1, 2010, enter on lines 24.94 (and if necessary, lines 24.95 and 24.96) the Medicare inpatient payment adjustment for low volume hospitals as applicable in accordance with the instructions in a forthcoming Change Request (CR). The forthcoming CR will provide instructions regarding the source(s) from which the entered amounts can be obtained and will specify in which situations line 24.95 (and if necessary line 24.96) must be completed. Identify the line label on each line as "Low Volume Adjustment Payment." Where difference low volume adjustment percentages apply during the cost reporting period, identify the label on each line as "Low Volume Adjustment Payment-1" increasing the number by one for each additional payment that applies. The low volume adjustment payment

must also be recorded on Worksheet E-1 as part of an interim payment. The adjustment will not be separately or specifically identified, but will be part of the overall interim payment and therefore will not be placed on a specific line on Worksheet E-1.

NOTE: *The immediately preceding transmittal 24 indicated the use of line 24.97 for the additional payment in accordance with the Health Care and Education Reconciliation Act (HCERA) of 2010, section 1109 which established an additional payment effective for cost reporting periods which end during Federal fiscal years 2011 and 2012 (one payment for each year) for qualifying providers under section 1886(d) of the Act and also indicated the use of Worksheet E-1, Part I, line 3.49, column 2 for the corresponding interim payment. Such instructions are hereby rescinded and eliminated as section 1109 payments will be funded by a separate appropriation unrelated to Part A of the Medicare trust fund and are accordingly excluded from the Medicare cost report.*

Effective for discharges occurring on or after October 1, 2008, enter on line 24.98 the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in Change Request 5860, transmittal 1509, dated May 9, 2008.

Only FI/contractors complete line 24.99 by entering the sum of lines 52, 53, 55, and 56.

Line 25--If you are filing under the fully prospective payment methodology for capital costs or on the basis of 100 percent of the Federal rate under the hold harmless methodology, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. For providers paid under the hold harmless reasonable cost methodology, compute gains or losses on the disposal of old assets in accordance with CMS Pub. 15-1, §§132-134.4. For gains or losses on new capital, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. (See 42 CFR 413.134(f)(1).)

NOTE: Section 1861 (v) (1) (O) of the Act sets a limit on the valuation of a depreciable asset that may be recognized in establishing an appropriate allowance for depreciation, and for interest on capital indebtedness after a change of ownership that occurs on or after December 1, 1997, and restricts the gain or loss on the sale or scrapping of assets.

Enter the amount of any excess depreciation taken as a negative amount.

Line 26--Enter the amount due you (i.e., the sum of the amounts on line 22 plus or minus lines 24 and 25 minus line 23).

Line 27--Enter the sequestration adjustment amount, if applicable.

Line 28--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 28.01. Include in interim payment the amount received as the estimated nursing and allied health managed care payments.

Line 29--Enter line 26 minus the sum of lines 27 and 28. Transfer to Worksheet S, Part II.

Line 30--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.

Lines 31 through 49 were intentionally skipped to accommodate future revisions to this worksheet.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART A. LINES 50 THROUGH 56 ARE FOR CONTRACTOR USE ONLY.

Line 50--Enter the original operating outlier amount from line 2.01 sum of all columns of this worksheet.

Line 51--Enter the original capital outlier amount from worksheet L, part I, line 3.01.

Line 52--Enter the operating outlier reconciliation adjustment in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5-§20.1.2.7

Line 53--Enter the capital outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7

Line 54--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7.)

Line 55--Enter the operating time value of money for operating related expenses.

Line 56--Enter the capital time value of money for capital related expenses.

NOTE: If a cost report is reopened more than one time, subscript lines 50 through 56, respectively, one time for each time the cost report is reopened.