

4005. WORKSHEET S-3 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA AND HOSPITAL WAGE INDEX INFORMATION

This worksheet consists of five parts:

- Part I - Hospital and Hospital Health Care Complex Statistical Data
- Part II - Hospital Wage Index Information
- Part III - Hospital Wage Index Summary
- Part IV - Hospital Wage Related Costs
- Part V - Hospital Contract Labor and Benefit Costs

4005.1 Part I - Hospital and Hospital Health Care Complex Statistical Data.--This part collects statistical data regarding beds, days, FTEs, and discharges.

Column Descriptions

Column 1--Enter the Worksheet A line number that corresponds to the Worksheet S-3 component line description.

Column 2--Refer to 42 CFR 412.105(b) and 69 FR 49093-49098 (August 11, 2004) to determine the facility bed count. Indicate the number of beds available for use by patients at the end of the cost reporting period.

A bed means an adult bed, pediatric bed, portion of inpatient labor/delivery/postpartum (LDP) room (also referred to as birthing room) bed when used for services other than labor and delivery, or newborn ICU bed (excluding newborn bassinets) maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in post-anesthesia, post-operative recovery rooms, outpatient areas, emergency rooms, ancillary departments (however, see exception for labor and delivery department), nurses' and other staff residences, and other such areas that are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes. (See CMS Pub. 15-1, chapter 22, §2205.)

For cost reporting periods beginning prior to October 1, 2012, beds in distinct ancillary labor and delivery rooms and the proportion of LDP room (birthing room) beds used for labor and delivery services are not a bed for these purposes. (See 68 FR 45420 (August 1, 2003).)

For cost reporting periods beginning on or after October 1, 2012, in accordance with 77 FR 53411-53413 (August 31, 2012), beds in distinct labor and delivery rooms, when occupied by an inpatient receiving IPPS-level acute care hospital services or when unoccupied, are considered to be part of a hospital's inpatient available bed count in accordance with 42 CFR 412.105(b) and are to be reported on line 32. Furthermore, the proportion of the inpatient LDP room (birthing room) beds used for ancillary labor and delivery services is considered part of the hospital's available bed count.

Column 3--Enter the total bed days available. Bed days are computed by multiplying the number of beds available throughout the period in column 2 by the number of days in the reporting period. If there is an increase or decrease in the number of beds available during the period, multiply the number of beds available for each part of the cost reporting period by the number of days for which that number of beds was available.

Column 4--CAHs accumulate the aggregate number of hours all CAH patients spend in each category on lines 1 and 8 through 12. This data is for informational purposes only.

Columns 5 through 7--Enter the number of inpatient days or visits, where applicable, for each component by program. Do not include HMO days except where required (lines 2 through 4, columns 6 and 7; line 13, column 7), organ acquisition, or observation bed days in these columns. Nursery days (all the days during which a newborn infant occupies a nursery) are reported on line 13, column 7, and include the in-state paid Medicaid days; in-state Medicaid eligible but unpaid days; out-of-state Medicaid paid days; out-of-state Medicaid eligible but unpaid days paid; and Medicaid HMO paid and eligible but unpaid days. Observation bed days are reported in columns 7 (title XIX) and 8 (total), line 28. For LTCH, enter in column 6, on the applicable line, the number of covered Medicare days (from the PS&R) and enter in column 6, line 33, the number of non-covered days (from provider's books and records) for Medicare patients. *See line 33 for further discussion.*

Report the program days for PPS providers (acute care hospital, IPF, IRF, and LTCH) in the cost reporting period in which the discharge is reported. This also applies to providers under the TEFRA/PPS blend. TEFRA providers should report their program days in the reporting period in which they occur.

**NOTE:** Medicaid days for Medicaid recipients who are members of an HMO as well as out-of-state days, Medicaid secondary payer patient days, Medicaid eligible days for which no payment was received, and nursery days are reported on lines 2, 3, 4, or 13, in accordance with 42 CFR 412.106(b)(4)(ii). Therefore, Medicaid patient days reported on line 1, column 7, do not include days for Medicaid patients who are also members of an HMO, out-of-State Medicaid days, Medicaid secondary payer patient days, Medicaid eligible days for which no payment was received, and nursery days.

Column 8--Enter the number of inpatient days for all classes of patients for each component. Include organ acquisition and HMO days in this column. This amount will not equal the sum of columns 5 through 7, when the provider renders services to other than titles V, XVIII, or XIX patients.

Column 9--Enter the number of intern and resident FTEs in an approved program, determined in accordance with 42 CFR 412.105(f), for the indirect medical education adjustment. The FTE residents reported by an IPF PPS facility or an IRF PPS facility (whether freestanding or a unit reported on line 16 or 17, respectively, of an IPPS hospital's cost report) shall be determined in accordance with 42 CFR 412.424(d)(1)(iii) for IPFs, and in accordance with the 70 FR 47929-47930 (August 15, 2005) for IRFs.

Columns 10 and 11--The average number of FTE employees for the period may be determined either on a quarterly or semiannual basis. When quarterly data are used, add the total number of hours worked by all employees on the first week of the first payroll period at the beginning of each quarter, and divide the sum by 160 (4 times 40). When semiannual data are used, add the total number of paid hours on the first week of the first payroll period of the first and seventh months of the period. Divide this sum by 80 (2 times 40). Enter the average number of paid employees in column 10, and the average number of nonpaid workers in column 11, for each component, as applicable.

Columns 12 through 14--Enter the number of discharges including deaths (excluding newborn and DOAs) for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.) Enter the title XVIII Medicare Advantage (MA) discharges in column 13, line 2. For cost reporting periods ending on or after June 30, 2014, enter the title XIX managed care discharges in column 14, line 2. For columns 13 and 14, lines 2 and 33 are a subset of column 15, line 1. For cost reporting periods ending on or after October 1, 2014, enter the title XIX managed care discharges in column 14, lines 3 and 4, for the IPF and IRF subproviders. For column 14, lines 3 and 4 are subsets of column 15, line 16 and 17, respectively. Lines 2 through 4, column 14, are collected for informational purposes only. *For LTCH, enter in column 13, line 1, the number of covered Medicare discharges (from the PS&R) and enter in column 13, line 33, the number of discharges associated with non-covered Medicare days (from provider's books and records). See line 33 for further discussion.*

Column 15--Enter the number of discharges including deaths (excluding newborn and DOAs) for all classes of patients for each component.

### Line Descriptions

Line 1--For cost reporting periods beginning before October 1, 2012, exclude from column 2 the portion of LDP room (birthing room) beds used for ancillary labor and delivery services, but include on this line beds used for routine adult and pediatric services (postpartum). In accordance with the instructions in 68 FR 45420 (August 1, 2003), compute this proportion (off the cost report) by multiplying the total number of occupied and unoccupied available beds in the LDP room by the percentage of time these beds were used for ancillary labor and delivery services. An example of how to calculate the "percentage of time" would be for a hospital to determine the number of hours for the cost reporting period during which each LDP room maternity patient received labor and delivery services and divide the sum of those hours for all such patients by the sum of the total hours (for both, ancillary labor and delivery services and for routine postpartum services) that all maternity patients spent in the LDP room during that cost reporting period. Alternatively, a hospital could calculate an average percentage of time maternity patients received ancillary labor and delivery services in an LDP room during a typical month.

For cost reporting periods beginning on or after October 1, 2012, include all the available LDP room (birthing room) beds in the available bed count in column 2. (See 77 FR 53411-53413 (August 31, 2012).) The proportion of available LDP room beds related to the ancillary labor and delivery services must not be excluded from column 2 for those cost reporting periods.

In columns 5, 6, 7 and 8, enter the number of adult and pediatric hospital days excluding the SNF and NF swing-bed, observation bed, and hospice days. In columns 6 and 7, also exclude HMO days. **Do not include in column 6 Medicare Secondary Payer/Lesser of Reasonable Cost (MSP/LCC) days.** Include these days only in column 8. However, do not include employee discount days in column 8.

Labor and delivery days (as defined in the instructions for Worksheet S-3, Part I, line 32) must not be included on this line.

Line 2--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans (§1876 of the Act). Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 1, column 7.

Line 3--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans (§1876 of the Act) that pertain to IPF subprovider patients. Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 16, column 7.

Line 4--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans (§1876 of the Act) that pertain to IRF subprovider patients. Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 17, column 7.

Line 5--Enter the Medicare covered swing-bed days (which are considered synonymous with SNF swing-bed days) for all title XVIII programs where applicable. (See 42 CFR 413.53(a)(2).) Exclude all MA days from column 6, include the MA days in column 8.

Line 6--Enter the non-Medicare covered swing-bed days (which are considered synonymous with NF swing-bed days) for all programs where applicable. (See 42 CFR 413.53(a)(2).)

Line 7--Enter the sum of lines 1, 5, and 6.

Lines 8 through 13--Enter the appropriate statistic applicable to each discipline for all programs.

Line 14--Enter the sum of lines 7 through 13 for columns 2 through 8, and for columns 12 through 15, enter the amount from line 1. For columns 9 through 11, enter the total for each from your records. Labor and delivery days (as defined in the instructions for Worksheet S-3, Part I, line 32) must not be included on this line.

Line 15--Enter the number of outpatient visits for CAHs by program and total. An outpatient CAH visit is defined in 42 CFR 413.70(b)(3)(iii).

Line 16--Enter the applicable data for the IPF subprovider.

Line 17--Enter the applicable data for the IRF subprovider.

Line 18--Enter the applicable data for other than IPF or IRF subproviders. If you have more than one subprovider, subscript this line. Treat this area as a nonreimbursable cost center for Medicare since it is not part of the Medicare certified hospital.

Line 19--If your State recognizes one level of care, complete this line for titles V, XVIII, and XIX, however, do not complete line 20. If you answered yes to line 92 of Worksheet S-2, Part I, complete all columns.

Line 20--Enter nursing facility days if you have a separately certified nursing facility for title XIX or you answered yes to line 92 of Worksheet S-2, Part I. Make no entry if your State recognizes only SNF level of care. If you operate an ICF/IID, subscript this line to 20.01 and enter the ICF/IID days. Do not report any nursing facility data on line 20.01.

Line 21--Enter data for an other long term care facility. Treat this area as a nonreimbursable cost center for Medicare since it is not part of the Medicare certified hospital.

Line 22--If you have more than one hospital-based HHA, subscript this line.

Line 23--Enter data for an ASC. If you have more than one ASC, subscript this line.

Line 24--Enter days applicable to hospice patients in a distinct part hospice.

Line 24.10--Effective for cost reporting periods beginning on or after October 1, 2011, enter in column 8, the days applicable to hospice patients currently under a valid hospice election who occupy general inpatient routine beds under a contractual arrangement between the hospital and hospice to provide general inpatient hospice and/or respite care services.

Line 25--CMHCs enter the number of partial hospitalization days as applicable. For reporting of multiple facilities follow the same format used on Worksheet S-2, Part I, line 17.

Line 26--Enter the number of outpatient visits for FQHC and RHC. If you have both a hospital-based FQHC and a hospital-based RHC, or multiples of either one, subscript this line as follows:

Report the first through twenty-fifth hospital-based RHCs on subscripted line numbers 26 through 26.24 and the twenty-sixth through thirty-sixth hospital-based RHCs on subscripted line numbers 26.50 through 26.60.

Report the first through twenty-fifth hospital-based FQHCs on subscripted line numbers 26.25 through 26.49 and the twenty-sixth through thirty-sixth hospital-based FQHCs on subscripted line numbers 26.61 through 26.71.

If the RHC/FQHC is approved to file a consolidated cost report, all data is reported in aggregate as a single provider. Report the consolidated primary RHC data on line 26 and consolidated primary FQHC data on subscripted line 26.25.

Line 28--Enter the total observation bed days in column 8. Divide the total number of observation bed hours by 24 and round up to the nearest whole day. These total hours should include the hours for observation of patients who are subsequently admitted as inpatients but only the hours up to the time of admission as well as the hours for observation of patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge from the facility. Observation bed days only need to be computed if the observation bed patients are placed in a routine patient care area. The bed days are needed to calculate the cost of observation beds since it cannot be separately costed when the routine patient care area is used. If, however, you have a distinct observation bed area, it must be separately costed (as are all other outpatient cost centers), and this computation is not needed.

Line 29--Enter in column 6, the total number of ambulance trips, as defined by §4531(a)(1) of the BBA. Do not subscript this line.

Line 30--Enter in column 8, the employee discount days if applicable. These days are used on Worksheet E, Part A, line 31, in the calculation of the DSH adjustment and Worksheet E-3, Part III, line 3, in the calculation of the LIP adjustment. The days reported on this line must reflect hospital services provided in the beds reported on line 1, column 2.

Line 31--Enter in column 8, the employee discount days, if applicable, for IRF subproviders.

Line 32--Effective for cost reporting periods beginning on or after October 1, 2012, enter in column 2, the total number of available beds located in the distinct ancillary labor and delivery rooms. In accordance with 42 CFR 412.105(b) and 77 FR 53411-53413 (August 31, 2012), distinct ancillary labor and delivery room beds, when occupied by an inpatient receiving IPPS-level acute care hospital services or when unoccupied, are considered to be part of a hospital's inpatient available bed count. These beds are not included in the inpatient routine beds reported on line 1. Note that the available bed days reported in column 3 are reduced on Worksheet E, Part A, by the equivalent of outpatient labor and delivery days from line 32.01.

Effective for cost reporting periods beginning on or after October 1, 2013, enter in column 6, the number of labor/delivery inpatient days for title XVIII. (See 78 FR 50730-50733 (August 19, 2013).)

Effective for cost reporting periods beginning on or after October 1, 2009, enter in column 7, the number of labor/delivery inpatient days for title XIX, and in column 8, the total number of labor/delivery inpatient days for the entire hospital. (See 74 FR 43899-43901 (August 27, 2009).)

For the purposes of reporting on this line, labor and delivery days are defined as days during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking, and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission (see CMS Pub. 15-1, chapter 22, §2205.2). Maternity patients must be admitted to the hospital as an inpatient for their labor and delivery days to be included on line 32. These days must not be reported on Worksheet S-3, Part I, line 1 or line 14. In the case where the maternity patient is in a single multipurpose labor/delivery/postpartum (LDP) room (also referred to as a birthing room), hospitals must determine the proportion of each inpatient stay that is associated with ancillary services (labor and delivery) versus routine adult and pediatric services (postpartum) and report the days associated with the labor and delivery portion of the stay on this line. An example of this would be for a hospital to determine the percentage of each stay associated with labor/delivery services and apply that percentage to the stay to determine the number of labor and delivery days of the stay. Alternatively, a hospital could calculate an average percentage of time maternity patients receive ancillary services in an LDP room during a typical month, and apply that percentage through the rest of the year to determine the number of labor and delivery days to report on line 32.

Line 32.01--Effective for cost reporting periods beginning on or after October 1, 2012, enter in column 8, the equivalent days for the entire hospital that are attributable to outpatient services provided in the distinct ancillary labor and delivery room. Calculate the number of days by dividing the total number of hours attributable to the outpatient services by 24, and round to the nearest whole day. These total outpatient hours include the hours for outpatients occupying the distinct ancillary labor and delivery room until they are admitted as inpatients or are discharged from the hospital. For example, one patient is admitted as an inpatient after first occupying the distinct ancillary labor and delivery room bed for 8 hours. Therefore, for this patient, 8 hours would be included in the sum of the total hours used to compute equivalent days to be entered on line 32.01. Another patient is admitted to the distinct ancillary labor and delivery room for monitoring of possible labor or for a sonogram. After spending 6 hours in this department (room), this patient is discharged from the hospital without being admitted as an inpatient. Therefore, for this patient, 6 hours would be included in the sum of the total hours used to compute the equivalent days to be entered on line 32.01. These outpatient labor and delivery days are used on Worksheet E, Part A, to reduce the available bed days reported on line 32 so that only those distinct ancillary labor and delivery room beds which are occupied by inpatients or are unoccupied are ultimately counted as "beds."

Line 33--*Enter in column 6, the number of LTCH non-covered Medicare days (from the provider's books and records). These LTCH non-covered Medicare days are a subset of total patient days reported in column 8, line 14, and may be part of a covered or non-covered stay for Medicare covered services. Enter in column 13, the number of LTCH discharges for Medicare stays comprised exclusively of non-covered Medicare days (from the provider's books and records). These LTCH discharges are a subset of discharges reported in column 15, line 1, and do not include discharges for a covered stay, where a portion of the stay is non-covered and the discharge is already included in column 13, line 1, and reflected in the PS&R.*

Line 33.01--Enter the LTCH site neutral days in column 6, and the LTCH site neutral discharges in column 13. NOTE: The data entered on this line is a subset of the data reported on line 1.