3527. WORKSHEET C - RATIO OF COST TO CHARGES FOR ANCILLARY OUTPATIENT COST CENTERS

This worksheet computes the ratio of cost to charges for ancillary services and, for costs not subject to the outpatient capital reduction, the outpatient ratio of cost to charges. This ratio is used on Worksheet D.

Column 1.--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 18 or Worksheet B, Part III, column 5. Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 18 or Worksheet B, Part III, column 5. However, report the charges applicable to such cost centers with a credit balance in column 2 of the applicable line on Worksheet C.

Column 2.--Enter on each cost center line the total gross patient charges including charity care for that cost center. Include in the applicable cost centers items reimbursed on a fee schedule (e.g., DME, oxygen, prosthetics and orthotics). DME, oxygen, and orthotic and prosthetic devices (except for enteral and parental nutrients and intraocular lenses furnished by providers) are paid by the DMERC or the regional home health intermediary based on the lower of the supplier's actual charge or a fee schedule. Therefore, do not include Medicare charges applicable to these items in the Medicare charges reported on Worksheet D. However, include your standard customary charges for these items in total charges on Worksheet C. This is necessary to avoid the need to split your organizational cost centers such as medical supplies between those items paid on a fee basis and those items subject to cost reimbursement.

Column 3.--Divide the cost for each cost center in column 1 by the total charges for the cost center in column 2 to determine the ratio of total cost to total charges. Enter the resultant department ratios in this column. Round ratios to 6 decimal places.

3530. WORKSHEET D - APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST AND REDUCTION OF THERAPY COST

A separate copy of this worksheet must be completed for each situation applicable under titles V, XVIII, and XIX.

3530.1 Part I - Calculation of Ancillary and Outpatient Cost.--This worksheet provides for the apportionment of cost applicable to inpatient and outpatient services reimbursable under titles V, XVIII, and XIX for SNFs, NFs, ICF/MR and Other in accordance with 42 CFR 413.53(b).

Outpatient physical therapy, outpatient speech pathology, and outpatient occupational therapy services are subject to a 10% reduction of reasonable cost for services rendered on and after January 1, 1998. This reduction is calculated on this worksheet

NOTE: For titles V and XIX, use columns 1, 2, and 4.

Column 1.--Enter the ratio of cost to charges developed for each cost center from Worksheet C, column 3.

Columns 2 and 3.--Enter from your records or the Provider Statistical & Reimbursement Report (PS&R) furnished by your intermediary, the program SNF charges for the indicated cost centers. If gross charges for provider component only were used, then use only the health care program gross charges for provider component in columns 2 and 3.

For title V, title XVIII, Part A, (cost reimbursement) and title XIX, transfer the program charges (less any professional component charges included therein) from column 2, the sum of lines 21 through 33, to Worksheet E, Part I, line 11. For a title XVIII PPS provider, transfer the program charges from column 2, sum of lines 21 through 33 to Worksheet E, Part III, line 4.

For title XVIII, Part B, transfer the charges (less any professional component charges included therein) from column 3, lines 21 through 33 to Worksheet E, Part II, line 8, or Worksheet E, Part III, line 23, as applicable.

Provide a reconciliation showing how the elimination of any professional component charges was accomplished.

Column 4.--Multiply the indicated program charges in column 2 by the ratio in column 1 to determine the program expenses. Transfer column 4, sum of lines 21 though 33, as follows:

Type of Provider	To
SNF - Cost	Worksheet E, Part I, line 1
SNF - PPS	Worksheet E, Part III, line 1
NF	Worksheet E, Part I, line 1
ICF/MR	Worksheet E, Part I, line 1

Column 6.--Enter the title XVIII inpatient physical therapy, inpatient speech pathology and inpatient occupational therapy charges for services rendered on and after January 1, 1998 on lines 25, 26, and 27 respectively.

Column 7.--Enter the total inpatient physical therapy, inpatient speech pathology, and inpatient occupational therapy costs associated with services rendered on and after January 1, 1998 on lines 25, 26, and 27 respectively.

Column 9.--Extend the net allowable Part B costs from column 5 less the reduction amounts in column 8, for lines 25, 26, and 27. Multiply the indicated title XVIII, Part B charges in column 3 by the ratio in column 1 to determine the title XVIII, ancillary, Part B expenses. Enter in column 9 the amounts in column 5, for lines 21 through 24, and lines 28 through 36. For line 48, enter in column 9, the lesser of the amount on line 48 column 5 or the limit from Worksheet S-2, line 48. Calculate the limit by multiplying the payment limit on Worksheet S-2, line 48, column 1, times he number of trips on Worksheet S-3, column 4, line 10. If your fiscal year begins on a date other than October 1st, the above calculation will be required twice, one for the rate and trips before October 1st, and once again for the rate on Worksheet S-2, line 48.01 column 1 times the number of trips on Worksheet S-3, column 4, line 10.01. Transfer column 9, sum of lines 21-33, for a cost SNF to Worksheet E, Part II, line 1. Transfer column 9, sum of lines 21-33, for a PPS SNF to Worksheet E, Part III, line 19.

Title XVIII outpatient, Part B expenses will be transferred from column 9, sum of lines 34-48, to Worksheet E, Part II, line 2.

NOTE: For titles V and XIX, use only columns 1, 2, and 4.

Line 29.--Enter only the program charges for medical supplies charged to patients that are not paid on a fee schedule (i.e., orthotics and prosthetics). DME (not to be confused with complex medical equipment such as air fluidized beds) is paid on a fee schedule through the DMERC for title XVIII and therefore is not paid through the cost report.

For cost reporting periods overlapping 04/01/2002 and after, subscript line 48 for ambulance services in accordance with the subscripting on Worksheet S-2, line 48 and report charges separately on line 48 and subscripts for the applicable periods.

3530.2 Part II - Apportionment Vaccine Cost. This part provides for the apportionment of the costs applicable to the administration and cost of the following vaccines: Pneumococcal, Hepatitis B, Influenza, and Osteoporosis.

Line 1.--Enter the cost to charges ratio from Worksheet C, column 3, line 30.

Line 2.--Enter the program charges from the PS&R or from provider records.

Line 3.--Multiply line 1 by line 2 and enter the result. Transfer this amount to Worksheet E, Part III, line 20.

3530.3 Part III - Calculation of Interns and Residents Pass Through for PPS SNF.--This part calculates the ancillary costs associated with I & R costs applicable for pass through. This calculation is to be completed for cost reporting periods beginning on and after July 1, 1998.

Column 1.--Enter on each ancillary line the total ancillary costs from Worksheet B, Part I, column 18

Column 2.--Enter the I & R costs allocated to ancillary cost centers on Worksheet B, Part I, column 14.

Column 3.--Calculate the ratio of I & R costs to total costs for each ancillary cost center. Divide the amounts in column 2 by the amounts in column 1.

Column 4.--Enter the title XVIII Part A cost from Part I, column 4 above.

Column 5.--Determine the title XVIII pass through amount for I & R costs by multiplying the ratios in column 3 times the cost in column 4. Transfer the total amount on line 75, column 5 to Worksheet E, Part III, line 1.

3531. WORKSHEET D-1 - COMPUTATION OF INPATIENT ROUTINE COSTS

This worksheet provides for the computation of SNF inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries) and 42 CFR 413.30 (limitations on reimbursable costs). This worksheet applies to all Title V, Title XVIII, and Title XIX inpatient routine costs.

A separate copy of this worksheet must be completed for the SNF, NF, and ICF/MR. Also, a separate copy of this worksheet must be completed for each health care program under which inpatient operating costs are computed. Report separately the required statistics for the SNF, NF, and ICF/MR.

3531.1 Part I - Calculation of Inpatient Routine Costs.

At the top of each page, indicate by checking the appropriate box the health care program and provider component for which the page is prepared.

Line Descriptions

Line 1.--Enter the following data depending on the health care program and provider component for which the page is completed:

Description	Inpatient Days From
SNF	Worksheet S-3, Part I, column 7, line 1, including private room days for title XVIII
NF	Worksheet S-3, Part I, column 7, line 3 for titles V and XIX
ICF/MR	Worksheet S-3, Part I, column 7, line 3.1 for title XIX

EXCEPTION: When the SNF is located in a State that licenses the provider as an SNF regardless of the level of care given for titles V and XIX patients, enter the days from Worksheet S-3, column 7, sum of lines 1 and 3.

Line 2.--Enter the total private room days. (From provider's records.)

Line 3.--Enter the following data depending on the health care program and provider component for which the page is completed:

Description	Inpatient Days From
SNF	Worksheet S-3, Part I, column 4, line 1, for title XVIII
NF	Worksheet S-3, Part I, column 3, line 3 for title V and Worksheet S-3, Part I, column 5, line 3 for title XIX
ICF/MR	Worksheet S-3, Part I, column 5, line 3.1 for title XIX

EXCEPTION: When the SNF is located in a State that certifies the provider as an SNF regardless of the level of care given for titles V and XIX patients, enter the program inpatient days from Worksheet S-3, column 3, lines 1 and 3 for title V and from Worksheet S-3, column 5, lines 1 and 3 for title XIX.

Line 4.--Enter the total medically necessary private room days applicable to each health care program and each provider component.

Line 5.--For a full cost report, enter the total general inpatient routine service costs from Worksheet B, Part I, column 18, SNF from line 16, NF from line 18, or ICF/MR from line 18.1. For a simplified cost report, enter the total general inpatient service costs from Worksheet B, Part III, column 5, SNF line 16, NF from line 18, or ICF/MR from line 18.1.

EXCEPTION: When the SNF is located in a State that certifies the provider as an SNF regardless of the level of care given for Titles V and XIX patients, enter the general inpatient routine service costs from lines 16 and 18.

Line 6.--Enter the total charges for general inpatient routine services for the SNF, the SNF-based NF, or the SNF-based ICF/MR as applicable. These charges agree with the amounts on Worksheet G-2, column 1, lines 1, 3, and 3.1. See exception after line 5 above.

Line 7.--Enter the general inpatient routine cost/charge ratio (rounded to six decimal places) by dividing the total inpatient general routine service costs (line 5) by the total inpatient general routine service charges (line 6).

Line 8.--Enter the private room charges from your records.

Line 9.--Enter the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the total charges for private room accommodations by the total number of days of care furnished in private room accommodations.

Line 10.--Enter the semi-private room charges from your records.

Line 11.--Enter the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the total charges for semi-private room accommodations by the total number of days of care furnished in semi-private room accommodations.

Line 12.--Subtract the average per diem charge for all semi-private accommodations (line 11) from the average per diem charge for all private room accommodations (line 9) to determine the average per diem private room charge differential. If a negative amount results from this computation, enter zero.

Line 13.--Multiply the average per diem private room charge differential (line 12) by the inpatient general routine cost/charge ratio (line 7) to determine the average per diem private room cost differential (rounded to two decimal places).

Line 14.--Multiply the average per diem private room cost differential (line 13) by the private room accommodation days (line 2) to determine the total private room accommodation cost differential adjustment.

Line 15.--Subtract the private room cost differential adjustment (line 14) from the general inpatient routine service cost (line 5) to determine the adjusted general inpatient routine service cost net of private room accommodation cost differential adjustment.

Line 16.--Determine the adjusted general inpatient routine service cost per diem by dividing the amount on line 15 by inpatient days (including private room days) shown on line 1.

Line 17.--Determine the routine service cost by multiplying the program inpatient days (including the private room days) shown on line 3 by the amount on line 16.

Line 18.--Determine the medically necessary private room cost applicable to the program by multiplying line 4 by the amount on line 13.

Line 19.--Add the amounts on lines 17 and 18 to determine the total program general inpatient routine service cost.

Line 20.--Enter the capital-related cost allocated to the general inpatient service cost center from Worksheet B, Part II, column 18, SNF from line 16, NF from line 18, or ICF/MR from line 18.1. See exception after line 5 above.

Line 21.--Determine the per diem capital-related cost by dividing line 20 by inpatient days on line 1.

Line 22.--Determine the program capital-related cost by multiplying line 20 by line 3.

Line 23.--Determine the inpatient routine service cost by subtracting the amount on line 21 from the amount on line 19.

Line 24.--Obtain the aggregate charges to beneficiaries for excess costs from your records.

Line 25.--Obtain the total program routine service cost for comparison to the cost limitation by subtracting the amount on lines 24 from the amount on line 23.

Line 26.--Enter the per diem limitation. This line will not be used for cost reporting periods beginning on and after July 1, 1998.

Line 27. --Obtain the inpatient routine service cost limitation by multiplying the number of inpatient days shown on line 3 by the cost limit for inpatient routine service cost applicable to you for the period for which the cost report is being filed. This amount is provided by your intermediary and is entered in the space provided in the line description. Line 27 will not be calculated for PPS cost reports with fiscal years beginning on and after July 1, 1998

Line 28.--Enter the amount of reimbursable inpatient routine service cost which is determined by adding line 22 to the lesser of lines 25 or 27. Transfer this amount to the appropriate Worksheet E, Part I, line 4. For PPS cost reports with fiscal years beginning on and after July 1, 1998, enter the amount from line 19. No amount will be transferred for title XVIII to Worksheet E, Part I.

3531.2 Part II - Calculation of Inpatient Intern and Resident Cost for PPS Passthrough.--This part is applicable for cost reporting periods beginning on and after July 1, 1998.

Line 1. --Enter the total inpatient days from Worksheet S-3, Part I, column 7, line 9, less the hospice days on line 8.

Line 2. --Enter the title XVIII inpatient days from Worksheet S-3, Part I, column 4, line 1.

Line 3. --Enter the program intern and resident cost from Worksheet B, Part I, column 14, line 14.

Line 4. --Calculate the ratio of program days to total days. Divide line 2 by line 1.

Line 5. --Calculate the intern and resident pass through cost. Multiply the amount on line 3 times the amount on line 4. Transfer this amount to Worksheet E, Part III, line 2.

3532. WORKSHEET D-2 - APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

3532.1 Part I - Not in Approved Teaching Program.--Use this part only if you have interns and residents who are not in an approved teaching program. (See CMS Pub. 15-I, chapter 4.)

Column 1.--Enter the percentage of time that interns and residents are assigned to each of the indicated patient care areas on lines 2 through 11, 13, and 14 (from your records).

Column 2.--Enter on line 1 the total cost of services rendered in all patient care areas from Worksheet B, Part I, column 18, line 49. Multiply the percent in column 1 for each line by the total cost in column 2, line 1. Enter the resulting amounts on the appropriate line in column 2.

A. Inpatient.--

Column 3.--Enter the total inpatient days applicable to the various patient care areas of the complex:

Description	Enter in Col. 3	Inpatient Days From
SNF	line 2	Worksheet S-3, Part I, col. 7, line 1
SNF PPS	line 2	Worksheet S-3, Part I col. 7, line 1
NF	line 4	Worksheet S-3, Part I col. 7, line 3
ICF/MR	Line 4.1	Worksheet S-3, Part I col. 7, line 3.1

Column 4.--Divide the allocated expenses in column 2 by the inpatient days in column 3 to arrive at the average per diem cost for each cost center.

Columns 5, 6, and 7.--Enter in the appropriate column the health care program inpatient days for each patient care area.

Titles V and XIX

Description	Enter in column 5 for title V or column 7 for title XIX	From
SNF	line 2	Worksheet D-1, line 3
NF	line 4	Worksheet D-1, line 3
ICF/MR	Line 4.1	Worksheet D-1, line 3

Title XVIII.--Enter in column 6, line 2 the total number of days in which beneficiaries were inpatients of the provider and had Medicare Part B coverage. Determine such days without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days. The following reconciliation format is recommended.

Cost Center	Part A Inpatient Days	plus	Part B Only Days	minus	No Part B Days	=	Medicare Part B Days

Part A Inpatient Days.--Enter the Medicare Part A inpatient days from Worksheet D-1, line 3 or Worksheet S-3, line 1, column 4.

Part B Only Days.--Enter the total number of days (from your records) in which inpatients were covered under Medicare Part B but did not have Part A benefits available.

No Part B Days.--Enter the total number of days (from your records) in which inpatients were covered under Medicare Part A but did not have Part B benefits available.

Columns 8, 9, and 10.--Multiply the average cost per day in column 4 by the health care program days in columns 5, 6, and 7, respectively. Enter the resulting amounts in columns 8, 9, and 10, as appropriate, for each cost center.

B. Outpatient.--

Column 3.--Enter the total charges applicable to each outpatient service area. Obtain the total charges from Worksheet C, column 2, lines 34 and 35.

Column 4.--Compute the total outpatient cost to charge ratio by dividing costs in column 2 by charges in column 3 for each cost center.

Columns 5, 6, and 7.--Enter in these columns program charges from your records for outpatient services.

NOTE: Line 15 in columns 5, 6, and 7 is UNSHADED, and the total of lines 13 and 14 is entered on this line. Line 16 in columns 5, 6, and 7 is SHADED, and no amounts are entered there.

Columns 8, 9, and 10.--Compute program outpatient costs for titles V, XIX, and title XVIII, Part B by multiplying the cost to charge ratio in column 4 by the program outpatient charges in columns 5, 6, and 7. Enter the resulting amounts in columns 8, 9, and 10, as appropriate, for each cost center.

Transfer program expenses:

From Title V (Column 8)/Title XIX (Column 10) - (cost reimbursed)

Line 16 TO Worksheet E, Part I, line 2

From Title V (column 8)/ Title XIX (column 10) (PPS)

Line 16 TO Worksheet E, Part III, line 2

From Title XVIII (Column 9)(Cost Reimbursed) only if Part II is not utilized

Line 16 TO Worksheet E, Part II, line 4

From Title XVIII (Column 9) (PPS) only if Part II is not utilized

Line 16 TO Worksheet E, Part III, line 21

3532.2 Part II - In Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only).--This part provides for reimbursement for inpatient routine services which are rendered by interns and residents in approved teaching programs to Medicare beneficiaries who have Part B coverage and are not entitled to benefits under Part A. (See HCFA Pub. 15-I, chapter 4, and §2120.)

Column 1.--Enter the amounts allocated in the cost finding process to the indicated cost centers. Obtain these amounts from Worksheet B, Part I, column 14.

Column 2.--Enter the total inpatient days applicable to the various patient care areas of the complex. See instructions for Part I, column 3. (If PPS SNF, obtain days from Worksheet S-3, Part I, line 1, column 7.)

Column 3.--Divide the allocated expense in column 1 by the inpatient days in column 2 to arrive at the average per diem cost for each cost center.

Column 4.--On line 17, enter the total number of days in which inpatients were covered under Medicare Part B but did not have Part A benefits available.

Column 8.--Transfer the amount on line 17 to Worksheet E, Part II, line 4.

Delete the line 19 description, and do not enter any amounts on this line.

3534. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E is used to calculate reimbursement settlement. Use the applicable part of Worksheet E as follows:

Part I - Part A - Inpatient Services

Part II - Part B - Medical and Other Health Services

Part III - SNF Reimbursement Under PPS

Part V - Reimbursement Under NHCMQ Demonstration

NOTE: Worksheet E Part I, Part II, and Part V will not be applicable for cost reporting periods (for PPS SNFs under title XVIII), beginning on and after July 1, 1998.

3534.1 Part I - Part A - Inpatient Services.--Use Worksheet E, Part I, to calculate reimbursement settlement for titles V, XVIII, and XIX services furnished by SNFs, NFs, and ICF/MRs reimbursed under cost principles.

Enter check marks in the appropriate boxes at the top of each page of Worksheet E, Part I, to indicate the program and the provider component for which it is used.

Line Descriptions

Line 1.--Enter the cost of ancillary services furnished to inpatients for titles V, XVIII, Part A, and XIX.

Transfer these amounts from Worksheet D, column 4, lines 21 through 33.

Line 2.--Transfer interns and residents (I & R) costs for title V from Worksheet D-2, column 8, line 16. Transfer the I & R cost for title XIX from Worksheet D-2, column 10, line 16.

Line 3.-- For titles V and XIX, enter the cost of outpatient services. Obtain the amount from Worksheet D, column 4, lines 34 through 48.

Line 4.--Enter the inpatient operating costs from Worksheet D-1, line 28.

Line 5.--Enter the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees applicable to the SNF. For utilization review that is performed for Medicare patients only, the amount is taken from Worksheet A-8, line 28.

Line 7.--Enter the applicable charge differential between semi-private and less than semi-private accommodations. The amount of the differential is the difference between the your customary charge for semi-private accommodations and your customary charge for the less than semi-private accommodations furnished for all program patient days when the accommodations furnished were provided not at the patients request nor for a reason which is consistent with program purposes.

Line 8.--Enter the amount on line 6 minus the amount on line 7.

Line 9.--Enter the amounts paid or payable by workmen's 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:

1. Workmen's compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered non-program services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges, but are not included in program patient days and charges. In this situation, no primary payer payment is entered on line 9.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and applicable deductibles and coinsurance. In situations 4 and 5, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductibles and coinsurance) less the primary payer payment; or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductibles and coinsurance. In all situations for services rendered on or after November 13, 1989, the primary payer payment is credited 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 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance (situations 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 9.

Line 10.--Enter the amount on line 8 minus the amount on line 9.

NOTE: For services provided by an SNF after October 1, 1993, return on equity capital is no longer reimbursable under title XVIII. Add a line for title V and title XIX if return on equity capital is applicable. Subscript line 9.

Lines 11 through 15.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 10.

Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see HCFA Pub. 15-I, §2104.3) and (2) provider charges to beneficiaries for excess costs as described in HCFA Pub. 15-I, §§2570 - 2577.

Enter on lines 11, 12, and 13 the Medicare charges for inpatient ancillary and for outpatient services, respectively. If the charges on Worksheet C do not include the professional component of provider-based physician remuneration, obtain the amount to be entered on line 11 from the appropriate Worksheet D, column 2, line 75 and obtain the amount to be entered on line 13 from the appropriate Worksheet D, column 3, line 75.

If the charges on Worksheet C do include such professional component, eliminate the amount of the professional component from the charges to be entered on lines 11, 12, and 13. Submit a schedule showing these computations with the cost report.

Line 11.--For titles V or XIX, enter the total charges for inpatient ancillary services from Worksheet D, column 2, line 75 net of professional component.

Line 13.--For titles V and XIX only, enter the total charges net of professional component from provider records.

Line 14.--Enter the program inpatient routine service charges from your records for the applicable component.

The amount on this line includes covered late charges which have been billed to the program where the patient's medical condition is the cause of the extended stay. In addition, these charges include the charges for semi-private accommodations of Medicare inpatients which workmen's compensation and other primary payers paid at the ward rate. Adjust these charges on line 15 in determining final settlement.

Line 15.--The amount entered on line 13 has not been adjusted to take into consideration the differential between semi-private room charges and charges for less than semi-private accommodations. Enter the amount from line 7.

Line 16.--Enter the sum of lines 11 through 14 minus line 15.

Lines 17 through 20.--These lines provide for the reduction of program charges when the provider does not actually impose such charges in the case of most patients liable for payment for services on a charge basis or fails to make reasonable efforts to collect such charges from those patients. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 17 through 19 but instead enter on line 20 the amount from line 16. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 20 exceed the actual charge on line 16.

Computation of Reimbursement Settlement

Line 21.--Enter the lesser of reasonable cost (line 8 before the application of the primary payer amount) or customary charges (line 20), minus the primary payer amount on line 9.

Line 22.--Enter the deductibles billed to title V and title XIX beneficiaries.

Line 23.--Enter the amount on line 21 minus the amount on line 22.

Line 24.--Enter the Part A coinsurance billed to Medicare beneficiaries. Include any primary payer payments applied to Medicare beneficiary coinsurance in situations where the primary payer payments do not fully satisfy the obligation of the beneficiary to the provider. Do not include any primary payer payments applied to Medicare beneficiary coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to the provider. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 25.--Enter the amount on line 23 minus the amount on line 24.

Line 26.--Enter program reimbursable bad debts net of bad debt recoveries for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services.

Line 27.--Enter the sum of the amounts on lines 25 and 26.

Line 28.--If your cost limit is raised as a result of your request for review, amounts which were erroneously collected on the basis of the initial cost limit are required to be refunded to the beneficiary. Enter any amounts which are not refunded either because they are less than $5.00 collected from a beneficiary or because the provider is unable to locate the beneficiary. (See HCFA Pub. 15-I, §2577.)

NOTE: The SNF is the only provider component using this worksheet which is still subject to cost limits.

Line 29.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See HCFA Pub. 15-I, §§136 - 136.16.)

Line 30.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from a cash basis to an accrual basis. (See HCFA Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Include the title XVIII portion of the amount of the State's bill for determining the validity of nurse aide training and testing under §1919(b)(5) of the Social Security Act. This adjustment includes the State's cost of deeming individuals to have completed training and testing requirements and the State's cost of determining the competency of individuals trained by or in a facility-based program.

Line 31.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss from the disposition of depreciable assets. (See HCFA Pub. 15-I, §§132-132.4.) Enter in parentheses ( ) the amount of any excess depreciation taken.

NOTE: Section 1861 (v) (1) (O) 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.

Line 32.--Enter the sum of the amounts on line 27, plus or minus lines 30 and 31, minus lines 28 and 29.

Line 33.--Enter the sequestration adjustment amount, if applicable.

Line 35.--Enter interim payments from Worksheet E-1, column 2, line 4.

Line 36.--Enter the amount on line 34 minus the amount on line 35. Enter a negative amount in parentheses ( ). Transfer the amount on this line to Worksheet S, Part II, line 1, columns 1 through 4, as applicable. Transfer titles V and XIX NF amounts to Worksheet S, Part II, line 3, columns 1 and 4, respectively. Transfer title XIX ICF/MR amounts to Worksheet S, Part II, line 3.1, column 4.

Line 37.--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated 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.

3534.2 Part II - Part B - Medical and Other Health Services.--Use Worksheet E, Part II, to calculate reimbursement settlement for Part B services for SNFs under title XVIII.

Line Descriptions

Line 1.--Enter the ancillary service cost furnished to inpatients under the medical and other health services benefit of Medicare Part B. These services are covered in this manner for Medicare beneficiaries with Part B coverage only when Part A benefits are exhausted. Obtain this amount from Worksheet D, column 9, lines 21-33, as applicable.

Line 2.--Enter the outpatient service costs from Worksheet D, column 9, lines 34 - 48.

Line 3.--Enter the vaccine cost from Worksheet D, Part II, line 3.

Line 4.--Transfer this amount from Worksheet D-2, Part II, column 8, line 17.

Line 5.--Enter the sum of lines 1, 2, 3, and 4.

Line 6.--Enter the amounts paid or payable by workmen's 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:

1. Workmen's compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered non-program services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient charges are included in total charges but are not included in program charges. In this situation, no primary payer payment is entered on line 6. In addition, exclude amounts paid by other primary payers for outpatient dialysis services which are reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and any deductibles and coinsurance. In situations 1, 2, and 3, primary payer payment is not credited toward the beneficiary's deductibles and coinsurance. In situations 4 and 5, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductibles and coinsurance) less the primary payer payment; or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductibles and coinsurance. In situations 4 and 5, primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered charges in program charges and include the charges in charges for cost apportionment purposes. Enter the primary payer payment on line 6 to the
extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance (situations 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 6.

Line 7.--Enter the amount on line 5 minus the amount on line 6.

Computation of Lesser of Reasonable Cost or Customary Charges.--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b)(2) or customary charges as defined in 42 CFR 413.13(b)(1).

NOTE: For services provided by an SNF after October 1, 1993, return on equity capital is no longer reimbursable under title XVIII.

Line Descriptions

Lines 8 through 10.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 7.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see HCFA Pub. 15-I, §2104.3) and (2) provider charges to beneficiaries for excess costs as described in HCFA Pub. 15-I, §§2570 through 2577.

Line 8.--Enter the total charges for title XVIII, Part B inpatient ancillary services from Worksheet D, Part I, column 3, lines 21 through 33, plus Part II, line 2.

NOTE: If the amounts entered on Worksheet D do include charges for professional services, eliminate the amount of the professional component from the charges entered on line 8. Submit a schedule showing these computations with the cost report.

Line 9.--Enter the total charges for outpatient services from Worksheet D, Part I, column 3, lines 34 through 48.

Line 11.--Enter the sum of lines 8 through 10.

Lines 12 through 15.--These lines provide for the reduction of program charges when the provider does not actually impose such charges in the case of most patients liable for payment for services on a charge basis or fails to make reasonable efforts to collect such charges from those patients. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 13 through 15 but instead enter on line 16 the amount from line 11. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 15 exceed the actual charges on line 11.

Line 16.--Enter the lesser of the reasonable cost or customary charges. Enter the lesser of line 5 or line 15, minus the primary payer amount on line 6

Line 17.--Enter the Part B deductibles and coinsurance billed to Medicare beneficiaries. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services.

Line 18.--Enter the amount from line 16 minus the amount on line 17.

Line 19.--Enter program reimbursable bad debts for deductibles and coinsurance for other services (from your records), excluding professional services and net of bad debt recoveries.

Line 20.--Enter the sum of the amounts on lines 18 and 19.

Line 21.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See HCFA Pub. 15-I, §§136 through 136.16.)

Line 22.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See HCFA Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 23.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See HCFA Pub. 15-I, §§132 - 132.4.) Enter the amount in parentheses ( ) of any excess depreciation taken.

NOTE: Section 1861 (v) (1) (O) 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.

Line 24.--Enter the sum of line 20, minus the amount on line 21, plus or minus the amounts on lines 22 and 23.

Line 27.--Enter interim payments from Worksheet E-1, column 4, line 4.

Line 28.--Enter the amount on line 26 minus the amount on line 27. Enter a negative amount in parentheses ( ). Transfer this amount to Worksheet S, Part II, column 3, line 1 or line 2, as applicable.

Line 29.--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximate the actual effect of the item as if it had been determined through the normal cost finding process. Attach a schedule showing the details and the computations for this line.

3534.3 Part III - SNF Reimbursement Under PPS.--Use this part to calculate reimbursement settlement under PPS for program services. For cost reporting periods beginning before July 1, 1998, use this part to calculate reimbursement settlement for Part A services to Medicare residents under the NHCMQ demonstration, Phase II and Phase III.

Part A Line Descriptions

NOTE: Do not make any entries on lines 1 through 6 if you are participating in the NHCMQ demonstration, Phase II and Phase III.

Line 1.--For cost reporting periods beginning before July 1, 1998, enter the cost of ancillary services furnished to inpatients for Title XVIII, Part A, Title V, and Title XIX. Obtain this amount from Worksheet D, Part I, column 4, sum of lines 21 through 33.

For cost reporting periods beginning on and after July 1, 1998, enter the inpatient ancillary services applicable to Intern and Resident Part A cost, from Worksheet D, Part III, column 5 line 75.

Line 2.--No entries should be made on this line for cost reporting periods beginning before July 1, 1998. For cost reporting periods beginning on and after July 1, 1998, enter the sum of title XVIII Intern and Resident cost, from Worksheet D-1, Part II, line 5.

Line 4.--Report the charges applicable to the ancillary services here from Worksheet D, column 2, sum of lines 21 through 33. Do not complete this line for cost reporting periods beginning on and after July 1, 1998

Line 5.--Enter the intern and resident charges from the provider's records. Do not complete this line for cost reporting periods beginning on and after July 1, 1998

Line 7.--The amount entered is the number of program days multiplied by the appropriate prospective payment rate. For providers, with a cost reporting period beginning on and after July 1, 1998, enter on line 7 the amount from Worksheet S-7, Part III, sum of columns 9 and 10, line 75. Providers with cost reporting periods ending on and after February 28, 2001 must enter the amount from Worksheet S-7, Part IV, column 5, line 46.

Line 8.--Enter the amounts paid or payable by workmen's compensation and other primary payers where program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

1. Workmen's compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered to be non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges but are not included in program days and charges. In this situation, no primary payer payment is entered on line 8.

However, if the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and any deductible and coinsurance. In situations 1, 2, and 3, primary payer payment is not credited toward the beneficiary's deductibles and coinsurance. In situations 4 and 5, 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 primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. In situations 4 and 5, primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

If 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 8 to the extent that

Enter the primary payer payment is not credited toward the beneficiary's deductible and coinsurance (situations 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 9.

Line 9.--Enter the Part A coinsurance billed to Medicare beneficiaries. Include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payments do not fully satisfy the obligation of the beneficiary to the provider. Do not include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to the provider. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 10.--Enter program reimbursable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services. *Report any recovery of bad debts on line 10.04 below.*

Line 10.01—Multiply the amount (including negative amounts) on line 10 by 100 percent for cost reporting periods beginning before 10/01/2005.

Line 10.02—Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 10.

Line 10.03—DRA 2005 SNF Bad Debt – For cost reporting periods beginning on or after October 1, 2005, calculate as follows: [(Line 10 – line 10.02) times .7], PLUS the amount on line 10.02. This is the adjusted SNF allowable bad debt in accordance with DRA 2005, section 5004. (10/01/2005)

Line 10.04—Recovery of reimbursable bad debts.

Line 11.--Enter the applicable program's share of the reasonable compensation paid to physicians for services in utilization review committees applicable to the SNF. Include this amount in the amount eliminated from total costs on Worksheet A-8, line 28.

Line 12.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in program utilization. (See §§136-136.16.)

Line 13.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See §§132 - 132.4.) Enter in parentheses ( ) the amount of any excess depreciation taken.

NOTE: Section 1861 (v) (1) (O) 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.

Line 14.—For cost reporting periods beginning prior to October 1, 2005, enter the sum of lines 3, 7, 10 and 11, minus lines 12, 8 & 9, plus line 13. For cost reporting periods beginning on and after October 1, 2005 enter the sum of lines *(3, 7,and line 10.03), minus line 10.04* for title XVIII, plus lines 11and 13, minus lines 8, 9, and 12.

Line 15.--Using the methodology outlined in §120, enter the sequestration adjustment.

Line 16.--Enter interim payments from Worksheet E-1.

NOTE: Include amounts received from PPS (for inpatient routine services) as well as amounts received from ancillary services.

Line 16.01.--Your fiscal intermediary will enter the Part A tentative adjustments from Worksheet E-1, column 2.

Line 16.20.--Enter OTHER adjustments from Worksheet E-1, column 2.

Line 17.--Enter the amount on line 14 minus the sum of lines 15, 16, and 16.01. Enter a negative amount in parentheses ( ). Transfer this amount to Worksheet S, Part II, column 2, line 1 or line 2, as applicable.

Line 18.--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 worksheet showing the details and computations for this line.

Part B Line Descriptions.-

Use this part to calculate reimbursement settlement for Part B services for SNFs under title XVIII.

Line Descriptions

Line 19.--Enter the amount of Part B ancillary services furnished to Medicare patients. Obtain this amount from Worksheet D, Part I column 9, line 75.

Line 21.--Enter the intern and resident cost from Worksheet D-2, column 8, lines 16 or 20 for title XVIII

Line 23.--Report the charges applicable to the ancillary services from Worksheet D, Part I, column 3, line 75, plus Part II, line 2.

Line 24.--Enter the intern and resident charges from the provider's records.

Line 26.--Enter the amounts paid or payable by workmen's 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:

1. Workmen's compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges but are not included in program patient days and charges. In this situation, no primary payer payment is entered on line 26.

However, if the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and any applicable deductible and coinsurance. In situations 1, 2, and 3, primary payer payment is not credited toward the beneficiary's deductibles and coinsurance. In situations 4 and 5, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductibles and coinsurance) less the primary payer payment; or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. In situations 4 and 5, primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

If 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 26 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 27.

Line 27.--Enter the Part B deductible and coinsurance billed to Medicare beneficiaries. Include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payments do not fully satisfy the obligation of the beneficiary to you. Do not include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to you. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 28.--Enter program reimbursable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

Line 31.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136 - 136.16.)

Line 32.--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.

Line 33.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132 - 132.4.) Enter in parentheses ( ) the amount of any excess depreciation taken.

NOTE: Section 1861 (v) (1) (o) 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.

Line 34.-- Enter the sum of the amounts on lines 25, 28, and 30, minus the amounts on lines 26, 27, and 31 plus or minus the amounts on lines 32 and 33.

Line 35.--Using the methodology outlined in §120, enter the sequestration adjustment.

Line 36.--Enter the Title XVIII interim payment from Worksheet E-1, column 4 line 4. Enter the Title V or Title XIX interim payment from your records.

Line 36.01.--Your Fiscal Intermediary will enter the Part B tentative adjustments from Worksheet E-1, column 4.

Line 36.20.--Enter OTHER adjustments from Worksheet E-1, column 4.

Line 37.--Enter the amount on line 34 minus the sum of lines 35, 36, and 36.01. Enter a negative amount in parentheses ( ). Transfer this amount to Worksheet S, Part II, column 3, line 1.

Line 38.--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 worksheet showing the details and computations for this line.

3534.4 Part V - Reimbursement Under NHCMQ Demonstration.--Use this part to calculate reimbursement if you are a part of the NHCMQ demonstration project. This Part will not be completed for cost reporting periods beginning on and after July 1, 1998.

Use Part A to calculate payment for title XVIII services furnished by NHCMQ demonstration participants. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration.

Line Descriptions

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

Line 2.--Enter the number of demonstration program days. Obtain this figure from Worksheet S-7, sum of columns 3.01 and 4.01, line 46.

Lines 3 through 5 calculate the net non-NHCMQ demonstration Part A inpatient ancillary services. These include radiology, laboratory, intravenous therapy, oxygen, electrocardiology, medical supplies charged to patients, and drugs charged to patients and others.

Line 3.--Enter the total Part A ancillary program costs. Obtain this figure from Worksheet D, column 4, line 75.

Line 4.--Complete this line for phase 3 only. Enter the physical, occupational, and speech therapy ancillary program costs. Enter the sum of lines 25, 26, and 27 from Worksheet D, column 4.

Line 5.--Subtract the amount on line 4 from line 3, and enter the difference. This amount represents the net ancillary services not applicable to the NHCMQ demonstration.

Line 6.-- Enter the NHCMQ demonstration inpatient routine/ancillary PPS amount paid. Obtain this figure from Worksheet S-7, column 5, line 46.

Line 7.-- Do not make any entries on this line.

Lines 8 and 9 calculate the program inpatient capital costs. The capital costs are not part of the PPS calculation. Instead the capital costs flow through the cost finding stepdown process on Worksheet B.

Line 8.--Enter the per diem capital related cost from the title XVIII SNF Worksheet D-1, line 21.

Line 9.-- Calculate the program capital related cost by multiplying the amount on line 8 by the amount on line 1.

Lines 10 through 24 calculate the indirect cost component of the demonstration ancillary services. The indirect cost component of the demonstration ancillary services is not part of the PPS calculation. Instead the indirect costs are passed through from cost finding on the cost report. For participants in the demonstration, ancillary services will be calculated as part of the PPS payment beginning in phase 3. Thus lines 10 through 24 are completed only for phase 3.

Line 10.--Enter the total general service cost allocation for physical therapy. Obtain this amount from Worksheet B, Part I, column 18, line 25

Line 11.--Enter the total general service cost allocation for occupational therapy. Obtain this amount from Worksheet B, Part I, column 18, line 26.

Line 12.--Enter the total general service cost allocation for speech therapy. Obtain this amount from Worksheet B, Part I, column 18, line 27.

Line 13.--Enter the direct cost for physical therapy. Obtain this amount from Worksheet B, Part I, column 0, line 25.

Line 14.--Enter the direct cost for occupational therapy. Obtain this amount from Worksheet B, Part I, column 0, line 26.

Line 15.--Enter the direct cost for speech therapy. Obtain this amount from Worksheet B, Part I, column 0, line 27.

Line 16.--Enter the amount on line 10, less the amount on line 13. This is the physical therapy indirect cost for the entire reporting unit.

Line 17.--Enter the amount on line 11, less the amount on line 14. This is the occupational therapy indirect cost for the entire reporting unit.

Line 18.--Enter the amount on line 12, less the amount on line 15. This is the speech therapy indirect cost for the entire reporting unit.

Line 19.--Enter the charge to charge ratio for physical therapy. To obtain this figure, divide the amount on Worksheet D, column 2, line 25 by the amount on Worksheet C, column 2, line 25.

Line 20.--Enter the charge to charge ratio for occupational therapy. To obtain this figure, divide the amount on Worksheet D, column 2, line 26 by the amount on Worksheet C, column 2, line 26.

Line 21.--Enter the charge to charge ratio for speech therapy. To obtain this figure, divide the amount on Worksheet D, column 2, line 27 by the amount on Worksheet C, column 2, line 27.

Line 22.--Calculate the physical therapy demonstration indirect cost by multiplying the amount on line 16 by the amount on line 19.

Line 23.--Calculate the occupational therapy demonstration indirect cost by multiplying the amount on line 17 by the amount on line 20.

Line 24.--Calculate the speech therapy demonstration indirect cost by multiplying the amount on line 18 by the amount on line 21.

Line 25.--Providers in Phase II, enter the sum of lines 5, 6, and 9. Transfer this amount to Worksheet E, Part III, line 7. Providers in Phase III, enter the sum of lines 5, 6, 9, 22, 23, and 24. Transfer this amount to Worksheet E, Part III, line 7.

3535. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Complete an analysis of payments to providers for services furnished for each component of the health care complex which has a separate provider number as shown on Worksheet S, Part I. Worksheet E-1 is used by the SNF when eliminating Medicare reimbursement, and the provider has received Medicare interim payments made by the intermediary. It must not be completed for purposes of reporting interim payments for titles V or XIX.

The following components use one of the indicated worksheets instead of Worksheet E-1:

- SNF-based HHAs use Worksheet H-7;
- SNF-based RHC/FQHCs use Worksheet I-5; and
- SNF-based outpatient rehabilitation facilities use Worksheet J-4.

The column headings designate two categories of payments:

Columns l and 2 - Inpatient Part A
Columns 3 and 4 - Part B

Complete lines 1 through 4. The remainder of the worksheet is completed by your intermediary. All amounts reported on this worksheet must be for services, the cost of which is included in this cost report.

NOTE: DO NOT reduce any interim payments by recoveries as result of medical review adjustments where recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not also adjusted.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to you. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must include amounts withheld from your interim payments due to an offset against overpayments to you, applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2.--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period but not paid as of the end of the cost reporting period.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Enter the total amount of the interim payments (sum of lines l, 2, and 3.99). Transfer these totals as follows:

Column	For Non PPS Reimbursement Transfer to:	or:	For PPS Reimbursement Transfer to:
2	Worksheet E, Part I, line 35		Worksheet E, Part III, Part A, Line 16
4	Worksheet E, Part II, line 27		Worksheet E, Part III, Part B, Line 36

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6.--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Line 7.--The sum of lines 4, 5.99, and 6, column 2, for inpatient Part A must equal Worksheet E, Part I, line 34. For Part B, the amount in column 4 must equal Worksheet E, Part II, line 26.

For SNFs electing reimbursement under prospective payment, the sum of lines 4, 5, and 6, column 2, for inpatient Part A must equal Worksheet E, Part III, Part A, line 14 minus line 15. The amount in column 4 (Part B) must equal Worksheet E, Part III, line 34 minus line 35.

3536. WORKSHEET G - BALANCE SHEET

3536.1 Worksheet G-1 - Statement of Changes in Fund Balances.--
3536.2 Worksheet G-2 - Statement of Patient Revenues and Operating Expenses.-
3536.3 Worksheet G-3 - Statement of Revenue and Expenses.--Prepare these worksheets from your accounting books and records. Additional worksheets may be submitted, if necessary.

Worksheets G and G-1 are completed by all providers maintaining fund-type accounting records. Nonproprietary providers which do not maintain fund-type accounting records complete the general fund columns only.