

4123. WORKSHEET C - RATIO OF COST TO CHARGES FOR ANCILLARY AND
OUTPATIENT COST CENTERS

Column 1.--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 18. Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 18. 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 DME MAC or the regional home health contractor 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, e.g., .102589241 is rounded to .102589.

4124. WORKSHEET D - APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST

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

4124.1 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).

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 contractor, 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 XVIII, Part B, transfer the charges (less any professional component charges included therein) from column 3, line 100, plus Part II, line 2 Worksheet E, Part I, line 20.

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

Columns 4 & 5.--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 40 through 52, to Worksheet E, Part I, line 1. Title XVIII outpatient, Part B expenses will be transferred from column 5, line 100, to Worksheet E, Part I, line 17.

Line 48.--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 DME MAC for title XVIII and therefore is not paid through the cost report.

4124.2 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 49.

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 I, line 18.

4124.3 Part III - Calculation of Pass Through Costs for Nursing & Allied Health.--This part calculates the ancillary costs associated with Nursing & Allied costs applicable for pass through for Title XVIII.

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

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

Column 3.--Calculate the ratio of Nursing & Allied Health 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 Nursing & Allied costs by multiplying the ratios in column 3 times the cost in column 4. Transfer the total amount on line 100, column 5 to Worksheet E, Part I, line 2.

4125. 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.

4125.1 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:

<u>Description</u>	<u>Inpatient Days From</u>
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 2 for titles V and XIX
ICF/MR	Worksheet S-3, Part I, column 7, line 3 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 2.

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:

<u>Description</u>	<u>Inpatient Days From</u>
SNF	Worksheet S-3, Part I, column 4, line 1, for title XVIII
NF	Worksheet S-3, Part I, column 3, line 2 for title V and Worksheet S-3, Part I, column 5, line 2 for title XIX
ICF/MR	Worksheet S-3, Part I, column 5, line 3 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 2 for title V and from Worksheet S-3, column 5, lines 1 and 2 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 30, NF from line 31, or ICF/MR from line 32.

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 30 and 31.

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, 2, and 3. See exception after line 5 above.

Line 7.--Enter the general inpatient routine cost/charge ratio (rounded to six decimal places, e.g., .102589241 is rounded to .102589) 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 (line 8) by the total number of days of care furnished in private room accommodations (line 2).

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 (line 10) by the total number of days of care furnished in semi-private room accommodations (line 1 – line 2).

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 30, NF from line 31, or ICF/MR from line 32. 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 21 by line 3.

Line 23.--Determine the inpatient routine service cost by subtracting the amount on line 22 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.--This line is not applicable for title XVIII, but may be currently used for title V and or title XIX. Enter the per diem limitation applicable to the respective title.

Line 27.--This line is not applicable for title XVIII, but may be currently used for title V and or title XIX. 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 contractor and is entered in the space provided in the line description.

Line 28.--This line is not applicable for title XVIII, but may be currently used for title V and or title XIX. 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 II, line 4.

4125.2 Part II - Calculation of Inpatient Nursing & Allied Health Cost for PPS Pass through.

Line 1.--Enter the total *SNF* inpatient days from Worksheet S-3, Part I, column 7, *line 1*.

Line 2.--Enter the *SNF* program inpatient days from Worksheet S-3, Part I, column 4, line 1.

Line 3.--Enter the program Nursing & Allied Health cost from Worksheet B, Part I, column 14, line 30 for SNF. *Do not complete for titles V or XIX.*

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

Line 5.--Calculate the Nursing & Allied Health pass through cost. Multiply the amount on line 3 times the amount on line 4. Transfer this amount to Worksheet E, Part I, line 2, for title XVIII.

4130. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII

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

Part I - SNF Reimbursement Under PPS

Part II - Reimbursement Settlement for Title V and Title XIX

4130.1 Part I - SNF Reimbursement Under PPS.--Use this part to calculate reimbursement settlement under PPS for program services. A free-standing SNF has been reimbursed for Medicare under PPS for cost reporting periods beginning after July 1, 1998.

Part A Line Descriptions

Line 1.--Enter the prospective payment amount from your PS&R.

Line 2.--Enter the sum of title XVIII Nursing & Allied Health costs, from Worksheet D, Part III, column 5, line 100 and Worksheet D-1, Part II, line 5.

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

Line 4.--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 4.

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 4 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 4.

Line 5.--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 6.--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 7.--Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 6.

Line 8.--DRA 2005 SNF Bad Debt--Calculate this line as follows: ((line 6 - line 7) times .7) PLUS the amount on line 7. This is the adjusted SNF reimbursable bad debt in accordance with DRA 2005, section 5004. *For cost reporting periods that begin on or after October 1, 2012, as amended by section 3201(b) of the Middle Class Tax Extension and Job Creation Act of 2012, calculate this line as follows: [(line 6 - line 7) times 65 percent] + (line 7 times 88 percent)]. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: [(line 6 - line 7) times 65 percent] + (line 7 times 76 percent)]. For cost reporting periods that begin on or after October 1, 2014, calculate this line as follows: line 6 times 65 percent.*

Line 9.--Enter the amount of recovery of reimbursable bad debts. This amount is for statistical purposes only, and does not enter into any reimbursement calculation.

Line 10.--Enter the applicable program's share of the reasonable compensation paid to physicians for services in utilization review committees applicable to the SNF.

Line 11.--Enter the sum of line 3, plus line 8 and 10 for title XVIII, plus or minus the sum of lines 4, and line 5.

Line 12.--Enter interim payments from Worksheet E-1, column 2, line 4.

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

Line 13.--Your contractor will enter the Part A tentative adjustments from Worksheet E-1, column 2.

Line 14.--Enter OTHER adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

Line 14.99.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times the sum of (line 11 plus or minus lines 14 through 14.98)].

Line 15.--Enter the *sum of the amount on* line 11 minus lines 12, *13 and 14.99*, plus or minus *line 14 and its subscripts not previously identified*. Enter a negative amount in parentheses (.). Transfer this amount to Worksheet S, Part III, column 2, line 1.

Line 16.--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 17.--Enter the amount of Part B ancillary services furnished to Medicare patients. Obtain this amount from Worksheet D, Part I column 5, line 100.

Line 18.-- Enter the vaccine cost from Worksheet D, Part II, line 3.

Line 19.-- Enter the sum of the amounts on lines 17 and 18.

Line 20.--Report the charges applicable to the ancillary services from Worksheet D, Part I, column 3, line 100, plus Worksheet D, Part II, Line 2.

Line 21.-- Enter the lesser of line 19 or 20.

Line 22.--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 22.

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 22 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 22.

Line 23.--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 24.--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 24.01.--For cost reporting periods that begin on or after October 1, 2012, enter the gross reimbursable bad debts for dually eligible beneficiaries. This amount must also be included in the amount on line 24.

Line 24.02.--For cost reporting periods that begin prior to October 1, 2012, enter the amount from line 24. For cost reporting periods that begin on or after October 1, 2012, calculate this line as follows: $[(\text{line } 24 - \text{line } 24.01) \text{ times } 65 \text{ percent}] + (\text{line } 24.01 \text{ times } 88 \text{ percent})$. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: $[(\text{line } 24 - \text{line } 24.01) \text{ times } 65 \text{ percent}] + (\text{line } 24.01 \text{ times } 76 \text{ percent})$. For cost reporting periods that begin on or after October 1, 2014, calculate this line as follows: $\text{line } 24 \text{ times } 65 \text{ percent}$.

Line 25.-- Enter the sum of the amounts on lines 21, and 24.02, minus the amounts on lines 22, and 23.

Line 26.--Enter interim payment from Worksheet E-1, column 4, line 4.

Line 27.--Your contractor will enter the Part B tentative adjustments from Worksheet E-1, column 4.

Line 28.--Enter OTHER adjustments

Line 28.99.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as $[(2 \text{ percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)}) \text{ times the sum of (line } 25 \text{ plus or minus lines } 28 \text{ through } 28.98)]$.

Line 29.--Enter the *sum of the* amount on line 25 minus lines 26, *27 and 28.99, plus or minus line 28 and its subscripts not previously identified.* Enter a negative amount in parentheses (). Transfer this amount to Worksheet S, Part III, column 3, line 1.

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 worksheet showing the details and computations for this line.

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4130.2 Part II – Calculation of Reimbursement Settlement for Title V and Title XIX Only.--Use Worksheet E, Part II, to calculate reimbursement settlement for titles V, and XIX services furnished by SNFs, NFs, and ICF/MRs reimbursed under cost principles.

Mark in the appropriate box at the top of each page of Worksheet E, Part II, 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, and XIX. Transfer these amounts from Worksheet D, Part I, column 4, lines 40 through 52.

Line 2.--Enter Nursing & Allied Health costs for title V or title XIX from Worksheet D-1, part II, line 5 accordingly.

Line 3. -- For titles V and XIX, enter the cost of outpatient services. Obtain the amount from Worksheet D, Part I, column 4, lines 60 through 71.

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, from the provider records.

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 customary charge for semi-private accommodations and the customary charge for the less than semi-private accommodations furnished for all program patient days when the accommodations provided were not medically necessary.

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.

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 CMS Pub. 15-1, §2104.3) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-1, §§2570 - 2577.

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 and 13. Submit a schedule showing these computations with the cost report.

Line 11.--For titles V or XIX only; enter the total charges for inpatient ancillary services from Worksheet D, Part I, column 2, lines 40 through 52 net of professional component.

Line 12.--For titles V and XIX only, enter the total charges for outpatient services from Worksheet D, Part I, column 2, lines 60 through 71 net of professional component.

Line 13.--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 inpatients which workmen's compensation and other primary payers paid at the ward rate. Adjust these charges on line 13 in determining final settlement.

Line 14.--If the amount entered on line 12 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 15.--Enter the sum of lines 11 through 13 minus line 14.

Lines 16 through 19.--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 16 through 18 but instead enter on line 19 the amount from line 15. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 19 exceed the actual charge on line 15.

Computation of Reimbursement Settlement

Line 20.--Enter the lesser of reasonable cost (line 8 before the application of the primary payer amount) or customary charges (line 19), minus the primary payer amount on line 9.

Line 21.--Enter the deductibles billed to title V and title XIX beneficiaries.

Line 22.--Enter the amount on line 20 minus the amount on line 21.

Line 23.--Enter the coinsurance billed to beneficiaries. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 24.--Enter the amount on line 22 minus the amount on line 23.

Line 25.--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 26.--Enter the sum of the amounts on lines 24 and 25.

Line 27.--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 is 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 CMS Pub. 15-1, §2577.)

Line 28.--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 CMS Pub. 15-1, §§136 - 136.16.)

Line 29.--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 CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

Include any 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 30.--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 CMS Pub. 15-1, §§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 31.--Enter the sum of the amounts on line 26, plus or minus lines 29 and 30, minus lines 27 and 28.

Line 32.--Enter the Title V or Title XIX interim payment from your records.

Line 33.-- Enter a negative amount in parentheses (). Transfer titles V and XIX SNF amounts on this line to Worksheet S, Part III, line 1, columns 1 or 4, as applicable. Transfer titles V and XIX NF amounts to Worksheet S, Part III, line 2, columns 1 or 4, respectively. Transfer title XIX ICF/MR amounts to Worksheet S, Part III, line 3, column 4.

4131. 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. Worksheet E-1 is used by the SNF when the provider has received Medicare interim payments made by the contractor. 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-5;
- SNF-based RHC/FQHCs use Worksheet I-5; and
- SNF-based CMHC's use Worksheet J-4.

The column headings designate two categories of payments:

Columns 1 and 2 - Inpatient Part A
Columns 3 and 4 - Part B

You should complete lines 1 through 4. Your contractor will complete lines 5 through 9. 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 1, 2, and 3.99). Transfer the total amount from column 2 Worksheet E, Part I, line 12 for inpatient Part A, and from column 4 to Worksheet E, Part I, Line 27 for Part B.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 8 ARE FOR CONTRACTOR 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 11. For Part B, the amount in column 4 must equal Worksheet E, Part I, line 26.

Line 8.--Enter the contractor name and the contractor number in columns 1 and 2, respectively.

4140. FINANCIAL STATEMENT WORKSHEETS

Prepare these worksheets from your accounting books and records.

Complete all worksheets in the "G" series. Complete Worksheets G and G-1 if you maintain fund-type accounting records, complete separate amounts for General, Specific Purpose, Endowment and Plant funds on Worksheets G and G-1. If you do not maintain fund-type accounting records, complete the general fund column only. Cost reports received with incomplete G worksheets are returned to you for completion. If you do not follow this procedure, you are considered as having failed to file a cost report. Where applicable, Worksheets G, G-1, G-2 and G-3 must be consistent with financial statements prepared by Certified Public Accountants or Public Accountants.

4140.1 Worksheet G - Balance Sheet--If the lines on the Worksheet G are not sufficient, use lines 5 (Other receivables), 9 (Other current assets), 41 (Other current liabilities), and 47 (Other long term liabilities), as appropriate, to report the sum of account balances and adjustments. Maintain supporting documentation or subscript the appropriate lines.

Enter accumulated depreciation as a negative amount.

Column 1--General Fund--Use only this fund column when you do not maintain fund-type accounting records. This fund is similar to a general ledger account and records all assets and liabilities of the entity

Column 2--Specific Purpose Fund--These accounts are used for funds held for specific purposes such as research and education.

Column 3--Endowment Fund--These accounts are for amounts restricted for endowment purposes.

Column 4--Plant Fund--These accounts are for amounts restricted for the replacement and expansion of the plant.

Line 1--Cash on Hand and in Banks--The amounts on this line represent the amount of cash on deposit in banks and immediately available for use in financing activities, amounts on hand for minor disbursements and amounts invested in savings accounts and certificates of deposit. Typical accounts would be cash, general checking accounts, payroll checking accounts, other checking accounts, impress cash funds, saving accounts, certificates of deposit, treasury bills and treasury notes and other cash accounts.

Line 2--Temporary Investments--The amounts on this line represent current securities evidenced by certificates of ownership or indebtedness. Typical accounts would be marketable securities and other current investments.

Line 3--Notes Receivable--The amounts on this line represent current unpaid amounts evidenced by certificates of indebtedness.

Line 4--Accounts Receivable--Include on this line all unpaid inpatient and outpatient billings. Include direct billings to patients for deductibles, co-insurance and other patient chargeable items if they are not included elsewhere.

Line 6--Less: Allowance for Uncollectable Notes and Accounts--These are valuation (or contra-asset) accounts whose credit balances represent the estimated amount of uncollectible receivables from patients and third-party payers. Enter this amount as a negative.

Line 7--Inventory--Enter the costs of unused hospital supplies. Perpetual inventory records may be maintained and adjusted periodically to physical count. The extent of inventory control and detailed record-keeping will depend upon the size and organizational complexity of the provider. The Skilled Nursing Facility inventories may be valued by any generally accepted method, but the method must be consistently applied from year to year.

Line 8--Prepaid Expenses--Enter the costs incurred which are properly chargeable to a future accounting period.

Line 9--Other Current Assets --These balances include other current assets not included in other asset categories.

Line 10--Due from Other Funds--There are four funds: General Fund, Specific Purpose Fund, Endowment Fund and Plant Fund. These are represented in columns 1 through 4, respectively. Amounts reported in each column should be the amount due from other funds in their respective columns on Worksheet G, line 41 (Due to Other Funds).

Line 12--Land--This balance reflects the cost of land used in hospital operations. Included here is the cost of off-site sewer and water lines, public utility, charges for servicing the land, governmental assessments for street paving and sewers, the cost of permanent roadways and of grading of a non-depreciable nature. Unlike building and equipment, land does not deteriorate with use or with the passage of time; therefore, no depreciation is accumulated.

The cost of land includes (1) the cash purchase price, (2) closing costs such as title and attorney's fees, (3) real estate broker's commission, and (4) accrued property taxes and other liens on the land assumed by the purchaser.

Land 13--Land Improvements--Amounts on this line include structural additions made to land, such as driveways, parking lots, sidewalks; as well as the cost of shrubbery, fences and walls, landscaping, on-site sewer and water lines, and underground sprinklers. The cost of land improvements includes all expenditures necessary to make the improvements ready for their intended use.

Line 15--Buildings--This line includes the cost of all buildings and subsequent additions used in hospital operations (including purchase price, closing costs, (attorney fees, title insurance, etc.), and real estate broker commission). Included are all architectural, consulting and legal fees related to the acquisition or construction of buildings, and interest paid for construction financing.

Line 17--Leasehold Improvements--All expenditures for the improvement of a leasehold used in SNF operations are included on this line.

Line 19--Fixed Equipment--Include the cost of building equipment that has the following general characteristics:

1. Affixed to the building, not subject to transfer or removal.
2. A life of more than one year, but less than that of the building to which it is affixed.
3. Used in SNF operations.

Fixed equipment includes such items as boilers, generators, engines, pumps, and refrigeration machinery, wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc.

Line 21--Automobiles and Trucks--Enter the cost of automobiles and trucks used in SNF operations.

Line 23--Major movable Equipment--Costs of equipment included on this line has the following general characteristics:

1. Ability to be moved, as distinguished from fixed equipment (but not automobiles or trucks).
2. A more or less fixed location in the building.
3. A unit cost large enough to justify the expense incident to control by means of an equipment ledger and greater than or equal to \$5,000.
4. Sufficient individuality and size to make control feasible by means of identification tags.
5. A minimum life of usually three years or more.
6. Used in SNF operations.

Line 25--Minor Equipment-Depreciable--Costs of equipment included on this line has the following general characteristics:

1. Ability to be moved, as distinguished from fixed equipment.
2. A more or less fixed location in the building
3. A unit cost large enough to justify the expense incident to control by means of an equipment ledger but less than \$5,000.
4. Sufficient individuality and size to make control feasible by means of identification tags.
5. A minimum life of usually three years or more.
6. Used in SNF operations.

Line 26--Minor Equipment-Nondepreciable--Costs of equipment included on this line has the following general characteristics:

1. Location generally not fixed; subject to requisition or use by various departments of the hospital.
2. Relatively small size.
3. Subject to storeroom control.
4. Fairly large number in use.
5. Generally a useful life of usually approximately three years or less.
6. Used in SNF operations.

Minor equipment includes such items as, but is not limited to wastebaskets, bed pans, syringes, catheters, basins, glassware, silverware, pots and pans, sheets, blankets, ladders, and surgical instruments.

Lines 14, 16, 18, 20, 22, and 24--Less Accumulated Depreciation--These balances, respectively, include the depreciation accumulated on the related assets used in hospital operations. Enter this amount as a negative.

Line 29--Investments--This field contains the cost of investments purchased with SNF funds and the fair market value (at date of donation) of securities donated to the SNF.

Line 30--Deposits on Leases--Report the amount of deposits on leases. This includes security deposits.

Line 31--Due from Owners/Officers--Report the amount loaned to the SNF by owners and/or officers.

Line 32--Other Assets--This is the amount of assets not reported on line 9 (other current assets) or any other line 1 through 31. This could include intangible assets such as goodwill, unamortized loan costs and other organization costs.

Line 33--Total Other Assets--Sum of lines 29 through 32.

Line 34--Total Assets--Sum of lines 11, 28 and 33.

Line 35--Accounts Payable--This amount reflects the amounts due trade creditors and others for supplies and services purchased.

Line 36--Salaries, Wages and Fees Payable--This amount reflects the actual or estimated liabilities of the SNF for salaries and wages/fees payable.

Line 37--Payroll Taxes Payable--This amount reflects the actual or estimated liabilities of the SNF for amounts payable for payroll taxes withheld from salaries and wages, payroll taxes to be paid by the SNF and other payroll deductions, such as hospitalization insurance premiums.

Line 38--Notes and Loans Payable (Short-Term)--The amounts on this line represent current amounts owing as evidenced by certificates of indebtedness coming due in the next 12 months.

Line 39--Deferred Income--Deferred income is received or accrued income which is applicable to services to be rendered within the next accounting period. Deferred income applicable to accounting periods extending beyond the next accounting period is included as other current liabilities. These amounts also reflect the effects of any timing differences between book and tax or third-party reimbursement accounting.

Line 40--Accelerated Payments--Accelerated payments are payments not yet due to be repaid to the contractor.

Line 41--Due to Other Funds--There are four funds: General Fund, Specific Purpose Fund, Endowment Fund and Plant Fund. These are in columns 1 through 4 respectively. Amounts are reported in the fund owing the amount. Each amount recorded as "due to" must also be reported on Worksheet G, line 10 (Due From Other Funds).

The sum of the amounts on line 10, columns 1 through 4 must equal the sum of the amounts on line 41, columns 1 through 4.

Line 42--Other Current Liabilities--This line is used to record any current liabilities not reported on lines 35 through 41.

Line 43--Total Current Liabilities--Enter the sum of lines 35 through 42.

Line 44--Mortgage Payable--This amount reflects the long-term financing obligation used to purchase real estate/property.

Line 45--Notes Payable--These amounts reflect liabilities of the SNF to vendors, banks and other, evidenced by promissory notes due and payable longer than one year.

Line 46--Unsecured Loans--These amounts are not loaned on the basis of collateral.

Line 48--Other Long-Term Liabilities--This line is used to record any long-term liabilities not reported on lines 46 through 48.

Line 50--Total Long-Term Liabilities--Enter the sum of lines 44 through 49.

Line 51--Total Liabilities--Enter the sum of lines 43 and 50.

Line 52--General Fund Balance--This represents the difference between the total of General Fund assets and General Fund Liabilities in column 1. This amount usually equals the end of period fund balance on Worksheet G-1, column 2, line 19.

Line 53--Specific Purpose Fund--This represents the difference between the total of Specific Purpose Fund assets and Specific Purpose Fund Liabilities in column 2.

Line 54--Donor Created - Endowment Fund Balance - Restricted--The sum of the amounts on lines 54, 55 and 56, represent the difference between the total of Endowment Fund assets and Endowment Fund Liabilities in column 3.

Line 55--Donor Created - Endowment Fund Balance - Unrestricted.

Line 56--Governing Body Created - Endowment Fund Balance.

Line 57--Plant Fund Balance - Invested in Plant--The sum of the amounts on lines 57 and 58, represent the difference between the total of Plant Fund assets and Plant Fund Liabilities in column 4.

Line 58--Plant Fund Balance - Reserves for Plant Improvement, Replacement and Expansion--The credit balances of the restricted funds reported on lines 54 through 56, represent the net amount of each restricted fund's assets available for its designated purpose. The accounts should be credited for all income earned on restricted fund assets, as well as gains on the disposal of such assets. If, however, such items are treated as General Fund income (considering legal requirements and donor intent), the restricted Fund Balance account is charged, and the Due to General Fund account credited, for such income.

For Investor-Owned Corporations, the accounts on lines 53 through 58 include stock, paid in capital and retained earnings. For Investor-Owned Partnerships, the amounts on lines 53 through 58 include capital and partner's draw. For Investor-Owned - Division of a Corporation, the amounts on lines 53 through 58 include the division's or subsidiary's stock, paid in capital and divisional equity.

Line 59--Total Fund Balances--Enter the sum of lines 52 through 58.

Line 60--Total Liabilities and Fund Balances--Enter the sum of lines 51 and 59.

For each Fund, the amount on line 34 equals the amount on line 60.

4140.2 Worksheet G-1 - Statement of Changes in Fund Balances--

Columns 1 and 2--General Fund.

Columns 3 and 4--Specific Purpose Fund--These accounts are used for funds held for specific purposes such as research and education.

Columns 5 and 6--Endowment Fund--These accounts are for amounts restricted for endowment purposes.

Columns 7 and 8--Plant Fund--These accounts are for amounts restricted for the replacement and expansion of the plant.

Line 1--Fund Balance at Beginning of Period--The fund balance at the beginning of the period comes from the prior year cost report Worksheet G-1, line 19, columns 2, 4, 6 and 8, respectively.

Line 2--Net Income--Transfer to column 2, the amount from Worksheet G-3, line 31. Columns 1, 3, 4, 5, 6, 7 and 8 are not completed.

Line 3--Total--For column 2, enter the sum of lines 1 and 2. Leave columns 1, 3, 5 and 7 blank. For columns 4, 6 and 8, bring down the amount on line 1.

Lines 5 through 9--Additions--Most income is included in the net income reported on line 2. Any increases affecting the fund balance not included in net income are reported on these lines. A description (not exceeding 36 characters) is entered for each entry on lines 5 through 9.

Line 10--Total Additions--In columns 2, 4, 6 and 8, enter the sum of lines 5 through 9 columns 1, 3, 5 and 7, respectively.

Line 11--Subtotals--Enter the sum of lines 3 and 10 for columns 2, 4, 6 and 8. Leave columns 1, 3, 5 and 7 blank.

Lines 13 through 17--Deductions--Most expenses are included in the net income reported on line 2. Any decreases affecting the fund balance not included in net income are reported on these lines. A description (not exceeding 36 characters) is entered for each entry on lines 13 through 17.

Line 18--Total Deductions--In columns 2, 4, 6 and 8, enter the sum of lines 13 through 17, columns 1, 3, 5 and 7, respectively.

Line 19--Fund Balance at the end of Period per Balance Sheet--Enter the result of line 11 minus line 18 for columns 2, 4, 6 and 8. Leave columns 1, 3, 5 and 7 blank. The amount in line 19, column 2 must agree with Worksheet G, line 52, column 1. The amount on line 19, column 4 must agree with Worksheet G, line 53, column 2. The amount on line 19, column 6 must agree with the sum of Worksheet G, column 3, lines 54 through 56. The amount on line 19, column 8 must agree with the sum of Worksheet G, column 4, lines 57 and 58.

These amounts will also be used to start next year's Worksheet G-1.

4140.3 Worksheet G-2, Parts I & II - Statement of Patient Revenues and Operating Expenses--The worksheets require the reporting of total patient revenues for the entire facility and operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statement, submit a reconciliation report with the cost report submission. If you have more than one SNF-based HHA and/or more than one outpatient rehabilitation provider, subscript the appropriate lines on Worksheet G-2, Part I, to report the revenue for each multiple based facility separately.

Part I - Patient Revenues--Enter total patient revenues associated with the appropriate cost centers on lines 1 through 4, and 6 through 13.

Line 1--SNF--Enter revenues generated by the SNF component of the complex. Obtain these amounts from your accounting books and/or records.

Line 2--Nursing Facility--Enter the nursing facility revenue from your accounting books and/or records.

Line 3--ICF/MC--Enter the ICF/MC revenue from your accounting books and/or records.

Line 4--Other Long Term Care-- Enter the revenue generated from other long term care sub providers from your accounting books and/or records. Subscript this line as necessary.

Line 5--Total General Inpatient Routine Care--Sum of lines 1 through 4.

Line 6--Ancillary Services--Enter in the appropriate column revenue from inpatient ancillary services and outpatient ancillary services from your accounting books and/or records.

Line 7--Clinic--Enter in the appropriate column revenue from clinic services from your accounting books and/or records.

Line 8--Home Health Agency-- Enter home health agency revenue from your accounting books and/or records. If there is more than one home health agency, include the revenues for all home health agencies on this line.

Line 9--Ambulance Services--Enter from your accounting books and/or records the revenue relative to the ambulance service cost reported on Worksheet A, line 71.

Line 10--RHC/FQHC--Enter in column 2 only, the revenue generated from RHC/FQHC.

Line 11--CMHC--Enter in column 2 only, the revenue generated from CMHC.

Line 12--Hospice--Enter from your accounting books and/or records in the appropriate column, the revenue generated from hospice services rendered. If there is more than one hospice, include the revenues for all hospices on this line.

Line 13--Other (specify).

Line 14--Total Patient Revenues--Enter the sum of lines 5 through 13.

Column 3--Enter the sum of columns 1 and 2, lines 1 – 14 respectively in column 3.

Part II - Operating Expenses--Enter the expenses incurred that arise during the ordinary course of operating the hospital complex.

Line 1--Operating Expenses--This amount is transferred from Worksheet A, line 100, column 3.

Lines 2 through 7--Add (Specify)--Identify on these lines additional operating expenses not included in line 1.

Line 8--Total Additions--Enter on line 8, column 2, the sum of lines 2 through 7, column 1.

Lines 9 through 13--Deduct (specify)-- Identify on these lines deductions from operating expenses not included in line 1.

Line 14--Total Deductions--Enter on line 14, column 2, the sum of lines 9 through 13, column 1.

Line 15--Total Operating Expenses--Enter in column 2, the result of line 1, column 2 plus line 8, column 2, less line 14, column 2.

4140.4 Worksheet G-3 - Statement of Revenues and Expenses--This worksheet requires the reporting of total revenues for the entire facility and total operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statement, submit a reconciliation report with the cost report submission.

Line 1--Total Patient Revenue--Transfer from Worksheet G-2, Part I, line 14, column 3.

Line 2--Less: Allowance and Discounts on Patient's Accounts--Enter on this line total patient revenues not received. This includes:

Provision for Bad Debts,
Contractual Adjustments,
Charity Discounts,
Teaching Allowances,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Line 3--Net Patient Revenues--Subtract line 2 from line 1.

Line 4--Less: Total Operating Expenses--Transfer from Worksheet G-2, Part II, line 15.

Line 5--Net Income from Service to Patients--Subtract line 4 from line 3.

Lines 6 through 23--Enter on the appropriate lines 6 through 23 all other revenue not reported on line 1. Obtain these amounts from your accounting books and/or records.

Line 24--Other (Specify)--Enter all other revenue not reported on lines 6 through 23. Obtain this from your accounting books and/or records. Subscript this line as necessary.

Line 25--Total Other Income--Enter the sum of lines 6 through 24.

Line 26--Total--Enter the sum of lines 5 plus line 25.

Line 27--Other Expenses (Specify)--Enter all other expenses not reported on lines 6 through 25.

Line 30--Total Other Expenses--Enter the sum of lines 27 through 29, including subscripts.

Line 31--Net Income (or Loss) for the Period--Enter the result of line 26 minus line 30.