

TO: All Skilled Nursing Facilities

FROM: CareFirst of Maryland, Inc.

DATE: May 16, 2003

SUBJECT: Skilled Nursing Facility Revised Provider Cost Reporting Forms and Instructions Chapter 35, Form CMS 2540-96

NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates Chapter 35 - Skilled Nursing Facility Cost Report Form CMS 2540-96, and is effective for cost reporting periods ending on and after December 31, 2002.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Line 43.--Indicate whether the provider is licensed in a state that certifies the provider as an SNF as described on line 4 above, regardless of the level of care given for Titles V and XIX patients.

Line 44.--This line is not used for cost reporting periods beginning on and after July 1, 1998. Indicate whether the provider participated in the NHCMQ demonstration during the cost reporting period. All NHCMQ demonstration participants must file FORM CMS 2540-96, including facilities reporting less than 1,500 program days which would otherwise be allowed to utilize the Form HCFA 2540S-97. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration. This demonstration will not be applicable for cost reporting periods beginning on and after July 1, 1998. At that time all SNFs will be reimbursed under PPS.

Section 222 (a)(1) of P.L. 92-603 (42 U.S.C. Section 1395b-1, note) authorizes the Secretary of the Department of Health and Human Services to engage in experiments and demonstrations regarding alternative methods of making payment on a prospective basis to SNFs and other providers. Section 222 (a)(3) authorizes the Secretary to grant waivers of certain Title XVIII requirements insofar as such requirements relate to methods of payment for services provided. Additional forms have been added to the SNF cost report to accommodate the NHCMQ demonstration project. Worksheet D-1 must be completed by a provider participating in the demonstration.

A provider participating in the NHCMQ demonstration, which otherwise is reimbursed by other than the Prospective Payment System and which indicates either an "O" or "N" on line 4, must complete Worksheet E, Part V in place of Worksheet E, Part I or Worksheet E, Part II.

Line 45.--List the total amount of malpractice premiums paid, (column 1) the total amount of paid losses, (column 2), and the total amount of self insurance, (column 3) allocated in this fiscal year.

Line 46.--Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.

Line 47.--Are you claiming ambulance costs? Enter in column 1, "Y" for yes or "N" for no. If this is your first year of providing and reporting ambulance services, you are not subject to the payment limit. Enter in column 2, Y if this is your first year of providing ambulance service, or N if it is not.

Line 48--If line 47 column 1 is Y, and column 2 is N, enter on line 48 column 1 the payment limit provided from your fiscal intermediary. If your fiscal year is OTHER than a year beginning on October 1st, enter in column 1 the payment limit for the period prior to October 1, and enter in column 2 the payment limit for the period beginning October 1st. The per trip rate is updated October 1st of each year. **Subscript this line as needed.**

Report your ambulance trip limits chronologically, in accordance with your fiscal year. Applicable chronological dates are 01/01/2001, 07/01/2001, 01/01/2002, 04/01/2002 (effective date of the blend), 01/01/2003, 01/01/2004, 01/01/2005, and 01/01/2006.

Line 48.01—For services rendered on or after 04/01/2002, enter if applicable, the fee schedule amount for the period. Ambulance services will be based on a blend until 100% fee schedule is transitioned on 01/01/2006. The blend is effective for services on 04/01/2002 through 12/31/2005.

Line 49.--Did you operate an ICF/MR facility for the purposes of title XIX? Enter “Y” for yes and “N” for no.

Line 50.-- Did this facility report less than 1500 Medicare days in its previous year’s cost report? Enter “Y” for yes or “N” for no.

Line 51.--If line 50 is yes, did you file your previous year’s cost report using the “simplified” step-down method of cost finding? (See §3500.) Enter “Y” for yes or “N” for no.

Line 52.--Is this cost report being filed under 42 CFR 413.321, (the “simplified” cost report)? Enter “Y” for yes, or “N” for no.

3509. WORKSHEET S-3 - SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

In accordance with 42 CFR 413.60(a), 42 CFR 413.24(a), and 42 CFR 413.40(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to SNF, nursing facility, ICF/MR, other long term care services, HHA, CORF, CMHC, and hospice. The data to be maintained, depending on the services provided by the component, include the number of beds available, the number of admissions, the number of discharges, the average length of stay, the number of inpatient days, the bed days available, and full time equivalents (FTEs).

Column Descriptions

Column 1.--Enter on the appropriate line the beds available for use by patients at the end of the cost reporting period (SNF on line 1, nursing facility on line 3, ICF/MR on line 3.1, SNF-based other long term care facility on line 4 or hospice on line 8). Do not enter any data on line 2.

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

Columns 3 through 6.--Enter the number of inpatient days for each component by program.

Column 4.--For fiscal years beginning on October 1st., enter on line 10 the number of ambulance trips, as defined by §4531(a)(1) of the BBA, provided for Medicare patients. If your fiscal year begins on a date other than October 1st, subscript line 10, to line 10.01. For cost reporting periods that overlap the October 1 date, enter on line 10 the trips prior to October 1 and enter on line 10.01 the number of trips after October 1. **Subscript line 10 to line 10.02 if you entered amounts on Worksheet S-2, line 48.02. If you further subscripted line 48.02 to account for more than one limit on Worksheet S-2, you must subscript line 10 further to account for the trips applicable to each set of rates.**

Column 7.--Enter the total number of inpatient days to include all classes of patients for each component.

Columns 8 through 11.--Enter the number of discharges, including deaths (excluding newborn and DOAs), for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.)

Column 12.--Enter the total number of discharges (including deaths) for all classes of patients for each component.

Columns 13 through 16.--The average length of stay is calculated as follows:

- | | | |
|----|-------------------------------|-------------------------------|
| a. | Column 13, lines 1 & 3 | Column 3 divided by column 8 |
| b. | Column 14, line 1 | Column 4 divided by column 9 |
| c. | Column 15, lines 1 & 3 | Column 5 divided by column 10 |
| d. | Column 16, lines 1, 3, 4, & 9 | Column 7 divided by column 12 |

EXCEPTION: Where the skilled nursing facility 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, combine the statistics on lines 1 and 3.

Columns 17 through 21.--Enter the number of admissions (from your records) for each component by program.

Columns 22 and 23.--The average number of employees (full-time equivalent) for the period may be determined either on a quarterly or semiannual basis. When quarterly data are used, add the total number of hours worked by all employees on the first payroll at the beginning of each quarter and divide the sum by four times the number of hours in the standard work period. When semiannual data are used, add the total number of hours worked by all employees on the first payroll of the first and seventh months of the period, and divide this sum by two times the number of hours in the standard work period. Enter the average number of paid employees in column 22 and the average number of non-paid worker's in column 23 for each component, an applicable.

3509.1 Part II - SNF Wage Index Information.--This part provides for the collection of skilled nursing facility and nursing facility data to develop an SNF wage index that is applied to the labor related portion of the SNF cost limits. The Social Security Act Amendments of 1994 (P.L. 103-432) requested the Secretary to begin collecting data on employee compensation and hours of employment specific to skilled nursing facilities for the purposes of constructing an SNF wage index. In order to collect the data necessary to develop an SNF wage index, CMS has developed an SNF wage index form, as part of the cost report, to be completed by all SNFs.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Line 1.--Enter the wages and salaries paid to employees from Worksheet A, column 1, line 75.

Line 2.--Enter physician salaries paid to employees which are included on Worksheet A, column 1, line 75.

Line 3.--Enter the total physician and physician assistant salaries and wage related costs that are related to patient care and are included on line 1. Under Medicare, these services are billed separately under Part B.

Line 4.--Enter from Worksheet A the sum of salaries reported in column 1 of line 14 for interns and residents. Base the hours reported in column 4 on 2080 hours per each full time intern and resident employee.

Line 5.--If you are a member of a chain or other related organization, as defined in CMS Pub 15-I, 2150, enter the allowable wages and salaries and wage related costs for home office personnel from your records that are included in line 1.

Line 6.--Enter the sum of lines 2 through 5.

Line 7.--Subtract line 6 from line 1 and enter the result.

Line 8.--Enter the total of Worksheet A, column 1, line 19. This amount represents other long term care.

| Line 9.- For cost reports ending on and after 11/30/1999, do not use this line.

Line 10.--Enter the amount from Worksheet A, column 1, line 49.

Line 11.--Enter the total of Worksheet A, column 1, lines 37 through 47. If these lines are subscribed to accommodate more than one HHA, also enter the total of the subscribed lines.

Line 12.--Enter the amount from Worksheet A, column 1, line 50.

Line 13.--Enter the amount from Worksheet A, column 1, line 55.

Line 14.--Enter the amount from Worksheet A, column 1, lines 58 through 63.

Line 15.--Enter the sum of lines 8 through 14.

Line 16.--Subtract line 15 from line 7 and enter the result.

Line 17.--Enter the amount paid (include only those costs attributable to services rendered in the SNF and/or NF), rounded to the nearest dollar, for contracted direct patient care services, i.e., nursing, therapeutic, rehabilitative, or diagnostic services furnished under contract rather than by employees and management contract services as defined below. Report only those personnel costs associated with these contracts. Eliminate all supplies and other miscellaneous items. Do not apply the guidelines for contracted therapy services under §1861(v)(5) of the Act and 42 CFR 413.106. For example, you have a contract with a nursing service to supply nurses for the general routine service area on weekends. Contracted labor for purposes of this worksheet does **NOT** include the following services: consultant contracts, billing services, legal and accounting services, Part A CRNA services, clinical psychologists and clinical social worker services, housekeeping services, planning contracts, independent financial audits, or any other service not directly related to patient care.

Include the amount paid (rounded to the nearest dollar) for contract management services, as defined below, furnished under contract rather than by employees. Report only those personnel costs associated with the contract. Eliminate all supplies, travel expenses, and other miscellaneous items. Contract management is limited to the personnel costs for those individuals who are working at the facility in the capacity of chief executive, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract labor does **NOT** include the following services: other management or administrative services, consultative services, unmet physician guarantees, physician services, clinical personnel, security personnel, housekeeping services, planning contracts, independent financial audits, or any other services not related to the overall management and operation of the facility.

Per instructions on Form HCFA-339, details, including the type of service, wages, and hours associated with each direct patient care related contract must be submitted to your intermediary as well as the aggregate total wages and hours for management contracts.

In addition, if you have no contracted labor as defined above or management contract services, enter a zero in column 1. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 1.

Report in column 2 the FTE contracted and consultant staff of the HHA.

Compute staff FTEs for column 1 as follows. Divide the sum of all hours for which employees were paid by 2080 hours. Round to two decimal places, e.g., round .62244 to .62. Compute contract

FTEs for column 2 as follows. Divide the sum of all hours for which contracted and consultant staff worked by 2080 hours.

If employees are paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the numerator in the calculations.

Lines 16 and 17. - Enter the total number of Metropolitan Statistical Areas (MSAs) served by this provider for this cost reporting period. List each MSA code on line 17.

3511.3 Part III – Compilation of PPS Activity Data.--

In accordance with 42 CFR §413.20 and §1895 of the Social Security Act, home health agencies are mandated to transition from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

The statistics required on this worksheet pertain to home health services furnished on or after October 1, 2000. The data to be maintained, depending on the services provided by the agency, includes the number of aggregate program visits furnished in each episode of care payment category for each covered discipline, the corresponding aggregate program charges imposed in each episode of care payment category for each covered discipline, total visits and total charges for each episode of care payment category, total number of episodes and total number of outlier episodes for each episode of care payment category, and total medical supply charges for each episode of care payment category.

All data captured in Part III of this worksheet must be associated only with episodes of care which terminate during the current fiscal year for payment purposes. Similarly, when an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all data required in Part III of this worksheet associated with that episode will appear in the fiscal year on the PS&R in which the episode of care terminates.

HHA Visits--See Part I of this section for the definition of an HHA visit.

Episode of Care--Under home health PPS, the 60 day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. Beneficiaries are covered for an unlimited number of non-overlapping episodes. The duration of a full length episode is 60 days. An episode begins with the start of care date and must end by the 60th day from the start of care.

Less than a full Episode of Care--

When 4 or fewer visits are provided by the HHA in a 60 day episode period, the result is a Low Utilization Payment Adjustment (LUPA). In this instance, the HHA is reimbursed based on a standardized per visit payment.

An episode may end before the 60th day in the case of a beneficiary elected transfer, or a discharge and readmission to the same HHA (including for an intervening inpatient stay). This type of situation results in a Partial Episode Payment (PEP) adjustment.

When a beneficiary experiences a Significant Change in Condition (SCIC) and subsequently, but within the same 60 day episode, elects to transfer to another provider, a SCIC within a PEP occurs.

A SCIC adjustment occurs when a beneficiary experiences a significant change in condition, either improving or deteriorating, during the 60 day episode that was not envisioned in the original plan of care. The SCIC adjustment reflects the proportional payment adjustment for the time both before and after the beneficiary experienced the significant change in condition during the 60 day episode.

Use lines 1 through 12 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 13 and 14 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 15 identifies the total number of episodes completed for each episode payment category. Line 16 identifies the total number of outlier episodes completed for each episode payment category. Outlier episodes do not apply to 1) Full Episodes without Outliers 2) LUPA Episodes. Line 17 identifies

the total medical supply charges incurred for each episode payment category. Column 7 displays the sum total of data for columns 1 through 6. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report and pertain only to services rendered on or after October 1, 2000.

Columns 1 through 6--Enter data pertaining to Title XVIII patients only for services furnished on or after October 1, 2000. Enter, as applicable, in the appropriate columns 1 through 6, lines 1 through 12, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episode of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only episodes) will not include any visit counts or corresponding charges that appear in column 5 (SCIC within a PEP) and vice versa. This is true for all episode of care payment categories in columns 1 through 6.

Line 13--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visits from lines 1, 3, 5, 7, 9, and 11.

Line 14--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total other of charges for all unspecified services reimbursed under PPS.

Line 15--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visit charges from lines 2, 4, 6, 8, 10, 12, and 14.

Line 16--Enter in columns 1 through 6 for each episode of care payment category, respectively, the total number of episodes of care rendered and concluded in the provider's fiscal year.

Line 17--Enter in columns 2 and 4 through 6 for each episode of care payment category identified, respectively, the total number of episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

Line 18-- Enter in columns 1 through 6 for each episode of care payment category, respectively, the total **non-routine medical supply** charges for services **relating to episodes of care** rendered and concluded in the provider's fiscal year.

Column 7-- Enter on lines 1 through 18, respectively, the sum total of amounts from columns 1 through 6.

3513. WORKSHEET S-6 - SKILLED NURSING FACILITY-BASED OUTPATIENT REHABILITATION STATISTICAL DATA

NOTE: If this component is paid 100% under established fee schedules, you are not required to complete lines 1 through 19, or the related J series worksheets for cost reporting periods beginning on or after 04/01/2001.

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics required to be reported on this worksheet pertain to a skilled nursing facility-based outpatient rehabilitation provider. Complete a separate schedule for each box checked at the top of this form. The data needed to be maintained, depending on the services provided by the outpatient rehabilitation facility, include number of program treatments, total number of treatments, number of program patients, and total number of patients. In addition, FTE data is required by employee staff, contracted staff, and total.

Lines 1 through 19--These lines provide statistical data related to the human resources of the outpatient rehabilitation provider checked. The human resources statistics are required for each of the job categories specified on lines 1 through 17. Enter any additional categories needed on lines 18 and 19.

Enter the number of hours in your normal work week in the space provided.

Report in column 1 the FTE employees on the outpatient rehabilitation provider's payroll. These are staff for which an IRS Form W-2 is issued.

Report in column 2 the FTE contracted and consultant staff of the outpatient rehabilitation provider.

Staff FTEs are computed for column 1 as follows: sum of all hours for which employees were paid divided by 2080 hours, rounded to two decimal places, e.g., round .4452 to .45. Contract FTEs are computed for column 2 as follows: sum of all hours for which contracted and consultant staff worked divided by 2080 hours, rounded to two decimal places.

If employees are paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the numerator in the calculations.

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3514. WORKSHEET S-7 - NHCMQ DEMONSTRATION AND PPS STATISTICAL DATA

NOTE: Public Law 105-33 (Balanced Budget Act of 1997) requires that all SNFs be reimbursed under PPS for cost reporting periods beginning on and after July 1, 1998. Therefore, SNFs will not be reimbursed under demonstration procedures for cost reporting periods beginning on and after that date. An expansion to Worksheet S-7 was needed to accommodate cost reporting periods which begin on and after July 1, 1998. This expansion is designated as Part II. Part I will continue as the original form as published in June 1996, and updated with Transmittal # 3, and will be in effect for providers with cost reporting periods which begin PRIOR to July 1, 1998. Part II will be used for ALL SNFs with cost reporting periods beginning on and after July 1, 1998.

3514.1 Part I - NHCMQ Demonstration Statistical Data-- Complete this part for cost reporting periods beginning prior to July 1, 1998.

The statistics reported on this worksheet pertain to SNF facilities participating in the NHCMQ demonstration. 42 CFR 413.30 provides waivers to enable the use of the Resource Utilization Group (RUG-III) case mix adjusted prospective payment rate setting methodology for routine costs and Part A ancillary rehabilitation services in place of the routine systems of cost finding/payment determination and/or prospective payment option for low utilization providers.

Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration. The data to be maintained for title XVIII demonstration days include, by group, the M3PI revenue code, the rate, the number of inpatient days, and the dollar amount for Medicare residents during this cost reporting period.

Column Descriptions

Column 1--The case mix group designations are already entered in this column.

Column 2--The M3PI revenue code designations are already entered in this column.

NOTE: Worksheet S-7 was designed to accommodate one RUG group rate applicable for the entire year. However, since this rate could change each calendar year, this worksheet needs to be modified to accommodate TWO rates. This form has been revised to reflect heading changes published in Transmittal #3. Column headings are as follows:

Services Prior To January 1st		Services On Or After January 1st	
Rate	Days	Rate	Days
3	3.01	4	4.01

Columns 3 and 4.--Enter the rate assigned to the provider for each applicable group. This rate is effective as of January 1 and may be changed each January 1. Providers with fiscal years other than the calendar year could have two rates to report. The second rate is entered in column 4. If your fiscal year begins January 1 and ends December 31, enter your rate in column 4, and do not use column 3.

Column 3.01.--Enter the number of demonstration inpatient days applicable to each group, associated with the rate in place at the beginning of your fiscal year. This column is not used for calendar year providers. Enter the total on line 46.

Subscript columns 3 and 4 of this worksheet to columns 3.01 and 4.01 respectively. Identify column 3.01 as "Federal Rate – High Cost Add-On", (for services between April 1, 2000 and September 30, 2000). Identify column 4.01 as "Add-On Days" (for services between April 1, 2000 and September 30, 2000). Enter in column 3.01 for each of the 15 lines identified above, 20 percent of the amount on the corresponding line in column 3. Enter in column 4.01 the days applicable to services, for the 15 lines listed above, from April 1, 2000 through September 30, 2000 or the end of the fiscal year. Where the fiscal year ends between April 2, 2000 and September 30, 2000 the provider should report in column 6.01 only the days applicable for April 1 through the end of the fiscal year. The days from the beginning of the next fiscal year through September 30, 2000 will be reported in column 4.01 of the subsequent cost report.

Section 101 of the BBRA also provides for an additional 4 percent increase in payment for ALL services furnished during fiscal years (FYs) 2001 and 2002. Therefore, for services furnished after September 30, 2000, and before October 1, 2002, columns 5 and 6 of this worksheet should be subscripted to columns 5.01 and 6.01, respectively. Identify column 5.01 as "Federal Rate – High Cost Add-On" (for services after September 30), and identify column 6.01 as "Add-On Days" (for services after September 30). Enter in column 5.01 for each line identified above, 20 percent of the Federal Case Mix Rate. Enter in column 6.01 the days applicable to services associated with the high cost RUGs (as listed above), from October 1, 2000 to the end of the provider's fiscal year.

All of the RUG rates will be increased by 4 percent. Enter in column 5, the Federal Case Mix Rate times 104 percent.

3514.4 Part IV - PPS Statistical Data for Electronic Filing.--Use Part IV for cost reporting periods ending on and after February 28, 2001. Use this part to report the Medicare days of the provider by RUG.

All SNF's which have elected the 100 percent Federal rate, or those that are on the 100 percent rate via the fourth transition year (or forward), should enter all days in column 3.01 with no calculations indicated. The amount previously indicated on line 46, column 5 is now to be entered on Worksheet E, Part III, line 7 as an input. However, this may not apply to SNF's in MSA's # 1123, 3810, and 7520, for cost reporting periods that overlap 12/01/01. Complete column 3.01.

For cost reporting periods beginning on and after July 1, 2001, the only data required to be reported are the days associated with each RUG. These days can be reported in column 3.01, and do not have to be split between "before and after" October 1. The calculation of the total payment for each RUG is no longer required. All payment data is reported as a total amount paid under the RUG PPS payment system on Worksheet E, Part III, line 7, and is generated from the PS&R or your records. The total on line 46 must agree with the amount on Worksheet S-3, column 4, line 1. DO NOT COMPLETE columns 3, 4, 4.01, 4.05 or 5.

Column Descriptions

Column 1--The case mix group designations are already entered in this column.

Column 2--The M3PI revenue code designations are already entered in this column.

Columns 3 and 4.--Enter the rate assigned to the provider for each applicable RUG, and period. This rate is updated annually effective October 1. Providers with fiscal years other than October 1 to September 30 may have two rates to report. Enter the rate prior to October 1 in column 3 and the rate on or after October 1 in column 4. Providers with a fiscal year October 1st to September 30th

use column 4 only. This Federal rate is adjusted for the labor portion by the update factor specific to the provider's MSA. This update factor is reported on Worksheet S-2, line 3.2 columns 1 and 2.

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Columns 3.01 and 4.01.--Enter in column 3.01 the days, for each RUG, of the period before October 1 and in column 4.01 for the days on and after October 1. Enter the total on line 46.

Column 4.05.--For cost reporting periods that end prior to April 1, 2000, do not complete this column. For services rendered on and after April 1, 2000, through September 30, 2000, enter the days associated with the high cost RUGs at an increase of 20 percent.

Column 5.--Multiply columns 3 and 4 times columns 3.01 and 4.01 (column 4 times column 4.01 for cost reporting periods beginning October 1) respectively, rounded to zero and add the two results. This becomes the Federal amount. Multiply the Federal amount by the appropriate transition period percentage, i.e. 25 percent, 50 percent, 75 percent, or 100 percent identified on Worksheet S-2 line 3.1, column 2. Add to the Federal amount the result of the calculation of (total days from columns 3.01 and 4.01 multiplied by the facility specific rate (that result rounded to zero) identified on worksheet S-2, line 3.1, column 1) times the reciprocal percentage applied to the Federal rate, i.e., 75 percent, 50 percent, 25 percent, or 0 percent. Enter the result on the appropriate line for each RUG. Enter the sum of lines 1 through 45 on line 46, and transfer this total to Worksheet E, Part III, line 7

3515. WORKSHEET S-8 - HOSPICE IDENTIFICATION DATA

In accordance with 42 CFR 418.310, hospice providers of service participating in the Medicare program are required to submit information for health care services rendered to Medicare beneficiaries. 42 CFR 413.20 requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a SNF-based hospice. Complete a separate Worksheet S-8 for each SNF-based hospice.

3515.1 Part I - Enrollment Days Based on Level of Care.

Lines 1--4.--Enter on line 1 through 4 the enrollment days applicable to each type of care. Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four types of care. Where a patient moves from one type of care to another, count only one day of care for that patient for the last type of care rendered. For line 5, an inpatient care day may be reported only where the hospice provides or arranges to provide the inpatient care.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Line 1.--**Continuous Home Care Day** - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.

Line 2.--**Routine Home Care Day** - A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

Line 3.--**Inpatient Respite Care Day** - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

Line 4.--**General Inpatient Care Day** - A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

Column 1.--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Transfer the totals in column 18:

From Worksheet B, Part I, Column 18

To Worksheet D-1, Line 5

Line 16, SNF

For SNF

Line 18, NF
Sum of lines 16 and 18

For Titles V or XIX. For NF (when you answer "yes" to question on Wkst. S-2, line 43).

Line 18.1, ICF/MR

For Title XIX. For ICF/MR (when you answer yes to question on Wkst. S-2, line 49).

Transfer the direct SNF-based HHA costs in column 18, lines 37 through 47, to Worksheet H-4, Part I, column 1, lines as indicated. **Transfer the HHA-Telemedicine cost in column 18, line 47.1 to Worksheet H-4, line 13.1.**

Transfer the total SNF-based outpatient rehabilitation provider costs in column 18, line 50, to the applicable Worksheet J-1, Part I, column 0, line 18.

The non-reimbursable cost center totals, lines 58 through 63, are not transferred.

Column Descriptions

Column 1.--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation.

Column 2.--Providers that do not directly assign the depreciation on movable equipment and expenses pertaining to movable equipment such as insurance, interest, and rent as part of their normal accounting systems must accumulate the expenses in this cost center.

Column 4.--Allocate the administrative and general expenses on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-1, column 4, line 4, is the difference between the amount on Worksheet B, Part I, column 4A and the amount entered on Worksheet B-1, column 4A.

A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

3524.1 Worksheet B, Part III - Cost Allocation - General Service Costs with Less Than 1500 Program Days, and Worksheet B-1, Part II - Cost Allocation - Statistical Basis with Less Than 1500 Program Days.--

Complete this worksheet **only** if you answered yes on Worksheet S-2 question # 52. Worksheet B, Part III provides the allocation of the expenses of each general service cost center with **less than 1500 Medicare days** to those cost centers which receive the services. The total direct expenses are obtained from Worksheet A, column 7. The cost centers and line numbers are consistent with Worksheet A. Note that several lines from Worksheet A are not needed on Worksheets B, Part III and B-1, Part II.

The general service cost centers listed on Worksheet A, column 7, lines 1-9, are listed in the order they are combined on Worksheet B, Part III, columns 1, 2, 3, and 4, line 15.1.

To Worksheet B, Part III

From Worksheet A, Column 7

Column 1

Sum of lines 1, 2, 5, and 7 *

Column 2

Line 3

Column 3

Sum of lines 6, 8, and 9

* Due to consolidation of HCFA 2540S-97 into HCFA 2540-96, Capital - Interest account replaced one of three accounts in HCFA 2540-96, which are Capital-Related Costs - Building & Fixture, Administrative and General, and Interest Expense.

Column 0, line 15.1 is the total of columns 1 through 4, line 15.1.

The amounts on Worksheet B, Part III, column 0, lines 16 through 33, 59, and 63 are transferred from Worksheet A, column 7, lines 16 through 33, 59, and 63.

Worksheet B-1, Part II provides for the proration of the statistical data with **less than 1500 Medicare days** needed to equitably allocate the expenses of the general service cost centers on Worksheet B, Part III.

The statistical basis shown at the top of each column on Worksheet B-1, Part II is the basis of allocation of the cost centers indicated. Total statistics indicated on Worksheet B-1, Part II line 71 refers to the sum of the statistics reported on lines 16 through 63 of Worksheet B-1, Part II. For the allocation of administrative and general costs in column 4, lines 16 through 63 are obtained from Worksheet B, Part III, sum of columns 0 through 3, lines 16 through 63.

If the amount of any combined cost center on Worksheet A, column 7 has a credit balance, this amount must be shown as a credit balance on Worksheet B, Part III, column 0. If a revenue producing cost center has a credit balance on Worksheet B, Part III, column 5, do not carry forward such credit balance to Worksheet C.

On Worksheet B-1, Part II, enter on line 71 in the column of the cost center group being allocated, the total statistical base (including accumulated cost for allocating administrative and general expenses) over which the expenses are allocated (e.g., for column 1, capital costs, enter on line 71 the total square feet of the building on which depreciation was taken).

For all cost centers to which the capital cost group are being allocated, enter that portion of the total statistical base applicable to each. The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total base entered on line 71.

Enter on line 70 of Worksheet B-1, Part II, the total expenses of the cost centers to be allocated; they are obtained from Worksheet B, Part III, line 15.1, columns 1 through 4.

Divide the amount entered on line 70 by the total statistics entered on line 71. Enter the resulting unit cost multiplier on line 72. The unit cost multiplier must be rounded to six decimals.

Multiply the unit cost multiplier by the portion of the total statistics applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B, Part III in the corresponding column and line. (See §3500.1 for rounding standards.)

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 through 33, as follows:

<u>Type of Provider</u>	<u>To</u>
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 the 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.

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 and net of bad debt recoveries.

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 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 5.99.

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 HCFA 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 HCFA 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 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 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 5.99.

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.

3544. WORKSHEET H-5 - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs. Complete a separate worksheet for each applicable title, Title V, Title XVIII, and Title XIX.

NOTE: Certain services may be rendered by an HHA that are not covered under the home health provision of §1832(a)(2)(A) of the Act. These services are covered under a different provision, i.e., §1832(a)(2)(B) of the Act. Under §1832(a)(2)(B) of the Act, any provider may render the services authorized under that section. An HHA may render medical and other health services. These services are reimbursed in accordance with §1833(a)(2)(B)

of the Act. If a beneficiary receives any of these services, the beneficiary is liable for coinsurance, i.e., 20 percent of the reasonable charges. The reimbursement for these services is subject to the lesser of reasonable cost or customary charges (LCC), and such reimbursement cannot exceed 80 percent of the reasonable cost of these services. These services are considered as Medicare services reimbursable under title XVIII of the Act and are includable as Medicare visits for statistical purposes. However, the costs associated with the visits are not subject to the cost per visit limit. (See 42 CFR 413.30.) The provider must maintain auditable records of the number of visits, charges, deductible and coinsurance applicable to those visits. A separate reimbursement computation and a separate LCC computation is required.

These services are reimbursable under Part B only and will be entered on lines 18 through 20, columns 3 through 6.

Payment on Basis of Location of Service.--Section 4604 of the Balanced Budget Act (BBA) of 1997, appends §1891(g) of the Social Security Act, effective for cost reporting periods beginning on or after October 1, 1997, requiring home health agencies to submit claims for payment for home health services under title XVIII on the basis of geographic location at which the service is furnished. This requires home health agencies to make Medicare program cost limitation comparisons based on the geographic location (Metropolitan Statistical Area (MSA) or Non-MSA) of services furnished to program beneficiaries. To accomplish this, Worksheet H-5, Part I, the aggregate cost per visit computation, must be completed only one time for the entire home health agency. Complete Worksheet H-5, Part II, computation of the lesser of aggregate Medicare cost or the aggregate of the Medicare limitation computation, once for each MSA where Medicare covered services were furnished during the cost reporting period.

3544.1 Part I - Aggregate Agency Cost Per Visit Computation.--This part provides for the computation of the average home health agency cost per visit used to derive each MSA's total allowable cost attributable to Medicare patient care visits. Complete this part once for the entire home health agency. This computation is required by 42 CFR 413.53 and 42 CFR 413.30.

Cost Per Visit Computation

Column Descriptions

Column 2.--Enter the cost for each discipline from Worksheet H-4, Part I, column 5, lines as indicated.

Column 3.--Enter the total agency visits from statistical data (Worksheet S-4, column 8, lines 1 through 6) for each type of discipline on lines 1 through 6.

Column 4.--Compute the average cost per visit for each type of discipline. Divide the number of visits (column 3) into the cost (column 2) for each discipline.

3544.2 Part II - Computation of Aggregate Medicare Cost and the Aggregate of the Medicare Limitation.--This part provides for the computation of the cost of Medicare patient care visits and the corresponding reasonable cost limitation for Medicare services provided in the MSA identified. Complete this part one time for each MSA where Medicare beneficiary visits were provided during the cost reporting period. Enter the MSA/Non-MSA code from Worksheet S-4, line 17, for which Medicare services were furnished. Lines 1 through 6 and column 11 are subscripted to isolate pre October 1, 2000, costs to facilitate the application of the lesser of aggregate cost or aggregate visit limits.

Effective for cost reporting periods beginning on or after October 1, 2000, the subscripted lines 1 through 6, and subscripted column 11 are not applicable, and should not be completed. Also, do not complete lines 8 through 14, as all HHAs are reimbursed under PPS and no longer subject to per visit cost limitations, but continue to complete lines 1 through 7.

Lines 1 through 7-

Column 4--Transfer the average cost per visit from Part I, column 4, lines as indicated. The average cost per visit for each discipline is identical for all MSAs.

Columns 5 and 8--To determine the Medicare Part A cost of services, multiply the number of covered Part A visits made to beneficiaries prior to October 1, 2000, (column 5, lines 1 through 6, excluding subscripts) from your records by the average cost per visit amount in column 4 for each discipline. Enter the product in column 8.

Columns 6 and 9--To determine the Medicare Part B cost of services not subject to deductibles and coinsurance, multiply the number of visits made to Part B beneficiaries prior to October 1, 2000, (column 6, lines 1 through 6, excluding subscripts) from your records by the average cost per visit amount in column 4 for each discipline. Enter the product in column 9.

Columns 5 and 6, lines 1.01, 2.01, 3.01, 4.01, 5.01, 6.01--Enter in column 5 the Medicare Part A visits furnished to program beneficiaries on or after October 1, 2000, **for episodes completed during the fiscal year**. Enter in column 6 the Medicare Part B visits not subject to deductibles and coinsurance furnished to program beneficiaries on or after October 1, 2000, **for episodes completed during the fiscal year**.

NOTE: The sum of Worksheets H-5, Part II, columns 5 and 6, lines 1.01, 2.01, 3.01, 4.01, 5.01 and 6.01, respectively, may not necessarily equal the corresponding amounts on Worksheet S-4, Part III, column 7, lines 1, 3, 5, 7, 9 and 11, respectively, due to the difference between visits contained in episodes terminating in the current fiscal year (Worksheet S-4, Part III), and visits rendered through the fiscal year end (Worksheet H-5, Part III).

For cost reporting periods which overlap October 1, 2000, the sum of Worksheet H-5, Part II columns 5 and 6, lines 1.01, 2.01, 3.01, 4.01, 5.01 and 6.01, respectively, must equal the corresponding amounts on Worksheet S-4, Part I, Column 2, lines 1 through 6. For cost reporting periods that begin on or after October 1, 2000, the sum of Worksheets H-5, Part II, columns 5 and 6, lines 1 through 6, respectively, must equal the corresponding amounts on Worksheet S-4, Part III column 7, lines 1, 3, 5, 7, 9, and 11.

Columns 7 and 10--**DO NOT USE THESE COLUMNS**, for cost reporting periods beginning on and after October 1, 1997.

NOTE: For reporting periods overlapping October 1, 2000, the sum of all Worksheets H-5, Part II, Medicare program visits, sums of line 1-6 (excluding subscripts) for columns 5 must be equal to or less than the sum of the visits shown on Worksheet S-4, Part I, Column 2, lines 1 through 6.

Column 11--Enter the total Medicare cost for each discipline (sum of columns 8 and 9) for visits rendered prior to October 1, 2000. Add the amounts on lines 1 through 6 (exclusive of subscripts). Enter this total on line 7. Enter in column 11.01 the total Medicare cost for each discipline, sum of columns 8 and 9, lines 1.01, 2.01, 3.01, 4.01, 5.01, and 6.01 for visits rendered on and after October 1, 2000. Enter this total on line 7.

Column Descriptions for Cost Limitation Computation

Lines 8 through 14-

Column 4--Enter the Medicare limitation (see §1861(v)(1)(L) of the Act) for the applicable MSA for each discipline on lines 8 through 13. The fiscal intermediary furnishes these limits to the provider.

Columns 5 and 8--To determine the Medicare limitation cost for Part A cost of services, multiply the number of covered Part A visits made to beneficiaries prior to October 1, 2000, (column 5) from your records by the Medicare cost limit amount in column 4 for each discipline. Enter the product in column 8.

Columns 6 and 9--To determine the Medicare limitation cost for Part B cost of services, multiply the number of visits made prior to October 1, 2000, to Part B beneficiaries not subject to deductibles and coinsurance (column 6) from your records by the Medicare cost limit amount in column 4 for each discipline. Enter the product in column 9.

Column 5, line 7 may not equal column 5, line 14. Column 6, line 7 may not equal column 6, line 14. Columns 5 and 6, respectively, lines 1-6 (excluding subscripts) must equal columns 5 and 6, lines 8-13.

Columns 7 and 10--**DO NOT USE THESE COLUMNS**, for cost reporting periods beginning on and after October, 1, 1997.

Column 11--Enter the total Medicare limitation cost for each discipline (sum of columns 8 and 9). Add the amounts on lines 8 through 13. Enter this total on line 14.

3544.3 Part III - Supplies and Drugs Cost Computation--Certain items covered by Medicare and furnished by an HHA are not included in the visit for apportionment purposes. Since an average cost per visit and the cost limit per visit do not apply to these items, the ratio of total cost to total charges is developed and applied to Medicare charges to arrive at the Medicare cost for these items. Enteral/parenteral nutrition therapy (EPNT) items which are considered prosthetic devices furnished by an HHA on or after March 14, 1986, are reimbursed on a reasonable charge basis through billings submitted to the DMERC. (As a prosthetic device, such services are reimbursable only under Part B.) Charges for these items must be included in the total charges, but excluded from Title XVIII charge statistics in the apportionment of medical supply costs on Part IV, line 15. Lines 15 and 16 are subscripted to isolate pre October 1, 2000, costs to facilitate the flow of these costs to Worksheet H-6 in order to apply LCC.

NOTE: For services furnished on or after January 1, 1989, the HHA Part A reimbursement for DME, prosthetics, and orthotics was changed from cost reimbursement to a fee schedule reimbursement.

Additionally, certain items furnished by an HHA on or after January 1, 1990, are not considered as DME. This includes medical supplies such as catheters, catheter supplies, ostomy bags, and supplies relating to ostomy care.

NOTE: Injectable drugs are a Part B service only.

Lines 15 and 16--Enter in column 2 the total applicable HHA costs for the entire cost reporting period for each line item from Worksheet H-4, Part I, column 5, lines 10 and 11, respectively (the costs entered on lines 15 and 15.01 must be equal; the costs entered on lines 16 and 16.01 must be equal). Enter in column 3 the total HHA charges for the entire cost reporting period for each line (the charges entered on lines 15 and 15.01 must equal; the charges entered on lines 16 and 16.01 must equal) Enter in column 4 the ratio of HHA costs (column 2) to HHA charges (column 3) for each line.

Line 15--Enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule for services rendered prior to October 1, 2000.

Line 15.01--For reporting periods which overlap October 1, 2000, enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule for services rendered from October 1, 2000, through the fiscal year end. For reporting periods that begin on or after October 1, 2000, eliminate line 15.01 and record all charges and resulting cost data on line 15.

Line 16--Enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration for services rendered prior to October 1, 2000. Enter in column 7 the charge for covered osteoporosis drugs for services rendered prior to October 1, 2000. (See §1833(m)(5) of the Act.)

Line 16.01—For reporting periods which overlap October 1, 2000, enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration rendered on or after October 1, 2000 through the fiscal

year end. Enter in column 7 the charges for covered osteoporosis drugs rendered on or after October 1, 2000, through the fiscal year end. (See §1833(m)(5) of the Act.) For reporting periods that begin on or after October 1, 2000, eliminate line 16.01 and record all charge and resulting cost data on line 16. Osteoporosis drugs will continue to be reimbursed on a cost basis for services rendered on and after October 1, 2000.

Column 8--To determine the Medicare Part A cost, multiply the Medicare charges (column 5) by the ratio (column 4) for each line item. Enter the product in column 8.

Column 9--To determine the Medicare Part B cost, multiply the Medicare charges (column 6) by the ratio (column 4) for each line item. Enter the product in column 9.

Column 10--To determine the Medicare Part B cost (subject to deductibles and coinsurance), multiply the Medicare charges (column 7) by the ratio (column 4). Enter the product in column 10.

3544.4 Part IV - Comparison of the Lesser of Aggregate Medicare Cost, the Aggregate of the Medicare Cost Per Visit Limitation and the Aggregate Per Beneficiary Cost Limitation.--This part provides for the comparison of the reasonable cost limitation, applied to each home health agency's total allowable cost attributable to Medicare patient care visits. This comparison is required by 42 CFR 413.53 and 42 CFR 413.30. For cost reporting periods beginning on or after October 1, 1997, §1861(v)(1)(L) of the Social Security Act is amended by §4601 of BBA 1997, requiring home health agency net cost of covered services to be based on the lesser of aggregate Medicare cost, the aggregate of the Medicare limitation, or the agency specific per beneficiary annual cost limit. The per beneficiary cost limitation is derived by totaling the application of each MSA/non-MSA's unduplicated census count (two decimal places) (see §3527) to the per beneficiary cost limitation for the corresponding MSA/non-MSA. To accomplish this, the sum of all worksheets H-5, Part II, amounts in column 11, line 7, plus the applicable cost of medical supplies is compared with the sum of all worksheet H-5, Part II amounts in column 11, line 14, plus the applicable cost of medical supplies and with the amount in column 6, line 24.

Line 18--Enter in columns 3, 4, and 6, respectively, the sum of the amounts from each Worksheet H-5 Part II, columns 8, 9, and 11, (exclusive of subscripts) respectively, lines 1-6, respectively, (exclusive of subscripts).

Line 19--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 20--Enter the sum of lines 18 and 19 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Effective for cost reporting periods beginning on and after October 1, 2000, do not complete lines 21 through 25, as all HHA's are reimbursed under PPS and are no longer subject to cost per visit limitations or annual beneficiary limitations.

Line 21--Enter the total cost per visit limitation for Medicare services which is the sum of the amounts from each Worksheet H-5, Part II, columns 8, 9, and 10 respectively, line 14.

Line 22--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 23--Enter the sum of lines 21 and 22 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Line 24--Enter the per beneficiary cost limitation for each MSA/non-MSA area serviced by the HHA. Line 24 will have to be subscripted for each area. For each MSA/non-MSA enter the following:

Column 0--Enter the MSA/non-MSA code from Worksheet S-4, Part II, line 17, and the corresponding subscripts thereof.

Column 1--Enter the corresponding Medicare program (Title XVIII) unduplicated census count (two decimal places) from your records associated with services rendered prior to October 1 2000, (See §3511.)

Column 2--Enter the applicable per beneficiary annual limit. Obtain this amount from your intermediary.

Columns 3 and 4--(Complete column 6 prior to the completion of columns 3 and 4.) Complete columns 3 and 4 only if column 6, line 25 is less than column 6, lines 18 and 21. Enter in column 3 the result of column 3, line 18 divided by column 6, line 18 multiplied by column 6, line 25. Enter on line 25 in column 4 the result of column 4, line 18 divided by column 6, line 18 multiplied by column 6, line 25.

Column 6--For each MSA/nonMSA determine, the beneficiary cost limitation by multiplying the unduplicated census count (column 1) by the per beneficiary annual cost limitation (column 2). Enter the result in column 6.

Line 25--In column 1 (two decimal places) and 6, respectively, enter the sum of lines 24 (line 24 plus all subscripted lines 24). Enter in column 3, the result of column 3, line 20 divided by column 6, line 20, multiplied by column 6, line 25. Enter on line 25 in column 4, the result of column 4, line 20, divided by column 6, line 20, multiplied by column 6, line 25. (The sum of columns 3 and 4 must equal column 6.)

NOTE: The total Medicare (Title XVIII) unduplicated census count (Worksheet S-4, column 3, line 9 (Pre October 1, 2000, Unduplicated Census Count)) must equal the sum of the unduplicated census count for all MSAs (Worksheet H-5, Part IV, column 1, line 25).

3544.5 Part V - Outpatient Therapy Reduction Computation--This section computes the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology and outpatient occupational therapy) provided under arrangement for beneficiaries who are not homebound as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998. For outpatient therapy services rendered on or after January 1, 1999, §4541 of the BBA 1997 mandates a fee schedule payment basis for outpatient physical, outpatient occupational therapy, and outpatient speech pathology. Therefore, any outpatient therapy services furnished on or after January 1, 1999, **must not be included** in this section due to the application of a fee schedule for these services, but the corresponding visits must be recorded in column 5.01. These outpatient therapy services are reimbursed the lesser of the fee schedule amount or the statutory limitation which is applied on a beneficiary specific basis through the Medicare claims system. This requires no provider input on the cost report.

Column 2--Enter in column 2 the average cost per visit amount for each discipline from Part I, column 4, lines as indicated.

Columns 3 and 4--To determine the Medicare Part B cost of services subject to deductibles and coinsurance, multiply the total number of covered Part B visits made before January 1, 1998 by non-homebound program beneficiaries to rehabilitation facilities under arrangement (column 3) from your records by the average cost per visit amount in column 2 for each discipline. Enter the result in column 4.

Columns 5, 5.01, 5.02, and 6--Enter in column 5 the number of Medicare covered Part B visits from your records made by non-homebound (not covered by a physician's plan of care) program beneficiaries to rehabilitation facilities under arrangement for services furnished January 1, 1998 through December 31, 1998 only. Enter in column 5.01 the number of Medicare covered Part B visits from your records made by non-homebound program beneficiaries to rehabilitation facilities under arrangement for services furnished **from January 1, 1999, through September 30, 2000**. Outpatient therapy service visits rendered **between January 1, 1999, and September 30, 2000**, are reimbursed based on a fee schedule as described above. Determine the Medicare cost of services subject to deductibles and coinsurance by multiplying the amount in column 5 by the average cost per visit amount in column 2 for each discipline. Enter the result in column 6. **Enter in column 5.02**

the number of Medicare covered Part B visits from your records made by non-homebound program beneficiaries to rehabilitation facilities under arrangement for services furnished on or after October 1, 2000. Outpatient therapy service visits furnished on or after October 1, 2000, are reimbursed under outpatient PPS. The non-homebound visits captured in column 5.01 and 5.02 are for statistical purposes only and do not impact the settlement

Column 7--Compute the reasonable cost reduction by multiplying the cost of Medicare services in column 6 by 90 percent (.90). This is the application of the 10% reasonable cost reduction. Enter the result in column 7.

Column 8--Compute the reasonable costs net of the reduction by adding column 7 to column 4. Enter the result in column 8.

Line 29--For columns 3 through 8, enter the sum of lines 26 through 28.

NOTE: For cost reporting periods beginning on and after October 1, 2000, the following line and/or columns will revert back to the standard line or column (eliminate the subscript(s)): lines 1-1.01, 2-2.01, 3-3.01, 4-4.01, 5-5.01, 6-6.01, revert to lines 1, 2, 3, 4, 5, and 6 respectively; column 11-11.01, lines 1-6 revert to column 11, lines 1-6; line 15-15.01 reverts to line 15; **line 16-16.01 reverts to line 16.**

3545. WORKSHEET H-6 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT - PART A AND PART B SERVICES

Worksheet H-6 consists of the following two parts:

- Part I - Computation of the Lesser of Reasonable Cost or Customary Charges. This part provides for the reimbursement calculation of title XVIII, Part A and Part B, and title V and title XIX. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30. Use column 1 for Titles V and XIX.
- Part II - Computation of HHA Reimbursement Settlement. Complete this part for Titles, XVIII, and XIX, as applicable.

3545.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges--Services not paid for based on a fee schedule are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the providers for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in 42 CFR 413.13(e). Use column 1 for Titles V and XIX.

NOTE: Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider completes only lines 1 and 7 of Part I. Transfer the resulting cost to line 8 of Part II.

Line Descriptions

Line 1.—For reporting periods beginning prior to October 1, 2000, enter the cost of services from **Worksheet H-5 as follows**. This line provides for the computation of reasonable cost of Title XVIII, Part A and Part B services. **For cost reporting periods beginning on or after October 1, 2000, transfer only the cost of osteoporosis drugs from Worksheet H-5, Part III, column 10, line 16 to column 3 of this worksheet.**

If the amount in column 6, line 20 is less than the amount in column 6, line 23, and the amount in column 6, line 25, transfer (aggregate Medicare cost):

To Worksheet H-6, Line 1

From Worksheet H-5

Col. 1, Part A.

Part IV, Col. 3, line 20

Col. 2, Part B.

Part III, Sum of col. 9, line 16 (excluding subscripted lines) and Part IV, col. 4, line 20

Col. 3, Part B.

Part III, Sum of col. 10, line 15 (excluding subscripted lines), 16 and 16.01 and Part V, col. 8, line 29

If the amount in column 6, line 23 is less than the amount in column 6, line 20, and the amount in column 6, line 25, transfer (aggregate Medicare limitation):

To Worksheet H-6, Line 1

From Worksheet H-5

Col. 1, Part A.

Part IV, Col. 3, line 23

Col. 2, Part B

Part III, Sum of col. 9, line 16 (excluding subscripted lines) and Part IV, col. 4, line 23

Col. 3, Part B.

Part III, Sum of col. 10, line 15 (excluding subscripted lines), 16 and line 16.01 and Part V, col. 8, line 29.

If column 6, line 25 is less than the amount in column 6, line 20, and the amount in column 6, line 23, transfer (aggregate per beneficiary limitation):

To Worksheet H-6, Line 1

From Worksheet H-5

Col. 1, Part A.

Part IV, Col. 3, line 25

Col. 2, Part B

Part III, Sum of col. 9, line 16 (excluding subscripted lines) and Part IV, col. 4, line 25

Col. 3, Part B.

Part III, Sum of col. 10, line 15 (except subscripted lines), 16 and line 16.01 and Part V, col. 8, line 29

Lines 2 through 6.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1. 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-I, chapter 21) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §2570. Where your operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Line 2.-- In columns 1, 2 and 3, enter from your records the charges for the applicable Medicare services rendered prior to October 1, 2000. Additionally, in columns 2 and 3, enter from your records the charges for the applicable Medicare covered drugs (see §3215.3) rendered prior to October 1, 2000.

Line 2.01--In column 3, enter from your records only the charges for applicable Medicare covered osteoporosis drugs (see 3215.3) rendered on and after October 1, 2000. LCC is applicable only for drug costs for services rendered on and after October 1, 2000. For all other services rendered on or after October 1, 2000, do not enter any charges in columns 1 and 2.

Line 7.--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 total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The

primary payment satisfies the beneficiary's liability when you accept that payment as payment in full.

This is noted on no-pay bills submitted in these situations.) The patient visits and charges are included in total patient visits and charges, but are not included in program patient visits and charges. In this situation, enter no primary payer payment on line 7. 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 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. 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 visits and charges, and include the total visits and charges in total visits and charges for 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. Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 7.

3545.2 Part II - Computation of HHA Reimbursement Settlement.--Check the applicable title for When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program visits and charges, and include the total visits and charges in total visits 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. this form.

Line 8.--Enter in column 1 the lesser of the amount in column 1, line 1 or line 6 less the amount on line 7. Enter in column 2 the sum of the lesser of the amounts in column 2, line 1 or line 6, plus the lesser of the amounts in column 3, line 1 or line 6 minus the amounts on line 7, columns 2 and 3.

Lines 8.01 through 8.15—Under PPS enter only payment amounts associated with episodes completed in the current cost reporting period. Payments for episodes of care which overlap fiscal years must be recorded in the fiscal year in which the episode was completed. Enter in column 1 for lines 8.01 through 8.06, as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 for lines 8.07 through 8.10, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1, line 8.11 the sum total of other payments. Enter in column 1, lines 8.12 through 8.14, the total DME, oxygen, prosthetics and orthotics payments, respectively. Obtain these amounts from your PS&R report.

Line 9.--Enter in column 2 the Part B deductibles billed to Medicare patients. Exclude coinsurance amounts. Include any amounts of deductibles satisfied by primary payer payments.

Line 11.--Enter all coinsurance billable to Medicare beneficiaries including amounts satisfied by primary payer payments.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of costs subject to coinsurance. Compute this amount by subtracting Part B deductibles on line 9 and primary payment amounts on line 7, column 3 from Part B costs subject to coinsurance on line 1, column 3. The resulting amount is multiplied by 20 percent and entered on this line.

Line 13.--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.

NOTE: Effective for services rendered on or after August 5, 1997, a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare cost sharing to the extent that payment under

Title XVIII for the service would exceed the payment amount required to be made by the State through the State plan. For example, if the amount the State is required to pay for a Qualified Medicare Beneficiary (QMB) is less than the amount billed for deductible or coinsurance, the provider is precluded from claiming as a bad debt the balance.

Line 15.--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, chapter 1.) Enter the amount of any excess depreciation taken as a negative amount.

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 16.--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. Submit the work papers which have developed this amount. (See CMS Pub. 15-I, chapter 1.)

Line 17.-- Where 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 collected from a beneficiary or because you are unable to locate the beneficiary. (See CMS Pub. 15-I, §2577.)

Line 18.--Enter line 14 minus the sum of lines line 16 and 17, plus or minus the amount on line 15.

Line 18.01.--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.) For purposes of reimbursing costs associated with the Outcome and Assessment Information Set (OASIS) (cost reporting periods beginning in Federal fiscal year 2000 only) report on this line in column 1, the result of multiplying the Medicare unduplicated census count on Worksheet S-4, column 2, line 9, (excluding subscripts) by \$10.00, minus the interim OASIS payment made to the provider on April 1, 2000. Do not include this interim OASIS payment on Worksheet S-7, but rather attach documentation supporting the payment(s). (For intermediary use only during final settlement.)

Line 19.--Enter the applicable sequestration adjustment. (See §120 for a detailed explanation.)

Line 20—Enter the amount on line 18 plus line 18.01 minus line 19.

Line 21—Enter the interim payments from Worksheet H-7, line 4. For intermediary final settlement, report on line 21.01 the amount from Worksheet H-7, line 5.99.

Line 22.--Enter the amount on line 20 minus the amount of line 21. The amounts on this line show the balance due to you or to the program and are transferred to Worksheet S, Part II, columns 2, 3, or 4, as appropriate, line 4. Indicate overpayments by parentheses ().

Line 23.--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of items as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the supporting details and computation for this line.

3551. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS

Use this worksheet only if you operate as part of your complex a certified SNF-based community mental health center (CMHC), a SNF-based comprehensive outpatient rehabilitation facility (CORF), a SNF-based outpatient rehabilitation facility (ORF) which generally furnishes outpatient physical therapy (OPT), a SNF-based outpatient occupational therapy (OOT), or a SNF-based

outpatient speech pathology (OSP). If you have more than one SNF-based outpatient rehabilitation provider, complete a separate worksheet for each provider. For other than CMHC's if all services are paid under established fee schedules do not complete these worksheets for cost reporting periods beginning on or after April 1, 2001, for CORFs and cost reporting periods beginning on or after July 31, 2003, for ORF's. CMHC's with cost reporting periods beginning on or after January 1, 2004, are reimbursed under 100% PPS.

3551.1 Part I - Allocation of General Service Costs to Outpatient Rehabilitation Provider Cost Centers.-- Worksheet J-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 18) from Worksheet A, column 7, line 50. Obtain the cost center allocation (column 0, lines 1 through 21) from your records.

3551.2 Part II - Computation of Unit Cost Multiplier for Allocation of Outpatient Rehabilitation Provider Administrative and General Costs.--

3551.3 Part III - Allocation of General Service Costs to Outpatient Rehabilitation Provider Cost Centers -Statistical Basis.--Worksheet J-1, Parts II and III provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet J-1, Part I.

To facilitate the allocation process, the general format of Worksheet J-1, Parts I and III, is identical.

The statistical basis shown at the top of each column on Worksheet J-1, Part III is the recommended basis of allocation of the cost center indicated.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year if received by the intermediary, in writing, within 90 days prior to the end of the fiscal year. The intermediary has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, is changed due to simplification of maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until an approval is made. If both sets of statistics are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used.

Lines 1 through 21.--On Worksheet J-1, Part III, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 22.--Enter the total of lines 1 through 21 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 50.

Line 23.--Enter the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B, Part I, line 50, from the same column used to enter the statistical base on Worksheet J-1, Part III (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 50).

Line 24.--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 23 by the total statistic entered in the same column on line 22. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet J-1, Part I in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 22, Part I) must equal the total cost on line 23, Part III.

Perform the preceding procedures for each general service cost center.

In column 16, Part I, enter the total of columns 3a through 15.

In Part II, compute the unit cost multiplier for allocation of the components' administrative and general costs as follows.

Line 1.--Enter the amount from Part I, column 18, line 22.

Line 2.--Enter the amount from Part I, column 18, line 1.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Divide the amount on line 2 by the amount on line 3 and enter the result rounded to six decimal places.

In column 19, Part I, for lines 2 through 21, multiply the amount in column 18 by the unit cost multiplier on line 4, Part II, and enter the result in this column. On line 22, enter the total of the amounts on lines 2 through 21. The total on line 22 equals the amount on column 18, line 1.

In column 20, Part I, enter on lines 2 through 17 the sum of the amounts in columns 18 and 19. The total in column 20, line 22 must equal the total in column 18, line 22.

3552. WORKSHEET J-2 - COMPUTATION OF COMPONENT COSTS

Use this worksheet if you operate a SNF-based CORF, a SNF-based CMHC, a SNF-based OPT, a SNF-based OOT, or a SNF-based OSP. Complete a separate worksheet for each provider.

3552.1 Part I - Apportionment of Outpatient Rehabilitation Provider Cost Centers.--

Column 1.--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, column 20. To facilitate the apportionment process, the line number designations are the same on both worksheets.

Column 2.--Enter the charges for each cost center. Obtain the charges from your records.

Column 3.--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

Columns 4, 6, 8 and 8.01.--For each cost center, enter the charges from your records for title V, title XVIII, and title XIX patients, respectively. Not all facilities are eligible to participate in all programs. For cost reporting periods which overlap August 1, 2000, you must subscript column 8, and column 9, to report CMHC charges and costs. Charges before August 1, 2000 are reported in column 8. Charges on or after August 1, 2000 are reported in column 8.01 to accommodate the implementation of prospective payment. For cost reporting periods beginning on or after August 1, 2000 no subscripting is required.

Columns 5, 7, 9 and 9.01.--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, 8, and 8.01 respectively, by the ratio in column 3.

Line 22.--Enter the totals for columns 1, 2, and 4 through 9.

Column 10, lines 3, 4, 5, 24, 25 and 26. --For each cost center, enter the title XVIII charges (from your records) for services rendered on and after January 1, 1998.

Column 11, lines 3, 4, 5, 24, 25 and 26. --Determine the title XVIII cost for services rendered on or after January 1, 1998 by multiplying the charges in column 10 by the ratio in column 3, and enter the result.

Column 12, lines 3, 4, 5, 24, 25 and 26. --Determine the reduction amount by multiplying the cost in column 11 by the ten percent cost reduction, and enter the result.

Column 13, lines 3, 4, 5, 24, 25 and 26. --Determine the title XVIII cost net of applicable cost reduction by subtracting the amount in column 12 from the amount in column 9. For lines 2, 6 through 21, 23, and 27 through 29, enter the cost from column 9.

3552.2 Part II - Apportionment of Cost of Outpatient Rehabilitation Services Furnished by Shared Skilled Nursing Facility Departments.--Use this part only when the SNF complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the skilled nursing facility's outpatient rehabilitation facility.

Column 3.--For each of the cost centers listed, enter the ratio of cost to charges that is shown on Worksheet C, column 3, from the appropriate line for each cost center.

Columns 4, 6, and 8.--For each cost center, enter the charges from your records for title V, title XVIII, and title XIX patients, respectively.

Columns 5, 7, and 9.--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8 respectively by the ratio in column 3.

Line 30.--Enter the totals for columns 4 through 7, 9 and 13.

3552.3 Part III - Total Rehabilitation Costs-- Use This Section to Determine the Applicable Facilities Rehabilitation Costs.--

Line 31. --Enter the amounts from Part I, column 13, line 22 and the amount from Part II, column 13, line 30. Add the amount from Part I, line 22 and Part II, line 30 for columns 8 through 11.

3553. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT OF REHABILITATION SERVICES

3553.1 Part I - Calculation of Reimbursement Settlement for SNF-Based Providers Not Subject to the Computation of the Lesser of Reasonable Costs or Customary Charges.--

This worksheet is to be completed if you operate a SNF-based CMHC, a SNF-based OPT, SNF-based OSP, and/or SNF-based OOT.

Line 1.--Enter the cost of rehabilitation services from Worksheet J-2, **Part III**, line 31 from columns 5, 7, 9 for title XVIII services prior to 8/1/2000, and 9.01 for services on and after 8/1/2000, or 13, as applicable (column 5 for title V, column 7 for title XIX, and columns 9, 9.01 or 13 for title XVIII).

NOTE: Subscript column 2, lines 1 through 10, for cost reporting periods which overlap August 1, 2000, **January 1, 2002, January 1, 2003, and December 31, 2003, to accommodate the transitional corridor payment calculation associated with the portion of the cost reporting period which overlaps any of the aforementioned dates.** Enter in column 2 data applicable to the CMHC prior to August 1, 2000. Enter in column 2.01 data applicable to the CMHC on and after August 1, 2000. **For cost reporting periods which overlap a transition date, enter in column 2 any data applicable to CMHC services rendered prior to the transition, and enter in column 2.01 data applicable to CMHC services rendered on or after the transition date. For cost reporting periods that do not overlap transition dates and for cost reporting periods beginning on and after January 1, 2004, complete only column 2.**

Lines 1.01 through 1.06 are to be completed by CMHCs for title XVIII, for services on or after August 1, 2000.

Line 1.01. Enter the cost of the health services for services rendered on or after August 1, 2000, from Worksheet J-2, Part II, column 9.01 (column 9 for cost reporting periods beginning after August 1, 2000).

Line 1.02.--Enter the PPS payments received including outliers.

Line 1.03.--Enter the 1996 SNF specific payment to cost ratio provided by your intermediary. If you did not file a cost report in 1996, you are not eligible for transition corridor payments.

Line 1.04.--Multiply line 1.01 times line 1.03.

Line 1.05.--Divide line 1.02 by line 1.04.

Line 1.06.--Enter the transition corridor payment amount calculated based on the following:

For services rendered on and after August 1, 2000 through December 31, 2001:

- a. If line 1.05 is \geq 90 percent but $<$ 100 percent, enter 80 percent of (line 1.04 minus line 1.02).
- b. If line 1.05 is \geq 80 percent but $<$ 90 percent, enter .71 of (line 1.04) minus .70 (line 1.02).
- c. If line 1.05 is \geq 70 percent but $<$ 80 percent, enter .63 of (line 1.04) minus .60 (line 1.02).
- d. If line 1.05 is $<$ 70 percent, enter 21 percent of line 1.04.

For services rendered on and after January 31, 2002 through December 31, 2002:

- a. If line 1.05 is \geq 90 percent but $<$ 100 percent, enter 70 percent of (line 1.04 minus line 1.02).
- b. If line 1.05 is \geq 80 percent but $<$ 90 percent, enter .61 of (line 1.04) minus .60 (line 1.02).
- c. If line 1.05 is $<$ 80 percent, enter 13 percent of line 1.04.

For services rendered on and after January 31, 2003 through December 31, 2003:

- a. If line 1.05 is \geq 90 percent but $<$ 100 percent, enter 60 percent of (line 1.04 minus line 1.02).
- b. If line 1.05 is $<$ 90 percent, enter 6 percent of line 1.04.

If the cost reporting periods overlap any of these effective dates you must subscript the column and make a separate transitional corridor payment for the appropriate periods.

Line 2.--Enter the amounts paid and payable by workmen's compensation and other primary payers (from your records).

Line 3.--Enter in column 2, the amount obtained by subtracting line 2 from line 1. Enter in column 2.01 the amount obtained by subtracting line 2 from the sum of lines 1, 1.02 and 1.06 for CMHC. For cost reporting periods beginning on and after August 1, 2000, enter in column 2, the sum of lines 1.02 and 1.06.

Line 6.--Enter in column 2, 80 percent of line 5 for Title XVIII services prior to August 1, 2000. Make no entry in column 2.01 for services on and after August 1, 2000. Make no entry for title V or title XIX.

Line 7.--Enter the actual coinsurance billed to program patients (from your records).

Line 9.--Enter reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records).

Line 10.--For services prior to August 1, 2000, enter in column 2 the lesser of line 6 or line 8; plus line 9. For services on and after August 1, 2000, enter in column 2.01 the sum of line 8 and 9. Combine the amount in column 2 and the amount in column 2.01, and bring one amount into the calculation for line 13 below.

Line 11.--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, §§132ff.) Enter the amount of any excess depreciation taken in parentheses ().

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 12.--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, §§136ff.)

Line 13.--Enter the amount on line 10, plus or minus the amount on line 11, minus the amount on line 12.

Line 14.--Using the methodology explained in §120, enter the sequestration adjustment on this line.

NOTE: Public Law 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman), provides for an automatic deficit reduction procedure to be established for Federal fiscal years (FYs) 1986 through 1991, unless the deficit would reach zero

For Title XVIII, reduce each payment amount by a specified percentage which could not exceed 1 percent for FY 1986 and 2 percent for each subsequent year in which sequestration (reduction of otherwise payable program payment amount pursuant to a Presidential Order under PL. 99-177) takes place. Section 120 outlines the methodology by which the sequestration adjustment is computed.

Line 15.--Enter the amount on line 13 minus the amount on line 14.

Line 16.--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4.

Line 17.--Enter the balance due provider/program and transfer this amount to Worksheet S, Part II, columns as appropriate, line 5.

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.

3553.2 Part II - Computation of Customary Charges for Rehab Services.--Pursuant to §4541 of BBA 1997, §1834(k) of the Social Security Act is amended to require that title XVIII services rendered in Calendar Year 1998 for CORF be subject to the lesser of charges imposed for those services or the adjusted reasonable costs.

If you have more than one SNF-based facility, a separate worksheet must be completed for each facility.

Line 1--Enter the total cost of outpatient rehabilitation services from Worksheet J-2, Part III, column 13, line 31.

Line 1.1--Enter the total reasonable cost of rehabilitation services prior to 1/1/98, from Worksheet J-2, Part II, column 9, line 31 minus the amount from column 11, line 31.

Line 1.2--Enter the total reasonable cost of rehabilitation services rendered on or after 1/1/98 by multiplying the amount from Worksheet J-2, Part II, column 11, line 31 by 90 percent.

NOTE: Line 1 must equal the sum of lines 1.1 and 1.2

Line 2--Enter (from your records) the amounts paid and payable by Workmen's Compensation and other primary payor.

Line 3--Enter the amount obtained by subtracting line 2 from line 1

Line 4--Enter the total charges from Worksheet J-2, Part III, column 8, line 31.

Lines 5, 6, 7, and 8--These lines provide for the reduction of Medicare charges where 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. Enter on line 8 the product of multiplying the ratio on line 7 by line 4. In no instance may the customary charges on line 8 exceed the actual charges on line 4.

Line 8.1--Enter the customary charges for rehabilitation services rendered prior to 1/1/98 from Worksheet J-2, Part II, column 8, line 31, minus the amount from column 10, line 31.

Line 8.2--Enter the customary charges for rehabilitation services rendered on or after 1/1/98 by multiplying the amount from Worksheet J-2, Part II, column 10 by 90 percent.

Line 8.3--Enter on line 8.3 the excess of total customary charges (8.2) over the total reasonable cost (line 1.2). When the total charges on line 8.2 are less than the total cost on line 1.2, enter zero (0) on line 8.3.

Line 8.4--Enter on line 8.4 the excess of total reasonable cost (line 1.2) over total customary charges (line 8.2). When the total cost on line 1.2 is less than the customary charges on line 8.2, enter zero (0) on line 8.4.

3553.3 Part III - Computation of Reimbursement Settlement of Outpatient Rehabilitation Services--

Line 9--Enter the cost of rehabilitation services from Part II, line 3.

Line 10--Enter the Part B deductibles billed to program patients (from your records) excluding any coinsurance amounts.

Line 11--Enter the amount obtained by subtracting line 10 from line 9.

Line 11.1--Enter the amount from Part II, line 8.4.

Line 12--Enter 80 percent of line 11.2.

Line 13--Enter the actual coinsurance billed to program patients (from your records).

Line 14--Enter the amount obtained by subtracting line 13 from line 11.2.

Line 15--Enter (from your records) reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance.

Line 16--Enter the lesser of the amounts on line 12 or 14 plus the amount on line 15.

Line 17--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. 15-1, §§132ff.) Enter the amount of any excess depreciation taken in parentheses. ().

NOTE: Effective for changes in ownership that occur on or after December 1, 1997, §4404 of BBA 1997 amends §1861(v)(1)(O) of the Act which states, in part, that "...a provider of services which has undergone a change of ownership, such regulations provide that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record...". That is, no gain or loss is recognized for such transactions on or after December 1, 1997.

Line 18--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See HCFA Pub. 15-I, §§136ff.)

Line 19--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See HCFA Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 20--Enter the amount from line 16 minus the amounts from lines 17 and 18, plus or minus the amount on line 19.

Line 21--Enter any applicable sequestration adjustment. (See §120.)

Line 23--Enter the total interim payments, if applicable. Transfer this amount from Worksheet J-4, column 2, line 4.

Line 24--Enter the balance due the provider/program and transfer this amount to Worksheet S, Part II, column 3, line 5.

Line 25--Enter the program reimbursement effect of nonallowable cost report items, which you are disputing. Compute the reimbursement effect in accordance with §115.2. Attach a schedule showing the supporting details and computation.

Line 26--Do not use this line for cost reporting periods beginning on or after October 1, 1997.

3562. WORKSHEET I-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

This worksheet must be completed for services furnished on and after January 1, 2003.

Line 1--Enter the health care staff cost from Worksheet I-1, column 7, line 10.

Line 2--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4--Enter the cost of pneumococcal and influenza vaccine medical supplies from your records.

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

Line 6--Enter the amount on Worksheet I-1, column 7, line 21. This is your total direct cost of the facility.

Line 7--Enter the amount from Worksheet I-2, line 16.

Line 8--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9--Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10--Enter the sum of the amounts on lines 5 and 9.

Line 11--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12--Enter the cost per pneumococcal and influenza vaccine injection by dividing the amount on line 10 by the number on line 11 and entering the result.

Line 13--Enter the number of pneumococcal and influenza vaccine injections from your records.

Line 14--Enter the Medicare cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15.--Enter the total cost of pneumococcal and influenza vaccine and its (their) administration by entering the sum of the amount in column 1, line 10 and the amount in column 2, line 10. Transfer this amount to Worksheet I-3, Part I, line 2.

Line 16.--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration. This is equal to the sum of the amount in column 1, line 14 and column 2, line 14. Transfer the result to Worksheet I-3, Part II, line 20.

3563. **WORKSHEET I-5 - ANALYSIS OF PAYMENTS TO SNF-BASED RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTERS**

Complete this worksheet for Medicare interim payments only. Complete a separate worksheet for each rural health clinic and federally qualified health center.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your intermediary.

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 program interim payments paid to the component. The amount entered reflects 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 include amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts. Nor does it include interim payments payable.

Line 2.--Enter the total program 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, and does not include payments reported on line 1.

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

Line 4.--Transfer the total interim payments to the title XVIII Worksheet I-3, Part II, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET I-5. 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.

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, where 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.--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet I-3, line 24.

3564. **WORKSHEET A-8-5 - REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998**

This worksheet provides for the computation of any needed adjustments to costs applicable to therapy services furnished by outside suppliers. The information required on this worksheet provides, in the aggregate, all data for therapy services furnished by all outside suppliers in determining the reasonableness of therapy costs. (See HCFA Pub.15-I, chapter 14.) For services rendered on and after January 1, 1999, therapy services are subject to a fee schedule. Therefore for cost reporting periods beginning on or after January 1, 1999 this form is no longer required for all SNF's, except complexes with SNF based home health agencies, or **SNF-based community mental health centers**.

NOTE: If you furnish therapy services under arrangement with outside suppliers, complete this worksheet. When reimbursement for such therapy services is subject to the provisions of PPS or the TEFRA rate of increase ceiling, adjust costs subsequently on Worksheet C, Part I.

If you contract with an outside supplier for therapy services, the potential for limitation and the amount of payment you receive depends on several factors:

- o An initial test to determine whether these services are categorized as intermittent part time or full time services;
- o The location where the services are rendered, i.e. at your site or HHA home visit;
- o For HHA services, whether detailed time and mileage records are maintained by the contractor and HHA;
- o Add-ons for supervisory functions, aides, overtime, equipment, and supplies; and
- o Intermediary determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

3564.1 Part I - General Information--This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Line 1--Enter the number of weeks that services were performed on site. Count only those weeks during which a supervisor, therapist, or an assistant was on site. For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the HHA. Weeks when services were performed both at your site and at the patient's home are counted only once. (See HCFA Pub.15-I, chapter 14.)

Line 2--Multiply the amount on line 1 by 15 hours per week. This calculation is used to determine whether services are full-time or intermittent part-time.

Line 3--Enter the number of days in which the supervisor or therapist (report only the therapist for respiratory therapy) was on site. Count only one day when both the supervisor and therapist were at the site during the same day.

Line 4--Enter the number of days in which the therapy assistant (PT, OT, SP only) was on site. Do not include days when either the supervisor or therapist was also at the site during the same day.

NOTE: Count an unduplicated day for each day the contractor has at least one employee on site. For example, if the contractor furnishes a supervisor, therapist, and assistant on one day, count one therapist day. If the contractor provides two assistants on one day (and no supervisors or therapists), count one assistant day.

Line 5--Enter the number of unduplicated HHA visits made by the supervisor or therapist. Count only one visit when both the supervisor and therapist were present during the same visit.

Line 6--Enter the number of unduplicated HHA visits made by the therapy assistant. Do not include in the count the visits when either the supervisor or therapist was present during the same visit.

Line 7--Enter the standard travel expense rate applicable. (See HCFA Pub.15-I, chapter 14.)

Line 8--Enter the optional travel expense rate applicable. (See HCFA Pub.15-I, chapter 14.) Use this rate only for services for which time records are available.

Line 9--Enter in the appropriate columns the total number of hours worked for each category..

Line 10--Enter in each column the appropriate adjusted hourly salary equivalency amount (AHSEA). This amount is the prevailing hourly salary rate plus the fringe benefit and expense factor described in HCFA PUB 15-I, chapter 14. This amount is determined on a periodic basis for appropriate geographical areas and is published as an exhibit at the end of HCFA Pub.15-I, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisory AHSEA, adjusted for administrative and supervisory responsibilities. Determine this amount in accordance with the provisions of HCFA Pub.15-I, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants aides and trainees respectively) the AHSEA from either the appropriate exhibit found in HCFA Pub.15-I, chapter 14 or from the latest publication of rates. If the going hourly rate for assistants in the area is unobtainable, use no more than 75 percent of the therapist AHSEA. The cost of services of a therapy aide or trainee is evaluated at the hourly rate, not to exceed the hourly rate paid to your employees of comparable classification and/or qualification, e.g., nurses' aides. (See HCFA Pub.15-I, §1412.2.)

Line 11--Enter the standard travel allowance equal to one half of the AHSEA. Enter in columns 1 and 2 one half of the amount in column 2, line 10. Enter in column 3 one half of the amount in column 3, line 10. (See HCFA Pub.15-I, §1402.4.)

Lines 12 and 13--Enter the number of travel hours and number of miles driven, respectively, for provider on-site. Time records of visits must be kept. (See HCFA Pub.15-I, §§1402.5 and 1403.1.)

Lines 12.01 and 13.01--Enter the number of travel hours and number of miles driven, respectively, for provider off-site. Time records of visits must be kept.

NOTE: There is no travel allowance for aides employed by outside suppliers.

3564.2 Part II - Salary Equivalency Computation--This part provides for the computation of the full-time or intermittent part-time salary equivalency.

When you furnish therapy services from outside suppliers to health care program patients but simply arrange for such services for non health care program patients and do not pay the non health care program portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of HCFA Pub.15-I, §2314, complete Part II, lines 14 through 20 and 23 in all cases and lines 21 and 22 where appropriate. However, where you cannot gross up costs and charges, complete lines 14 through 20 and 23.

Line 14 - 20--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 9) by the adjusted hourly salary equivalency amount for supervisors, therapists, assistants, aides and trainees (for respiratory therapy only).

Line 17--Enter the sum of lines 14 and 15 for respiratory therapy or sum of lines 14 through 16 for all others.

Line 20--Enter the sum of lines 17 through 19 for respiratory therapy or sum of lines 17 and 18 for all other.

Lines 21 and 22--If the sum of hours in columns 1 and 2 for respiratory therapy or 1 through 3 for all others, line 9 is less than or equal to the product found on line 2, complete these lines. (See the exception above where you cannot gross up costs and charges, and services are provided to program patients only.) Enter on line 21 the result of line 17 divided by the sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others.

Line 23--If there are no entries on lines 21 and 22, enter the amount from line 20. Otherwise, enter the sum of the amounts on lines 18, 19, and 22 for respiratory therapy or lines 18 and 22 for all others..

3564.3 Part III - Standard and Optional Travel Allowance and Travel Expense Computation - Provider Site.--This part provides for the computation of the standard and optional travel allowance and travel expense for services rendered on site.

Lines 24 - 28--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed at your site. One standard travel allowance is recognized for each day an outside supplier performs skilled therapy services at your site. For example, if a contracting organization sends three therapists to you each day, only one travel allowance is recognized per day. (See HCFA Pub.15-I, §1403.1 for a discussion of standard travel allowance and §1412.6 for a discussion of standard travel expense.)

Line 24--Include the standard travel allowance for supervisors and therapists. This standard travel allowance for supervisors does not take into account the additional allowance for administrative and supervisory responsibilities. (See HCFA Pub.15-I, §1402.4.)

Line 25--Include the standard travel allowance for assistants for physical therapy occupational therapy and speech pathology.

Line 26--Enter the amount from line 24 for respiratory therapy or the sum of lines 24 and 25 for physical therapy, occupational therapy, or speech pathology.

Line 27--Enter the result of line 7 times line 3 for respiratory therapy or line 7 times the sum of lines 3 and 4 for all others.

Lines 29 - 35--Complete these lines for computing the optional travel allowance and expense when proper records are maintained.

Line 31--Enter the amount on line 29 for respiratory therapy or the sum of lines 29 and 30 for all others.

Line 32--Enter the result of line 8 times the sum of columns 1 and 2, line 13 for respiratory therapy or columns 1, 2, and 3, line 13 for all other.

Lines 33 through 35--Enter an amount in one of these lines depending on the method utilized.

3564.4 Part IV - Standard and Optional Travel Allowance and Travel Expense Computation - Provider Off Site.--This part provides for the computation of the standard travel allowance, the standard travel expense, the optional travel allowance, and the optional travel expense. (See HCFA Pub.15-I, §§1402ff, 1403.1 and 1412.6.) This part is completed for physical therapy, speech pathology, and occupational therapy only. If there are multiple HHAs, subscript lines where appropriate.

Lines 36-39--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with HHA visits. Only use these lines if you do not use the optional method of computing travel. A standard travel allowance is recognized for each visit to a patient's residence. If services are furnished to more than one patient at the same location, only one standard travel allowance is permitted, regardless of the number of patients treated.

Lines 40 - 43--Complete the optional travel allowance and optional travel expense computations for physical therapy, occupational therapy, and speech pathology services in conjunction with home health services only. Compute the optional travel allowance on lines 40 through 42. Compute the optional travel expense on line 43.

Lines 44 - 46--Choose and complete only one of the options on lines 44 through 46. However, use lines 45 and 46 only if you maintain time records of visits. (See HCFA Pub.15-I, §1402.5.)

3564.5 Part V - Overtime Computation.--This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for you in excess of your standard work week. No overtime allowance is given to a therapist who receives an additional allowance for supervisory or administrative duties. (See HCFA Pub.15-I, §1412.4.)

Line 47--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 5 are either zero, equal to or greater than 2080 for a 12 month cost report, (2240 hours for a 13 month cost report, 2400 hours for a 14 month cost report, or 2560 hours for a 15 month cost report), the overtime computation is not applicable. Make no further entries on lines 48 through 55. (If there is a short period prorate the hours.) Enter zero in each column of line 56. Enter in column 5 the sum of the hours recorded in columns 1, 3 and 4 for respiratory therapy, and columns 1 through 3 for physical therapy, speech pathology, and occupational therapy.

Line 48--Enter in the appropriate column the overtime rate (the AHSEA from line 10, column as appropriate, multiplied by 1.5).

Line 50--Enter the percentage of overtime hours by class of employee. Determine this amount by dividing each column on line 47 by the total overtime hours in column 5, line 47.

Line 51--Use this line to allocate your standard work year for one full-time employee. Enter the numbers of hours in your standard work year for one full-time employee in column 4. Multiply the standard work year in column 4 by the percentage on line 50 and enter the result in the corresponding columns.

Line 52--Enter in columns 1 through 3 for physical therapy, speech pathology and occupational therapy the AHSEA from Part I, line 10, columns 2 through 4, as appropriate. Enter in columns 1, 3 and 4 the AHSEA from Part I, line 10 columns 2, 4, and 5.

Line 56--Enter in column 5 the sum of the amounts recorded in columns 1, 3 and 4 for respiratory therapy and columns 1 through 3 for physical therapy, speech pathology, and occupational therapy.

3565. WORKSHEET K – ANALYSIS OF SNF BASED HOSPICE COST

In accordance with 42 CFR 413.20, the methods of determining costs payable under Title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. This worksheet provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets K, K-4, Parts I & II, the line numbers are consistent, and the total line is set at 34). Not all of the cost centers listed apply to all providers using these forms.

Column 1--Obtain salaries to be reported from Worksheet K-1, column 9, line 3-34.

Column 2--Obtain employee benefits to be reported from Worksheet K-2 column 9 lines 3-34.

Column 3--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center, enter them on line 22.

Column 4--Obtain the contracted services to be reported from Worksheet K-3, column 9 lines 3-34.

Column 5--Enter in the applicable lines in column 5 all costs which have not been reported in columns 1 through 4.

Column 6--Add the amounts in columns 1 through 5 for each cost center and enter the total in column 6.

Column 7.--Enter any reclassifications among cost center expenses in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses as negative amounts.

Column 8.--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 34.

Column 9.--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §3519.)

Column 10.--Adjust the amounts in column 8 by the amounts in column 9, (increases or decreases) and extend the net balances to column 10.

Transfer the amount in column 10, line 1 through 34 to the corresponding lines on Worksheet K-4, Part I, column 0.

Line Description

Lines 1 and 2.--Capital Related Cost - Buildings and Fixtures and Capital Related Cost - Movable Equipment.--These cost centers should include depreciation, leases and rentals for the use of the facilities and/or equipment, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care.

Do not include in these cost centers the following costs: costs incurred for the repair or maintenance of equipment or facilities; amounts included in the rentals or lease or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Line 3 - Plant Operation and Maintenance.--This cost center contains the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of plant, and protecting the employees, visitors, and agency property.

Plant operation and maintenance include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment. This cost center also includes the cost of maintenance and repair of building, parking facilities and equipment, painting, elevator maintenance, performance of minor renovation of buildings, and equipment. The maintenance of grounds such as landscape and paved areas, streets on the property, sidewalk, fenced areas, fencing, external recreation areas and parking facilities are part of this cost center. The care or cleaning of the interior physical plant, including the care of floors, walls, ceilings, partitions, windows (inside and outside), fixtures and furnishings, and emptying of trash containers, as well as the costs of similar services purchased from an outside organization which maintains the safety and well-being of personnel, visitors and the provider's facilities, are all included in this cost center.

Line 4 - Transportation-Staff.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5 - Volunteer Service Coordination.--Enter all of the cost associated with the coordination of service volunteers. This includes recruitment and training costs.

Line 6 - Administrative and General.--Use this cost center to record expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs.

Line 7 - Inpatient - General Care.--This cost center includes costs applicable to patients who receive this level of care because their condition is such that they can no longer be maintained at home.

Generally, they require pain control or management of acute and severe clinical problems which cannot be managed in other settings. The costs incurred on this line are those direct costs of furnishing routine and ancillary services associated with inpatient general care for which other provisions are not made on this worksheet.

Costs incurred by a hospice in furnishing direct patient care services to patients receiving general inpatient care either directly from the hospice or under a contractual arrangement in an inpatient facility is to be included in the visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24 hours nursing care within the facility, patient meals, laundry and linen services, and housekeeping. Plant operation and maintenance cost is recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient general care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet K-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting services section.

Therefore, obtain the amounts to be entered on Worksheet K-4, Part II, column 6, from Worksheet K-4, Part I, columns 0 through 5.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet K-4, Part I, column 0) for purposes of determining the basis of allocation (Worksheet K-4, Part II, column 5) of the A&G costs. This procedure may be followed when the hospice contracts for services to be performed for the hospice and the contract identifies the A&G costs applicable to the purchased services.

The contracted A&G costs must be added back to the applicable cost center after allocation of the hospice A&G cost before the reimbursable costs are transferred to Worksheet K-5. A separate worksheet must be included to display the breakout of the contracted A&G costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Intermediary approval does not have to be secured in order to use the above described method of cost finding for A&G.

Worksheet K-4, Part II, Column 6A.--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet K-4, column 5A, line 34 and the accumulated cost reported on Worksheet K-4, Part II, column 6, line 6. Enter any amounts reported on Worksheet K-4, column 5A for (1) any service provided under arrangements to program patients that is not grossed up, and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead.

In addition, report on line 6 the administrative and general costs reported on Worksheet K-4, column 6, line 6 since these costs are not included on Worksheet K-4, Part II, column 6 as an accumulated cost statistic.

For fragmented or componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 6 (A&G), the reconciliation column designation must be 6A.

Worksheet K-4, Part II, Column 6.--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet K-4, Part II, column 6, line 6, is the difference between the amounts entered on Worksheet K-4, column 5A and Worksheet K-4, Part II, column 6A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

3570. WORKSHEET K-5 - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Use this worksheet only if you operate a certified SNF-based hospice as part of your complex. If you have more than one SNF-based hospice, complete a separate worksheet for each facility.

3570.1 Part I - Allocation of General Service Costs to Hospice Cost Centers.--Worksheet K-5, Part I, provides for the allocation of the expenses of each general service cost center of the SNF to those cost centers which receive the services. Worksheet K-5, Part II provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-5, Part I.

Obtain the total direct expenses (column 0 line 29) from Worksheet A, column 7, line 55. Obtain the cost center allocation (column 0, lines 1 through 28) from Worksheet K-4, lines as indicated. The amounts on line 29, columns 0 through 16 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 16, line 55. Calculate the amounts entered on lines 1 through 17, columns 1 through 16.

NOTE: Worksheet B, Part I, established the method used to reimburse direct graduate medical education cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 17, excluded the costs of interns and residents, column 17 on this worksheet must also exclude these costs.

Line 30.--Enter the unit cost multiplier (column 16, line 1), divided by the sum of column 16, line 29 minus column 16, line 1, rounded to 6 decimal places. Multiply each amount in column 16, lines 2 through 28, by the unit cost multiplier, and enter the result on the corresponding line of column 17.

3570.2 Part II - Allocation of General Service Costs to Hospice Cost Centers - Statistical Basis.--To facilitate the allocation process, the general format of Worksheet K-5, Parts I and II, is identical.

The statistical basis shown at the top of each column on Worksheet K-5, Part II, is the recommended basis of allocation of the cost center indicated.

NOTE: If you wish to change your allocation basis for a particular cost center, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See HCFA Pub. 15-I, §2313.)

If there is a change in ownership, the new owners may request that the intermediary approve a change of allocation basis in order to be consistent with their established cost finding practices. (See HCFA Pub. 15-I, §2313.)

Lines 1 through 28.--On Worksheet K-5, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 29.--Enter the total of lines 1 through 28 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 55.

Line 30.--Enter the unit cost multiplier which is obtained by dividing the cost entered in Part I, line 29 by the total statistic entered in the same column in Part II, line 29. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet K-5, Part I, in the corresponding column and line.

Perform the preceding procedures for each general service cost center.

In column 18, Part I, enter the total of columns 4A through 15.

In column 17, Part I, for lines 2 through 28, multiply the amount in column 17 by the unit cost multiplier on line 30, Part I, and enter the result in this column. On line 29, enter the total of the amounts on lines 2 through 28. The total on line 29 equals the amount in column 16, line 1.

In column 18, Part I, enter on lines 2 through 28 the sum of columns 16 and 17. The total on line 29 equals the total in column 18, line 29.

3570.3 Part III- Apportionment Hospice Shared Services.--This worksheet provides for the shared therapy, drugs, or medical supplies from the SNF to the hospice.

Column Description

Columns 1 & 2.-- Enter in column 2, the cost for each discipline from Worksheet K-5, Part I, col. 18, lines as indicated in column 1.

Column 3 & 4.--Where applicable, enter in column 4 the cost to charge ratio from Worksheet C, I column 3, lines as indicated in column 3.

Column 5.--Where SNF departments provides services to the hospice, enter on the appropriate lines the charges, from the provider's records, applicable to the SNF-based hospice.

Column 6.--Multiply the amount in column 5 by the ratios in column 4 and enter the result in column 6.

Column 7.--Add the amounts in column 2 to the amounts in column 6 and enter the result in column 7 in order to compute the total shared cost.

Line 9.--Sum of column 7 lines 1 through 8.

3571. WORKSHEET K-6 - CALCULATION OF PER DIEM COST

Worksheet K-6 calculates the average cost per days in providing care for a hospice patient. It is only an average and should not be misconstrued as the absolute.

Line 1.--Total cost from Worksheet K-5, Part I, line 29, less line 28, column 18, plus Worksheet K-5, Part III, column 6, line 9. This line reflects the true cost including shared cost and excluding any non hospice related costs.

Line 2.--Total unduplicated days from Worksheet S-8, line 5, col. 6.

Line 3.--Average total cost per day. Divide the total cost from line 1 by the total number of days from line 2.

Line 4.--Unduplicated Medicare days from Worksheet S-8, line 5, column 1.

Line 5.--Average Medicare cost. Multiply the average cost from line 3 by the number of unduplicated Medicare days on line 4 to arrive at the average Medicare cost.

Line 6.--Unduplicated Medicaid days from Worksheet S-8, line 5, column 2.

Line 7.--Average Medicaid cost. Multiply the average cost from line 3 by the number of unduplicated Medicaid days on line 6 to arrive at the average Medicaid cost.

Line 8.--Unduplicated SNF days from Worksheet S-8, line 5, column 3.

Line 9.--Average SNF cost. Multiply the average cost from line 3 by the number of unduplicated SNF days on line 8 to arrive at the average SNF cost.

Line 10.--Unduplicated NF days from Worksheet S-8, line 5, column 4.

Line 11.--Average NF cost. Multiply the average cost from line 3 by the number of unduplicated NF days on line 10 to arrive at the average NF cost.

Line 12.--Unduplicated other days from Worksheet S-8, line 5, column 5.

Line 13.--Average other cost. Multiply the average cost from line 3 by the number of unduplicated other days on line 5 to arrive at the average other cost.

(Source: Transmittal#12; Provider Reimbursement Manual Part 2)

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