Health Financial Systems

Medicare Cost Report Update

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The Leader in
Medicare Cost Report Software

2552-10 Transmittal #4

- Advance copy distributed 9/20/2013
- Test Case distributed to vendors 9/23/2013
- Initial HFS comments on test case submitted 9/24/2013
- Follow up comments submitted 9/27/2013
- Published on CMS website 9/27/2013
  - www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals.html
- HFS Test Case submitted 10/2/2013
- Currently waiting on CMS revised test case for HFS comments.

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2552-10 Transmittal #4

- Effective Date – "Cost Reporting Periods Beginning on or After October 1, 2012."
- Some provisions effective earlier
  - Sequestration effective for services 4/1/2013
  - Bad Debt reductions effective FYB 10/1/2012
  - ESRD PPS effective FYE on or after 1/1/2011
  - ACA Section 5503 I&R changes effective FYE on or after 7/1/2011
- Other retroactive changes

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Worksheet S-2, Part I

	Inpatient PPS Information							
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N					
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N					
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	14,645	886	100	101	135	65	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	

- W/S S-2 part I, line 24 (Medicaid days), will now be edited to tie to S-3 part I, column 7 – If line 23 is "3".
- W/S S-2 part I, line 24, column 6 now to report LDR days
- W/S S-2 part I, line 25 (IRF Medicaid days), will now be edited to tie to S-3 part I, column 7 - If line 23 is "3".
- W/S S-2 part I, line 25, column 6 (IRF "Other" Medicaid days), is NO LONGER TO BE USED.

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Worksheet S-2, Part I

		Y/N	Y/N
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y

- Line 39
  - Column 1 – "qualify for LVA?
  - Column 2 "meet mileage"?
- Will Trigger LVA on Worksheet E, Part A, lines 70.96 and 70.97
- Will compute HFS LVA Worksheet if payments entered

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FY 2013 IPPS Update

Section 5503 Redistribution Clarification

- Previous - Hospitals that received 5503 increase shall ensure during the 5-year period beginning on the date of increase:
  - Number of FTEs for primary care is not less than average FTE for primary care during 3 most recent cost reporting periods
  - Not less than 75% of the positions attributable to increase are in primary care or general surgery

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FY 2013 IPPS Update

Section 5503 Redistribution Clarification

- Revised - Hospitals that received 5503 must use all of the awarded slots in it's final cost reporting period of the 5-year period beginning 7/1/2011 and ending 6/30/2016 or the cap will be reduced for unused slots for cost reporting periods beginning on or after 7/1/2016. Used slots are determined as:
  - Lessor of the number of slots used for an expansion in the fourth 12-month cost report or the final cost report.
  - For a new program, the number of slots used in the final cost report.
  - The portion of slots used are subject to the 75% test and 3-year primary care average requirement.

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Worksheet S-2, Part I

- Worksheet S-2, Part I, instructions:

Requirements During Five Year Period Following Implementation of Increases to Hospitals' FTE Resident Caps Under Section 5503 of the ACA, Lines 61 and Subscripts--Section 5503 of the ACA states that a hospital that receives an increase to its FTE resident cap under section 5503 shall ensure, during the 5-year period beginning on July 1, 2011, that:

(I) The number of FTE primary care residents is not less than the average number of FTE primary care residents during the three most recent cost reporting periods ending prior to the date of enactment of section 5503; and

(II) Not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency.

Failure to comply with either of these two requirements, known as the 3-year primary care average requirement (I) and the 75 percent test (II) means permanent removal of all section 5503 slots from the earliest applicable cost reporting period under the regulations at 42 CFR 413.79(n)(2).

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Worksheet S-2

		Y/N	IME	Direct GME	IME	Direct GME
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	Y			25.00	17.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		125.24	132.75		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		130.00	140.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		135.00	138.00		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		150.00	155.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		15.00	17.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		5.00	3.00		

- ACA Redistribution
  - Line 61 columns 2 and 3 were 3 year "average" primary care residents now reported on line 61.01
  - T-4 – Line 61 columns 4 and 5 for awarded slots
  - Line 61.02 - primary care FTE's actually added as a result of ACA
  - 61.03 - Base line FTE count for Primary care/general surgery for 75% test
  - 61.04 – Primary care FTEs in current year for comparison.
  - 61.05 – line 61.04 – 61.03
  - 61.06 – FTEs awarded and used for cap relief

Worksheet S-2, Part I

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.	FAMILY MEDICINE	1350	2.00	3.00
61.11		PEDIATRICS	2000	3.00	4.00
61.12		PREVENTIVE MEDICINE	2150	2.00	3.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.	FAMILY MEDICINE	1350	2.00	2.00
61.21		PEDIATRICS	2000	4.00	4.00
61.22		PREVENTIVE MEDICINE	2150	2.00	2.00

- W/S S-2 part I, lines 61.10 to 61.19 added for specifying NEW programs and FTEs added as a result of ACA slot allocations. Similar to lines 65 and 67.
- W/S S-2 part I, lines 61.20 to 61.29 added for specifying EXPANDED programs and FTEs added as a result of ACA slot allocations . Similar to lines 65 and 67.

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Worksheet S-2, Part I

	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.		Y	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		0	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.50	
			Beginning	Ending
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2012	09/30/2013

- W/S S-2 part I, line 169 – Ratio changes based on HIT Stage
- W/S S-2 part I, line 170, new to report HIT "reporting period".
- Will impact HIT/Sequestration calculation.

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EHR Reporting Period

- From CMS Website:
  - In the first year of participation, providers must demonstrate meaningful use for a 90-day EHR reporting period.
  - in subsequent years, providers will demonstrate meaningful use for a full year EHR reporting period (an entire fiscal year for hospitals) except in 2014.
  - For 2014 only, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a 3-month EHR reporting period.
- Cost Report instructions – "If the EHR reporting period ending date is on or after April 1, 2013, the EHR incentive payment will be subject to the 2 percent sequestration adjustment."

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Worksheet S-2 part IX

- S-2 part IX is an unofficial HFS worksheet, to enable users to have Titles V or XIX calculate differently than Title XVIII (Medicare).
- The 7 questions default to follow Medicare, so if there is no reason to change calculations for Titles V or XIX, do nothing with S-2 part IX.
- If you change something and realize it should not have been changed, you can delete the worksheet and get back to the defaults. Forms, Delete, S-2 part IX.

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Worksheet S-2 part IX

- Line 1 is to have I&R NOT carve out the Post Stepdown Adjustment (B part I, column 25), so the "cost" flowing to the Title V or XIX W/S C is different than Title XVIII.
- The instructions for W/S S-2 part IX are under HELP, but you must open S-2 part I, then click on HELP, CMS Instructions, then scroll down to S-2 part IX.
- If there are other scenarios we need to add to S-2 part IX, please email support@hfssoft.com.

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Counting Inpatient Days

- Effective for cost reporting periods beginning on or after 10/1/2011
  - Use of acute care beds under a contractual agreement for un-related Hospice provider included in total days for DSH
  - Not patient of hospital – excluded from Medicaid/SSI days
  - Associated revenues will be offset on A-8
- Effective for cost reporting periods beginning on or after 10/1/2012
  - Labor and delivery room beds included as available beds for IME/DSH
  - No change for DGME or Medicare utilization
  - Outpatient use of beds to be excluded similar to observation beds

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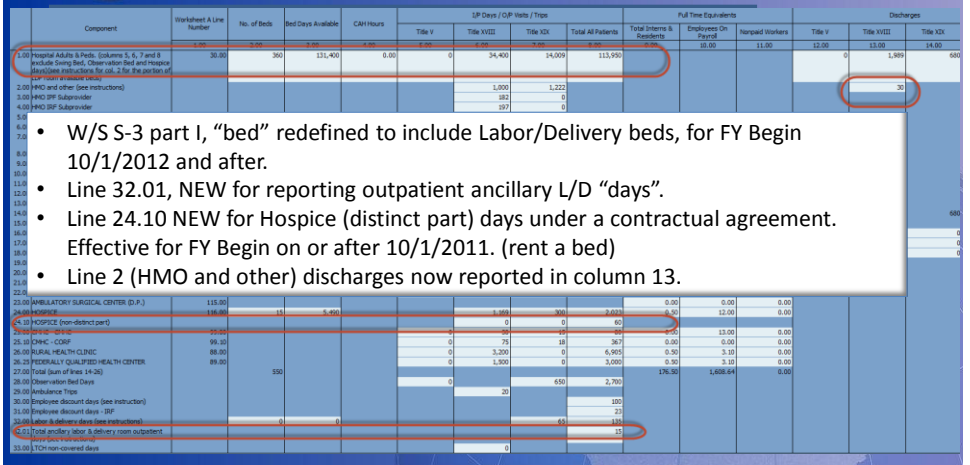
Worksheet S-3, Part I



- W/S S-3 part I, "bed" redefined to include Labor/Delivery beds, for FY Begin 10/1/2012 and after.
- Line 32.01, NEW for reporting outpatient ancillary L/D "days".
- Line 24.10 NEW for Hospice (distinct part) days under a contractual agreement. Effective for FY Begin on or after 10/1/2011. (rent a bed)
- Line 2 (HMO and other) discharges now reported in column 13.

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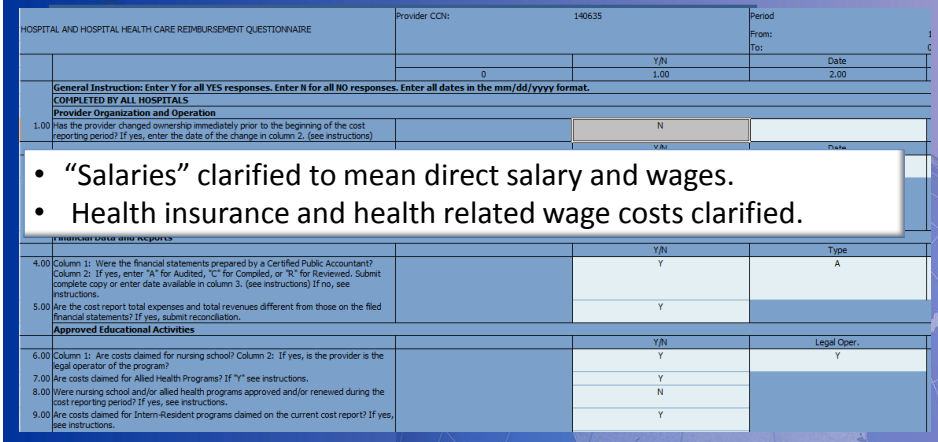
Worksheet S-3, Part II



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140635		Period From: To:
			Y/N	Date
		0	1.00	2.00
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N	
			Y/N	Type
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		Y	
	Approved Educational Activities			
			Y/N	Legal Oper.
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		Y	Y
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		Y	
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N	
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		Y	

- "Salaries" clarified to mean direct salary and wages.
- Health insurance and health related wage costs clarified.

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Worksheet S-5 – ESRD PPS

- Revised ESRD bundled payment system implemented for services effective 1/1/2011.
- Extensions NOT provided for hospital-based ESRD units prior to T-4.
  - Hospital based ESRDs instructed to submit cost reports using the new 2552-10, with the existing T-2/3 I series worksheets.
  - Will providers be required to re-file or MACs be required to reopen for cost reports previously filed on earlier transmittal?

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Worksheet S-5

	ESRD PPS		
		Y/N	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)	N	
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)	N	
		Prior to 1/1	After 12/31
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)	2	3

- W/S S-5, NEW line 10.01 added for Low Volume adjustment.
- W/S S-5, NEW lines 10.02-10.03 added for PPS status. HFS will edit for appropriate transition periods.

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Worksheet S-5

	EPOETIN					
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.					
14.00	Epoetin amount from Worksheet A for Home Dialysis program					
15.00	Number of EPO units furnished relating to the renal dialysis department					
16.00	Number of EPO units furnished relating to the home dialysis department					
	ARANESP					
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.					
18.00	ARANESP amount from Worksheet A for Home Dialysis program					
19.00	Number of ARANESP units furnished relating to the renal dialysis department					
20.00	Number of ARANESP units furnished relating to the home dialysis department					
	PHYSICIAN PAYMENT METHOD					
21.00	Enter "X" if method(s) is applicable	X				
	ESAs					
		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)	EPO	1,700	0	30	0
22.01		ARANESP	2,800	0	10	0

NEW effective for FYE ending after 12/31/2012, lines 13-20 are NOT USED. Instead, use NEW line 22 and subscripts, to report ESAs.

- Previously filed cost reports?

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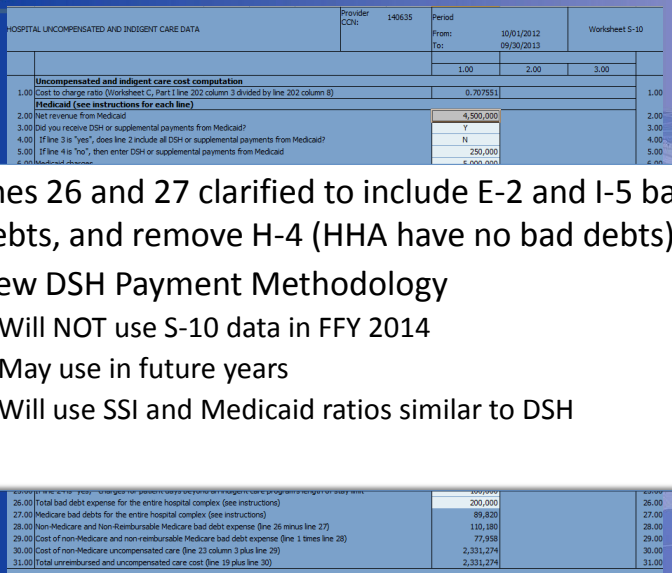
Worksheet S-10



HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140635 | Period From: 10/01/2012 To: 09/30/2013 | Worksheet S-10

		1.00	2.00	3.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.707551			1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	4,500,000			2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	250,000			5.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	200,000			26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	89,820			27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)	110,180			28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	77,958			29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	2,331,274			30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,331,274			31.00

- lines 26 and 27 clarified to include E-2 and I-5 bad debts, and remove H-4 (HHA have no bad debts).
- New DSH Payment Methodology
  - Will NOT use S-10 data in FFY 2014
  - May use in future years
  - Will use SSI and Medicaid ratios similar to DSH

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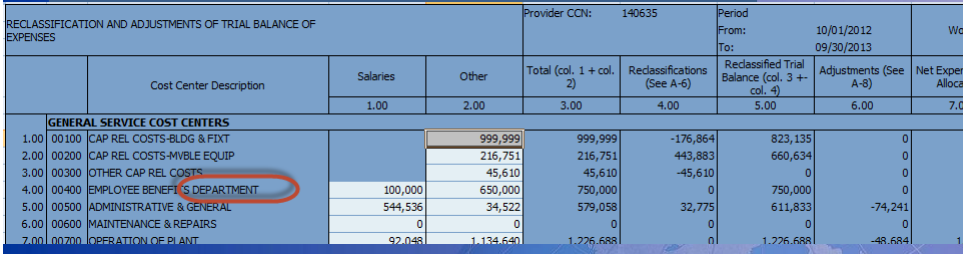
Worksheet A



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140635 | Period From: 10/01/2012 To: 09/30/2013

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	Adjustments (See A-8)	Net Expe Alloca
			1.00	2.00	3.00	4.00	5.00	6.00	7.0
		GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		999,999	999,999	-176,864	823,135	0	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		216,751	216,751	443,883	660,634	0	
3.00	00300	OTHER CAP REL COSTS		45,610	45,610	-45,610	0	0	
4.00	00400	EMPLOYEE BENEFI S DEPARTMENT	100,000	650,000	750,000	0	750,000	0	
5.00	00500	ADMINISTRATIVE & GENERAL	544,536	34,522	579,058	32,775	611,833	-74,241	
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	0	
7.00	00700	OPERATION OF PLANT	92,048	1,134,640	1,226,688	0	1,226,688	-48,684	1

- Clarified line 4 for Employee Benefits "Department" and not benefit costs.
- Retroactive effective date

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Worksheet A-8

ADJUSTMENTS TO EXPENSES		Provider CCN: 140635		Period From: 10/01/2012 To: 09/30/2013		Worksheet A-8
	Description (1)	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
				Cost Center	Line #	
	1.00	2.00		3.00	4.00	5.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0
3.00	Investment income - other (chapter 2)		0		0.00	0
4.00	Trade, quantity, and time discounts (chapter 8)	B	-19,884	CENTRAL SERVICES & SUPPLY	14.00	0
5.00	Refunds and rebates of expenses (chapter 8)	B	-3,011	ADMINISTRATIVE & GENERAL	5.00	0
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-62,180	ADMINISTRATIVE & GENERAL	5.00	0
8.00	Television and radio service (chapter 21)	A	-13,862	OPERATION OF PLANT	7.00	0
16.00	Sale of medical and surgical supplies to other than patients	B	-8,676	CENTRAL SERVICES & SUPPLY	14.00	0
17.00	Sale of drugs to other than patients	B	-19,765	PHARMACY	15.00	0
18.00	Sale of medical records and abstracts	B	-6,146	MEDICAL RECORDS & LIBRARY	16.00	0
19.00	Nursing school (tuition, fees, books, etc.)	B	-745,206	NURSING SCHOOL	20.00	0
20.00	Vending machines	B	-11,689	OPERATION OF PLANT	7.00	0
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	A	-3,808	ADMINISTRATIVE & GENERAL	5.00	0
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	
25.00	Utilization review - physicians' compensation (chapter 21)	A	-24,471	UTILIZATION REVIEW-SNF	114.00	
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0
28.00	Non-physician Anesthetist	A	-189,020	NONPHYSICIAN ANESTHETISTS	19.00	
29.00	Physicians' assistant		0		0.00	0
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	
30.99	Hospice (non-distinct) (see instructions)	B	-6,826	ADULTS & PEDIATRICS	30.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	

Line 30.99 (hardcoded)--When the hospital enters into a contractual arrangement with a hospice for the use of general inpatient routine beds, enter the amount received under contract from the hospice. This amount must be used to offset general inpatient routine care costs on Worksheet A, line 30.

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Worksheet B-2

POST STEPDOWN ADJUSTMENTS				Provider CCN:	Worksheet B-2
	Description	Worksheet Part	Worksheet Line No.	Amount	
	1.00	2.00	3.00	4.00	
1.00	ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00	ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00	ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00	ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	-4,500	5.00
6.00	ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00

W/S B-2 added NEW lines 5 and 6 for ESA reductions (from S-5 new line 22 and subscripts). Lines 1-4 no longer used, effective FYE 12/31/2012 and after.

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Worksheet E, Part A Available Beds

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider 140635	Period From: 10/01/2012 To: 09/30/2013	Worksheet E, Part A	
	Title XVIII	Hospital	PPS	
		before 1/1	on/after 1/1	
		0	1.00	1.01
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS			
1.00	DRG Amounts Other than Outlier Payments	6,242,792		1.00
2.00	Outlier payments for discharges. (see instructions)	200,000		2.00
2.01	Outlier reconciliation amount	-100,000		2.01
3.00	Managed Care Simulated Payments	5,703,696		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	386.65		4.00

- W/S E part A, line 4 (bed days available), modified calculation for FY Begin 10/1/2012 and after, to exclude Hospice days (S-3 line 24.10) and outpatient ancillary L/D days (S-3 line 32.01).

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Worksheet E, Part A IME

	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	130.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR	25.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	10.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	8.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	20.00	8.01
8.02	The amount of the case if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02

- W/S E part A line 8.01 (ACA section 5503 cap slots), is to be ZERO if S-2 part I, line 61.02, column 2, is less than line 61.01 column 2.

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Worksheet E, Part A DSH

	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		25.55
31.00	Percentage of Medicaid patient days (see instructions)		12.78
32.00	Sum of lines 30 and 31		38.33
33.00	Allowable disproportionate share percentage (see instructions)		19.90
34.00	Disproportionate share adjustment (see instructions)		1,242,316

- Clarified that SSI/Medicaid ratios on lines 30-32 can be completed even if provider does not qualify for DSH..

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Worksheet E, Part A ESRD Additional Payment

	Additional payment for high percentage of ESRD beneficiary discharges			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	500		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	40	85	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	25.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see	500		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.571429		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	425.82	435.60	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	30,890		46.00

- W/S E part A lines 40 and 41 (ESRD discharges), was clarified for FY Begin on or after 10/1/2011, to enter total Medicare discharges for all beneficiaries entitled to Part A who received I/P dialysis.

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Worksheet E, Part A Other Adjustments

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider 140635	Period From: 10/01/2012 To: 09/30/2013	Worksheet E, Part A

- Worksheet E, Part A, line 70.92, ACA Bundled payments for care improvement initiative (also referred to as Model 1)
  - Effective services (demonstration services) on or after 10/1/2013
- Worksheet E, Part A, line 70.93 Hospital Value Based Purchasing
  - Effective services on or after 10/1/2012
  - Could be negative or positive
  - From PS&R
- Worksheet E, Part A, line 70.94 Hospital Readmissions Reduction program
  - Effective services on or after 10/1/2012
  - Only negative
  - From PS&R

68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	24,789	68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)	-36,048	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.92	Bundled Model 1 discount amount	120,000	70.92
70.93	HVBP incentive payment (see instructions)	500,000	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)	-375,000	70.94

Worksheet E, Part A Low Volume Adjustment

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider 140635	Period From: 10/01/2012 To: 09/30/2013	Worksheet E, Part A
	Title XVIII	Hospital	PPS
		before 1/1	on/after 1/1
	0	1.00	1.01

- Lines 70.96-70.97 from Exhibit 4 OR input
- CMS has not mandated use of Exhibit 4

69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)		-36,048	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.92	Bundled Model 1 discount amount		120,000	70.92
70.93	HVBP incentive payment (see instructions)		500,000	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-375,000	70.94
70.95	Recovery of Accelerated Depreciation		0	70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to	2,012	0	70.96
70.97	Low Volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on	2,013	0	70.97
70.98	Low Volume Payment-3		0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		13,483,757	71.00
71.01	Sequestration adjustment (see instructions)		134,838	71.01
72.00	Interim payments		7,556,887	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		5,792,032	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section		0	75.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		200,000	90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		24,567	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		-100,000	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		-10,000	93.00
94.00	The rate used to calculate the Time Value of Money		7.40	94.00

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Bad Debt Reductions

- Middle Class Tax Relief and Job Creation Act of 2012
  - Reduction to bad debt amounts
  - Also impacts "bad debt moratorium" – Eliminated for cost reporting periods beginning on or after October 1, 2012
- Final Rule Provision for:
  - Hospital bad debts
  - Skilled Nursing Facility bad debts
  - All other provider types
  - Did NOT address bad debt moratorium

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Bad Debt Reductions

- Hospital
  - From 70% allowable to 65% allowable for hospital cost reporting periods beginning during Federal fiscal year 2013 and subsequent fiscal years.
- Skilled Nursing Facility
  - Non-dual eligible - From 70% allowable to 65% allowable for cost reporting periods beginning during Federal fiscal year 2013 and subsequent fiscal years.
- Swing-bed Services
  - Non-dual eligible - From 100% allowable to 65% allowable for cost reporting periods beginning during Federal fiscal year 2013 and subsequent fiscal years.

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Bad Debt Reductions

- SNF and Swing-bed – dual Eligible
  - Cost reporting periods beginning during FFY 2013 – 12%
  - Cost reporting periods beginning during FFY 2014 – 24%
  - Cost reporting periods beginning during FFY 2015 and Subsequent – 35%
- All other Provider Types (CAHs, ESRD, CMHC,FQHC, RHC)
  - Cost reporting periods beginning during FFY 2013 – 12%
  - Cost reporting periods beginning during FFY 2014 – 24%
  - Cost reporting periods beginning during FFY 2015 and Subsequent – 35%

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Sequestration

- Technically, the sequestration is effective for a one-year period beginning April 1, 2013 through March 31, 2014.
- Ending date subject to budget reconciliation.
- CMS will not be placing a through date in the cost reporting instructions but will refer to the period as “the cost reporting period that occurs during the sequestration period beginning on or after April 1, 2013”.

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Sequestration

- Cost report impact
  - "Bottom Line" adjustment to total reimbursement
  - Prorated amount based on cost reporting period
    - For example, a 9/30/2013 FYE is 183 days on or after 4/1/2013, or 183/365 times 2%, rounded to 4 places; 183/365 = 0.5014 times 2% = 0.01

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Worksheet E, Part A

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider 140635		Period From: 10/01/2012 To: 09/30/2013	Worksheet E, Part A	
		Title XVIII		Hospital	PPS	
				before 1/1	on/after 1/1	
			0	1.00	1.01	
47.00	Subtotal (see instructions)			9,959,361		47.00
64.00	Allowable bad debts (see instructions)			27,000		64.00
65.00	Adjusted reimbursable bad debts (see instructions)			17,550		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			5,000		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			13,299,594		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			24,789		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)			-36,048		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		70.00
70.92	Bundled Model 1 discount amount			120,000		70.92
70.93	HVBP incentive payment (see instructions)			500,000		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			-375,000		70.94
70.95	Recovery of Accelerated Depreciation			0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to		2,012	0		70.96
70.97	Low Volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on		2,013	0		70.97
70.98	Low Volume Payment-3			0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			13,483,757		71.00
71.01	Sequestration adjustment (see instructions)			134,838		71.01
72.00	Interim payments			7,556,887		72.00
73.00	Tentative settlement (for contractor use only)			0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73			5,792,032		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section			0		75.00

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Worksheet E, Part B

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140635	Period From: 10/01/2012 To: 09/30/2013	Worksheet E, Part B	
	Title XVIII	Hospital	PPS	
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
	Customary charges			
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		7,463	33.00
34.00	Allowable bad debts (see instructions)		1,500	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		975	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		750	36.00
37.00	Subtotal (see instructions)		888,183	37.00
38.00	MSP-LCC reconciliation amount from PS&R		20,000	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		868,183	40.00
40.01	Sequestration adjustment (see instructions)		8,682	40.01
41.00	Interim payments		273,519	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		585,982	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
	TO BE COMPLETED BY CONTRACTOR			

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Worksheet E-2

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 140635	Period From: 10/01/2012	Worksheet E-2	
	Component CCN: 14U635	To: 09/30/2013		
	Title XVIII	Swing Beds - SNF	PPS	
		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	14,976	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		2.20	4.00
5.00	Program days	156	125	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		275	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	14,976	275	8.00
9.00	Primary payer payments (see instructions)	500	0	9.00
10.00	Subtotal (line 8 minus line 9)	14,476	275	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	1,254	0	11.00
12.00	Subtotal (line 10 minus line 11)	13,222	275	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		220	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	13,222	220	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	4,500	60	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	3,339	45	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,800	25	18.00
19.00	Total (see instructions)	16,561	265	19.00
19.01	Sequestration adjustment (see instructions)	166	3	19.01
20.00	Interim payments	10,000	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	6,395	262	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

Worksheet E-3, Part II

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140635	Period From: 10/01/2012	Worksheet E-3, Part II
	Component CCN: 14S635	To: 09/30/2013	
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	500	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	325	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	100	25.00
26.00	Subtotal (sum of lines 22 and 24)	121,018	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	1,512	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	122,530	31.00
31.01	Sequestration adjustment (see instructions)	1,225	31.01
32.00	Interim payments	300,000	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	-178,695	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	5,000	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

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Worksheet E-3, Part III

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140635	Period From: 10/01/2012	Worksheet E-3, Part III
	Component CCN: 14T635	To: 09/30/2013	
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	500	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	325	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	50	26.00
27.00	Subtotal (sum of lines 23 and 25)	355,711	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	6,040	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	361,751	32.00
32.01	Sequestration adjustment (see instructions)	3,618	32.01
33.00	Interim payments	300,000	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	58,133	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	15,000	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

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Worksheet E-3, Part IV

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140635	Period From: 10/01/2012 To: 09/30/2013	Worksheet E-3, Part IV
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.99	Recovery of Accelerated Depreciation	0	21.99
22.00	Total amount payable to the provider (see instructions)	0	22.00
22.01	Sequestration adjustment (see instructions)	0	22.01
23.00	Interim payments	0	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)	0	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	26.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part IV, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

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Worksheet E-3, Part V

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140635	Period From: 10/01/2012 To: 09/30/2013	Worksheet E-3, Part V
	Title XVIII	Hospital	PPS

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	0	19.00
20.00	Deductibles (exclude professional component)	0	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	0	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	0	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	0	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	0	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
31.00	Interim payments	0	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	0	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

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Worksheet E-3, Part VI

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140635	Period From: 10/01/2012	Worksheet E-3, Part VI
	Component CCN: 145481	To: 09/30/2013	
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	629,144	1.00
2.00	Routine service other pass through costs	2,342	2.00
3.00	Ancillary service other pass through costs	2,641	3.00
4.00	Subtotal (sum of lines 1 through 3)	634,127	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	2,700	6.00
7.00	Coinsurance	3,200	7.00
8.00	Allowable bad debts (see instructions)	700	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	100	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	478	10.00
11.00	Utilization review	24,471	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	653,176	12.00
13.00	Inpatient primary payer payments	3,000	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	650,176	15.00
15.01	Sequestration adjustment (see instructions)	6,502	15.01
16.00	Interim payments	616,000	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	27,674	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19Pub. 15-2, section 115.2	0	19.00

Worksheet E-1, Part II

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140635	Period From: 10/01/2012	Worksheet E-1, Part II

- Lines 9 and 10 added for sequestration
- Full 2% computed for ANY report with EHR reporting period ending date on Worksheet S-2, line 170, column 2 on or after April 1, 2013

7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	483,774	8.00
9.00	Sequestration adjustment amount (see instructions)	9,675	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	474,099	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	789,452	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-315,353	32.00
	CONTRACTOR OVERRIDES		
		Overrides	
108.00	Override of HIT payment	0	108.00

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Worksheet E-4

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 140635	Period From: 10/01/2012 To: 09/30/2013	Worksheet E-4
	Title XVIII	Hospital	PPS

		1.00	2.00	3.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	135.00			1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	8.00			2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	25.00			3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	5.00			3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	0.00			4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/	20.00			4.01
4.02	ACA stra				02
5.00	FTE subs				00
6.00	Unw instr				00
7.00	Ente				00

- As with W/S E part A, Line 4.01 (ACA section 5503 cap slots), is to be ZERO if S-2 part I, line 61.02, column 3, is less than line 61.01 column 3.

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Worksheet H-4

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
10.00	Total reasonable cost (see instructions)	-1,389	200	10.00
11.00				11.00
12.00				12.00
13.00				13.00
14.00				14.00
15.00				15.00
16.00				16.00
17.00				17.00
18.00				18.00
19.00				19.00
20.00				20.00
21.00				21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	666,287	200	22.00
23.00	Excess reasonable cost (from line 8)	0	20	23.00
24.00	Subtotal (line 22 minus line 23)	666,287	180	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	666,287	180	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	666,287	180	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	666,287	180	31.00
31.01	Sequestration adjustment (see instructions)	6,600	2	31.01
32.00	Interim payments (see instructions)	695,750	0	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00

- CMS shaded bad debt lines (are there HHA bad debts for drugs?)
- HHA only component where sequestration from PS&R and NOT calculated by system

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Worksheet I-4

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 140635 Component CCN: 143510 Period From: To: Rate 0 Renal

		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Program Treatments (col. 2 ÷ col. 1)	Number of Program Treatments (prior to Jan. 1)	Number of Program Treatments (on/after Jan. 1)	Total Program Expenses (see instructions)	Total Program Payment (prior to Jan. 1)	Total Program Payment (on/after Jan. 1)
		1.00	2.00	3.00	4.01	4.02	5.00	6.01	6.02
1.00	Maintenance - Hemodialysis	3,324	471,395	141.82	600	1,800	340,368	111,150	333,450
2.00	Maintenance - Peritoneal Dialysis	758	129,178	170.42	125	375	85,210	18,169	54,506
3.00	Training - Hemodialysis	2,990	689,169	230.49	489	1,466	450,608	95,258	285,773
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0	0	0	0
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0	0	0	0
6.00									0
7.00									0
8.00									0
									Jan. 1)
9.00									0
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0	0	0	0
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6)	7,072	1,289,742		1,214	3,641	876,186	224,577	673,729
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))	7,072							

- I Series revised for ESRD PPS effective 1/1/2011
  - CMS to issue instructions for filed cost report?

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Worksheet I-5

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

Provider CCN: 140635 Period From: 10/01/2012 To: 09/30/2013 Worksheet I-

	Description	1.00	2.00
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		
1.00	Total expenses related to care of program beneficiaries (see instructions)	876,186	
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)		
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)	224,577	224,187
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)	673,729	671,972
2.03	Total payment due (see instructions)	898,306	896,159
2.04	Outlier payments	20,000	
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)		
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)	8,050	8,036

- In addition to ESRD PPS Worksheet I-5 revised for bad debt reductions and elimination of ESRD bad debt limitation

	after 1/1/2011 but before 1/1/2012		
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	3,000	2,995
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	5,500	5,486
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014		
5.05	Total bad debts (sum of line 5 through line 5.04)	8,500	8,481
6.00	Allowable bad debts (see instructions)	7,463	
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	400	
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	63,098
9.00	Program payment (see instructions)	0	700,764

Form 2540-10 T-5

The SNF, 2540-10 system was updated to Transmittal 5 by CMS, in May 2013. Transmittal 5 is effective for FY overlapping 4/1/2013, for the Sequestration reduction (i.e. all FYE on or after 4/1/2013 MUST use Transmittal 5). In addition Transmittal 5 includes bad debt changes effective for FY Begin on or after 10/1/2012.

- HFS was approved for Transmittal 5 on July 31, 2013.
- Transmittal 5 changes included:
  - CMS revised Worksheet S-2, Part I, line 43 to only identify providers with Home Office cost allocations. If line 43 is answered as "Y", line 44 and 45-47 must also be completed. If a provider has related organization costs but no home office, Worksheet S-2, Part I, line 18 will be answered "Y", but line 43 would be "N".
  - CMS clarified that Worksheet D-1, Part II, is not applicable to Titles V or XIX.
  - CMS modified various settlement worksheets to introduce the 2% Sequestration reduction for services on or after 4/1/2013.
    - This change is to implement section 251A of the Balanced Budget and Emergency Deficit Control Act
    - Sequestration will be computed as days on or after 4/1/2013 divided by total days in the FY, times 2%. Thus, a 6/30/2013 FYE would have about a half percent reduction. Worksheets impacted include, Worksheet E, Part I (lines 14.99 and 28.99), Worksheet H-4 (line30.99), Worksheet I-3 (line 25.01) and Worksheet J-3 (line 17.01)

Form 2540-10 T-5 (cont.)

- §3101 of the Middle Class Tax Relief and Job Creation Act of 2012, reduced payments for bad debts as follows:
  - Non-dual eligible - From 70% allowable to 65% allowable for cost reporting periods beginning during Federal fiscal year 2013 and subsequent fiscal years.
  - SNF dual Eligible - for cost reporting periods beginning during FFY 2013, 88%, for cost reporting periods beginning during FFY 2014, 76%, for cost reporting periods beginning during FFY 2015 and Subsequent, 65%.
  - CMHC, RHC and ESRD - for cost reporting periods beginning during FFY 2013, 88%, for cost reporting periods beginning during FFY 2014, 76%, for cost reporting periods beginning during FFY 2015 and Subsequent, 65%.
  - Worksheets impacted include, Worksheet E, Part I (lines 8 and 24.02), Worksheet I-3 (line 22.01) and Worksheet J-3 (line 13.01)
- CMS added level one edit 1046S to ensure that If line 43 is answered as "Y", line 44 and 45-47 must also be completed. Edit 1045S was eliminated to no longer requires that line 18 is answered "N".

1728-16 HHA Transmittal 16

The HHA, 1728-94 system was updated to Transmittal 16 by CMS, in May 2013. Transmittal 16 is effective for FY Beginning on or after 10/1/2012, for the Bad Debt changes (i.e. all FYB on or after 10/1/2012 MUST use Transmittal 16). Transmittal 16 changes included:

- HFS was approved for Transmittal 16 on 8/20/2013
- Transmittal 16 was primarily to implement the Bad Debt reduction changes as of FY Begin 10/1/2012, and the 2% Sequestration reduction for services on or after 4/1/2013. Sequestration will be computed as days on or after 4/1/2013 divided by total days in the FY, times 2%. Thus, a 6/30/2013 FYE would have about a half percent reduction. The Bad Debt reduction is 12% for FY Begin 10/1/2012 to 9/30/2013; 24% for FY Begin 10/1/2013 to 9/30/2014; and 35% for FY Begin 10/1/2014 and after.
- Bad Debts are N/A for the HHA component, but DO APPLY for an HHA based CMHC (W/S CM-3), or an HHA based RHC/FQHC (W/S RF-3). Sequestration applies to all components.
- The Sequestration reduction is computed on W/S D, part II, line 26, as 2% of the sum of lines 25 and 25.50; CM-3, line 23 (2% of line 22); or RF-3, line 24.01 (2% of line 24).
- The Bad Debt reduction is computed on W/S CM-3, line 17.01; and on RF-3, line 22.01.
- CMS clarified in T.16, the rounding standards to compute the Sequestration reduction.
- CMS activated in T.16, W/S D part II, line 26, to accommodate the 2% Sequestration reduction.

1728-16 HHA Transmittal 16

- Transmittal 16 changes included:
  - CMS added (codified) in T.16, W/S S-4 part I, line 16, column 3, to capture the Total Visits performed by Interns & Residents, to facilitate the calculation of GME pass through cost. This was already in the HFS system, per a CMS interim communication.
  - CMS added (codified) W/S RF-2, lines 7.01 (Medical Nutrition Therapist) and 7.02 (Diabetes Self-Management Training. This was already in the HFS system, per a CMS interim communication.
  - CMS added in T.16, W/S S part I, line 8.51 to determine if an approval was granted for an exception to the Productivity Standards.
  - CMS added in T.16, W/S CM-3 part II, lines 17.01 and 17.02, to implement the Bad Debt reduction.
  - CMS added in T.16, W/S RF-3, lines 22.01 and 22.02, to implement the Bad Debt reduction.
  - CMS clarified in T.16, various portions of the Electronic Specifications, which are to be followed by all Vendors.

265-11 ESRD Transmittal 2

The ESRD, 265-11 system was updated to Transmittal 2 by CMS, in June 2013. Transmittal 2 is effective for FY overlapping 4/1/2013, for the Sequestration reduction (i.e. all FYE on or after 4/1/2013 MUST use Transmittal 2). In addition Transmittal 2 includes bad debt changes effective for FY Begin on or after 10/1/2012.

- Transmittal 2 changes included:
  - Effective for cost reporting periods ending on or after 12/31/2012 ESRD facilities will no longer report statistics relating to Epoetin or Aranesp on Worksheet S-1 lines 14 and 15 respectfully. Instead all erythropoiesis stimulating agent (ESA) statistics will be reported on line 15.01-15.99. Each type of ESA administered should be reported as a separate subscript beginning with line 15.01.
  - Rebates taken on epoetin and aranesp purchased between 1/1/2011 and 12/31/2011 will be reported on Worksheet A-2, lines 19 and 20 respectively. Effective for purchases on or after 1/1/2012 rebates received for each ESA will be reported on Worksheet A-2, line 20.01 and subsequent subscripts of line 20.
  - The instructions to Worksheet D, Column 4.02 and 6.02, were clarified to indicate that these columns should be used to report services rendered on or after 1/1/2014, for cost reporting periods that straddle 1/1/2014.
  - Revised the instructions to Worksheet E, Part I line 7.03 to calculate total deductibles at 20% of net ESRD PPS payments (line 2.03 column 2) if the sum of lines 7-7.02 is less than 20% of line 2.03, column 2)

265-11 ESRD Transmittal 2

- Transmittal 2 changes included:
  - §3101 of the Middle Class Tax Relief and Job Creation Act of 2012, reduced payments for ESRD bad debts ESRD for cost reporting periods beginning during FFY 2013, 88%, for cost reporting periods beginning during FFY 2014, 76%, for cost reporting periods beginning during FFY 2015 and Subsequent, 65%. The bad debt reduction is implemented on Worksheet E, Part I, line 16. In addition, for cost reporting periods beginning on or after 1/1/2013, the ESRD bad debts will no longer be limited to the unrecovered costs for Medicare ESRD services.
  - Sequestration will be computed as days on or after 4/1/2013 divided by total days in the FY, times 2%. Thus, a 6/30/2013 FYE would have about a half percent reduction. Sequestration is implemented on Worksheet E, Part I, line 19.
  - CMS added level one edit 1000D to ensure total treatments on Worksheet D, column 1, line 11 are greater than -0-.
  - CMS added level one edit 1000E to ensure that if Medicare visits were reported on Worksheet D, columns 4-4.02, then Medicare payments on Worksheet E, Part I, line 1 must be greater than -0-.

222-92 RHC/FQHC Transmittal 11

The RHC/FQHC, 222-92 system was updated to Transmittal 11 by CMS, in May 2013. Transmittal 11 is effective for FY overlapping 4/1/2013, for the Sequestration reduction (i.e. all FYE on or after 4/1/2013 MUST use Transmittal 11). In addition Transmittal 11 includes bad debt changes effective for FY Begin on or after 10/1/2012.

- Transmittal 11 was primarily to implement the Bad Debt reduction changes as of FY Begin 10/1/2012, and the 2% Sequestration reduction for services(FYE) on or after 4/1/2013. Sequestration will be computed as days on or after 4/1/2013 divided by total days in the FY, times 2%. Thus, a 6/30/2013 FYE would have about a half percent reduction. The Bad Debt reduction is 12% for FY Begin 10/1/2012 to 9/30/2013; 24% for FY Begin 10/1/2013 to 9/30/2014; and 35% for FY Begin 10/1/2014 and after.
- The Sequestration reduction is computed on W/S C, line 24.11, as 2% of the sum of lines 21 and 24.10.
- The Bad Debt reduction is computed on W/S C, line 24.10.
- CMS clarified in T.11, the rounding standards to compute the Sequestration reduction.

222-92 RHC/FQHC Transmittal 11

- CMS added in T.11, W/S S part I, line 8.50 to capture the Visits performed by Interns & Residents, to facilitate the calculation of GME pass through cost.
- CMS added in T.11, W/S S part I, line 8.51 to determine if an approval was granted for an exception to the Productivity Standards.
- CMS added in T.11, W/S A, line 20.50, to provide for allowable GME pass through cost.
- CMS added in T.11, W/S A, line 53.50, to provide for non-allowable GME pass through cost.
- CMS clarified in T.11, W/S B part I, column 3, Productivity Standards.
- CMS added in T.11, W/S B part II, line 14.01, to provide for allowable GME pass through cost.
- CMS added in T.11, W/S B part II, line 14.02, to identify net facility overhead cost.
- CMS added in T.11, W/S C part II, line 15.10, to accommodate allowable GME pass through cost.
- CMS added in T.11, W/S C part II, line 24.02, to accommodate Tentative Settlement.
- CMS added in T.11, W/S C part II, line 24.10, to implement the Bad Debt reduction.
- CMS added in T.11, W/S C part II, line 24.11, to accommodate the 2% Sequestration reduction.
- CMS clarified in T.11, various portions of the Electronic Specifications, which are to be followed by all Vendors.

CMHC 2088-92 Transmittal 8/9

The CMHC, 2088-92 system was updated to Transmittal 8/9 by CMS, in April 2013. Transmittal 8 is effective for FY Beginning on or after 10/1/2012, for the Bad Debt changes (i.e. all FYB on or after 10/1/2012 MUST use Transmittal 8/9).

- HFS was approved for Transmittal 8/9 on 8/13/2013.
- Transmittal 8/9 was primarily to implement the Bad Debt reduction changes as of FY Begin 10/1/2012, and the 2% Sequestration reduction for services on or after 4/1/2013. Sequestration will be computed as days on or after 4/1/2013 divided by total days in the FY, times 2%. Thus, a 6/30/2013 FYE would have about a half percent reduction. The Bad Debt reduction is 12% for FY Begin 10/1/2012 to 9/30/2013; 24% for FY Begin 10/1/2013 to 9/30/2014; and 35% for FY Begin 10/1/2014 and after.
- The Sequestration reduction is computed on W/S D, part I, line 17.01, as 2% of line 17.
- The Bad Debt reduction is computed on W/S D, line 11.02.
- CMS clarified in T.8/9, the rounding standards to compute the Sequestration reduction.
- CMS clarified in T.8/9, various portions of the Electronic Specifications, which are to be followed by all Vendors.

OPO 216-94 Transmittal 5

The OPO, 216-94 system was updated to Transmittal 5 by CMS, in April 2013. Transmittal 5 is effective for FY overlapping 4/1/2013, for the Sequestration reduction (i.e. all FYE on or after 4/1/2013 MUST use Transmittal 5). Bad debts are N/A in the OPO, so the Bad Debt changes effective for FY Begin on or after 10/1/2012, are moot.

- HFS was approved for Transmittal 5 on April 24, 2013.
- Transmittal 5 was primarily to introduce the 2% Sequestration reduction for services on or after 4/1/2013. This will be computed as days on or after 4/1/2013 divided by total days in the FY, times 2%. Thus, a 6/30/2013 FYE would have about a half percent reduction.
- The Sequestration reduction is computed on W/S D, line 6, as 2% of line 5. If line 5 is negative, no reduction is computed.
- CMS clarified in T.5, the rounding standards to compute the Sequestration reduction.
- CMS clarified in T.5, that W/S S part I, line 4 is to be subscripted as line 4.01 if the provider is an OPO and a Lab.

OPO 216-94 Transmittal 5

- CMS clarified in T.5, various portions of the Electronic Specifications, which are to be followed by all Vendors.
- CMS clarified in T.5, that W/S A line 19 is to be subscripted, and line 20 is NOT used, for FY Begin 5/1/2012 and after. Lines 9 and 21 are to be subscripted as needed.
- CMS clarified in T.5, that W/S A line 8, and W/S B column 6, must be subscripted similarly.
- CMS clarified in T.5, that W/S A line 19 and subscripts, will transfer to W/S B, line 9, and subscripts. Same for W/S A line 25 and W/S B line 14.
- W/S B line 15 is not to be used for FY Begin 5/1/2012 and after.
- CMS clarified in T.5, that W/S C, parts I and II, line 3, is calculated and rounded to 6 decimal places.
- CMS clarified in T.5, various portions of the Electronic Specifications, which are to be followed by all Vendors.

VENDOR APPROVAL LISTING

Effective for FYE Overlapping 4/1/2013 and/or FY Begin on or after 10/1/2012

SYSTEM	VENDOR	APPROVED
Hospital, 2552-10, Transmittal #4 Ver. 4.1.147.0	HFS, C05 KPMG C01	??
SNF, 2540-10, Transmittal #5 Ver. 5.1.146.0	HFS, C05 KPMG, C01 Optimizer, C02 Progressive Provider Services (PPS), C31	7/31/2013 7/31/2013 7/31/2013 8/19/2013
ESRD, 265-11, Transmittal #2 Ver. 2.1.146.0	HFS, B05 KPMG, B01	8/5/2013 8/9/2013
RHC/FQHC, 222-92, Transmittal #11 Ver. 11.1.146.0	HFS, D05 KPMG, B01	8/5/2013 8/9/2013
HHA, 1728-94, Transmittal #16 Ver. 16.1.146.0	HFS, J05 PPS, J31 Optimizer, J02 KPMG, J01	8/20/2013 8/20/2013 8/27/2013 8/30/2013

VENDOR APPROVAL LISTING

Effective for FYE Overlapping 4/1/2013 and/or FY Begin on or after 10/1/2012

SYSTEM	VENDOR	APPROVED
CMHC, 2088-92, Transmittal #9 Ver. 9.1.146.0	HFS, B05 KPMG, B01 Optimizer, B02	8/13/2013 8/16/2013 8/26/2013
Hospice, 1984-99, Transmittal #9 Ver. 9.31.146.0	HFS, C05 KPMG, C01 Optimizer, C02 PPS,C31	11/1/2011 11/1/2011 11/1/2011 11/1/2011
Home Office, 287-05, Transmittal #1 Ver.1.49.146.0	HFS, A05 KPMG, A01 Optimizer, A02 Med-Calc Systems, A31	2/13/2006 2/13/2006 2/13/2006 2/13/2006
OPO, 216-94, Transmittal #5 Ver. 5.5.146.0	HFS, A05 KPMG, A01	4/24/2012 4/24/2012