

**4121. WORKSHEET B, PART II - ALLOCATION OF CAPITAL-RELATED COSTS**

This worksheet provides for the determination of direct and indirect capital-related costs allocated to inpatient general routine services, special care, and ancillary services as well as to other cost centers. This worksheet is needed to provide CMS with data on capital-related costs for program purposes.

Use this worksheet in conjunction with Worksheets B, Part I, and B-1. The format and allocation process employed are identical to that used on Worksheets B, Part I, and B-1.

Column 0.--If capital-related costs have been directly assigned to specific cost centers on Worksheet A, column 2, enter those amounts directly assigned from your records. If you include costs incurred by a related organization in your cost report, the portion of these costs that are capital-related costs are considered directly assigned capital-related costs of the applicable cost center. For example, a provider that is part of a chain organization includes some costs incurred by the home office of the chain organization in its administrative and general cost center. The amount so included representing capital-related cost is included in this column.

Columns 1 and 2.--The amounts entered in column 1, lines 3 through 95, are obtained from Worksheet B, Part I, column 1, lines 3 through 95. The amounts entered in column 2, lines 3 through 95, are obtained from Worksheet B, Part I, column 2, lines 3 through 95.

Enter on Worksheet B-1, line 104, for each cost center (column) the capital-related costs to be allocated. Report these costs on the first line of each column on Worksheet B, Part II. Complete a unit cost multiplier for each column by dividing the amount on line 104 of Worksheet B-1 by the statistic reported on the first line of the same column. Enter the unit cost multiplier on line 105 and round to six decimal places, e.g., .102589241 is rounded to .102589. The allocation process on Worksheet B, Part II, is identical to that used on Worksheets B, Part I, and B-1.

Multiply the unit cost multiplier by the portion of the total statistic applicable to each cost center. Enter the result of each computation on Worksheet B, Part II, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers, the total cost on Worksheet B, Part II, line 100, of all the cost centers receiving the allocation must equal the amount being allocated on the first line of the column. These procedures must be performed for each general service cost center. Each cost center must be completed on Worksheets B-1 and B, Part II, before proceeding to the next cost center.

**4122. WORKSHEET B-2 - POST STEP DOWN ADJUSTMENTS**

This worksheet provides an explanation of the post Step down adjustment reported in column 17 of Worksheet B, Parts I and II.

Column 1.--Enter a brief description of the post Step down adjustment.

Column 2.--The post Step down adjustment may be made on Worksheet B, Parts I and II. Enter the appropriate part to which the post Step down adjustment applies.

Column 3.--Enter the Worksheet B line number to which the adjustment applies.

Column 4.--Enter the amount of the adjustment. Transfer these amounts to the applicable lines on Worksheet B, Parts I or II, column 17.

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

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

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

Column 3.--Divide the cost for each cost center in column 1 by the total charges for the cost center in column 2 to determine the ratio of total cost to total charges. Enter the resultant department ratios in this column. Round ratios to 6 decimal places, e.g., .102589241 is rounded to .102589.

4124. WORKSHEET D - APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST

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

4124.1 Part I - Calculation of Ancillary and Outpatient Cost.--This worksheet provides for the apportionment of cost applicable to inpatient and outpatient services reimbursable under titles V, XVIII, and XIX for SNFs, NFs, ICF/MR and Other in accordance with 42 CFR 413.53(b).

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

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

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

For title XVIII, Part B, transfer the charges (less any professional component charges included therein) from column 3, lines 40 through 52 to Worksheet E, Part I, line 21,

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 40 through 52, to Worksheet E, Part I, line 1. Title XVIII outpatient, Part B expenses will be transferred from column 5, sum of lines 40-52, to Worksheet E, Part I, line 18.

Line 48.--Enter only the program charges for medical supplies charged to patients that are not paid on a fee schedule (i.e., orthotics and prosthetics). DME (not to be confused with complex medical equipment such as air fluidized beds) is paid on a fee schedule through the DME MAC for title XVIII and therefore is not paid through the cost report.

4124.1 Part II - Apportionment Vaccine Cost. This part provides for the apportionment of the costs applicable to the administration and cost of the following vaccines: Pneumococcal, Hepatitis B, Influenza, and Osteoporosis.

Line 1.--Enter the cost to charges ratio from Worksheet C, column 3, line 49.

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

Line 3.--Multiply line 1 by line 2 and enter the result. Transfer this amount to Worksheet E, Part I, line 24.

4124.2 Part III - Calculation of Nursing & Allied Health Pass Through for PPS SNF.--This part calculates the ancillary costs associated with Nursing & Allied costs applicable for pass through.

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

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

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

Column 6. -- Enter the title XVIII Part B cost from Part I, column 5 above.

Column 7. -- Determine the title XVIII pass through amount for Nursing & Allied costs by multiplying the ratios in column 3 times the cost in column 6. Transfer the total amount on line 100, column 7 to Worksheet E, Part I, line 20.

## 4125. WORKSHEET D-1 - COMPUTATION OF INPATIENT ROUTINE COSTS

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

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

4125.1 Part I - Calculation of Inpatient Routine Costs.

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

Line Descriptions

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

<u>Description</u>	<u>Inpatient Days From</u>
SNF	Worksheet S-3, Part I, column 7, line 1, including private room days for title XVIII
NF	Worksheet S-3, Part I, column 7, line 2 for titles V and XIX
ICF/MR	Worksheet S-3, Part I, column 7, line 3 for title XIX

**EXCEPTION:** When the SNF is located in a State that licenses the provider as an SNF regardless of the level of care given for titles V and XIX patients, enter the days from Worksheet S-3, column 7, sum of lines 1 and 2.

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

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

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

**EXCEPTION:** When the SNF is located in a State that certifies the provider as an SNF regardless of the level of care given for titles V and XIX patients, enter the program inpatient days from Worksheet S-3, column 3, lines 1 and 2 for title V and from Worksheet S-3, column 5, lines 1 and 2 for title XIX.

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

Line 5.--For a full cost report, enter the total general inpatient routine service costs from Worksheet B, Part I, column 18, SNF from line 30, NF from line 31, or ICF/MR from line 32. For a simplified cost report, enter the total general inpatient service costs from Worksheet B, Part III, column 5, SNF line 30, NF from line 31, or ICF/MR from line 32.

**EXCEPTION:** When the SNF is located in a State that certifies the provider as an SNF regardless of the level of care given for Titles V and XIX patients enter the general inpatient routine service costs from lines 30 and 31.

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

Line 7.--Enter the general inpatient routine cost/charge ratio (rounded to six decimal places, e.g., .102589241 is rounded to .102589) by dividing the total inpatient general routine service costs (line 5) by the total inpatient general routine service charges (line 6).

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

Line 9.--Enter the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the total charges for private room accommodations (line 8) by the total number of days of care furnished in private room accommodations (line 2).

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

Line 11.--Enter the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the total charges for semi-private room accommodations (line 10) by the total number of days of care furnished in semi-private room accommodations (line 1 – line 2).

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

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

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

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

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

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

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

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

Line 20.--Enter the capital-related cost allocated to the general inpatient service cost center from Worksheet B, Part II, column 18, SNF from line 30, NF from line 31, or ICF/MR from line 32. See exception after line 5 above.

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

Line 22.--Determine the program capital-related cost by multiplying line 21 by line 3.

Line 23.--Determine the inpatient routine service cost by subtracting the amount on line 22 from the amount on line 19.

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

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

Line 26. - This line is not applicable for title XVIII, for cost reporting periods beginning on and after July 1, 1998, but may be currently used for title V and or title XIX. Enter the per diem limitation applicable to the respective title.

Line 27. - This line is not applicable for title XVIII, for cost reporting periods beginning on and after July 1, 1998, but may be currently used for title V and or title XIX. Obtain the inpatient routine service cost limitation by multiplying the number of inpatient days shown on line 3 by the cost limit for inpatient routine service cost applicable to you for the period for which the cost report is being filed. This amount is provided by your contractor and is entered in the space provided in the line description

Line 28.--Enter the amount of reimbursable inpatient routine service cost which is determined by adding line 22 to the lesser of lines 25 or 27. Transfer this amount to the appropriate Worksheet E, Part II, line 4

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

Line 1. --Enter the total inpatient days from Worksheet S-3, Part I, column 7, line 7, less the hospice days on line 6.

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

Line 3. --Enter the program Nursing & Allied Health cost from Worksheet B, Part I, column 14, line 14.

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

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

## 4130. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

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

Part I - SNF Reimbursement Under PPS

Part II - Reimbursement Settlement for Title V and Title XIX

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

Part A Line Descriptions

Line 1. -- Enter the inpatient ancillary services applicable to Part A cost, from Worksheet D, Part I, column 4, line 100.

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

Line 4. -- Enter the prospective payment amount from your PS&R.

Line 5.--Enter the amounts paid or payable by workmen's compensation and other primary payers where program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered to be non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges but are not included in program days and charges. In this situation, no primary payer payment is entered on line 5.

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



If the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 8 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance (situations 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 6.

Line 6.--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 7.--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 8.—Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 7.

Line 9 --DRA 2005 SNF Bad Debt – For cost reporting periods beginning on or after October 1, 2005, calculate as follows: [( Line 7– line 8) times .7], PLUS the amount on line 8. This is the adjusted SNF allowable bad debt in accordance with DRA 2005, section 5004. (10/01/2005)

Line 10.—Enter the amount of recovery of reimbursable bad debts. This amount is for statistical purposes only, and does not enter into any reimbursement calculation.

Line 11.--Enter the applicable program's share of the reasonable compensation paid to physicians for services in utilization review committees applicable to the SNF.

Line 12. — Enter the sum of line 3, plus line 4, plus line 9 and 11 for title XVIII, plus , minus the sum of lines 5, and line 6.

Line 13.--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 14.--Your fiscal contractor will enter the Part A tentative adjustments from Worksheet E-1, column 2.

Line 15.--Enter OTHER adjustments

Line 16.--Enter the amount on line 12 minus the sum of lines 13 and 14, plus or minus line 15. Enter a negative amount in parentheses ( ). Transfer this amount to Worksheet S, Part III, column 2, line 1.

Line 17.--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 18.--Enter the amount of Part B ancillary services furnished to Medicare patients. Obtain this amount from Worksheet D, Part I column 5, line 100.

Line 19. --Enter the vaccine cost from Worksheet D, Part II, line 3.

Line 20.--Enter the sum of title XVIII Nursing & Allied Health cost from Worksheet D, Part III column 7, line 100.

Line 21 – Enter the sum of the amounts on lines 18, 19, and 20.

Line 22.--Report the charges applicable to the ancillary services from Worksheet D, Part I, column 3, line 100, plus Worksheet D, Part II, Line 2.

Line 24.--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 24.

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 30 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 24.

Line 25.--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 26.--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 27.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 28.-- Enter the sum of the amounts on lines 23, and 26, minus the amounts on lines 24, and 25, plus or minus the amounts on line 27.

Line 29.--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 30.--Your contractor will enter the Part B tentative adjustments from Worksheet E-1, column 4.

Line 31.--Enter OTHER adjustments

Line 32.--Enter the amount on line 28 minus the sums of line 29, 30 and 31. Enter a negative amount in parentheses ( ). Transfer this amount to Worksheet S, Part III, column 3, line 1.

Line 33.--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.

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

Mark in the appropriate box at the top of each page of Worksheet E, Part II, to indicate the program and the provider component for which it is used.

#### Line Descriptions

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

Transfer these amounts from Worksheet D, Part I, column 4, lines 40 through 52.

Line 2.--Enter Nursing & Allied Health costs for title V or title XIX.

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

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

Line 5.--Enter the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees applicable to the SNF, from the provider records.

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

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



Line 9.--Enter the amounts paid or payable by workmen's compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

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

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

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance (situations 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 9.

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

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

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

Enter on lines 11, 12, and 13 the Medicare charges for inpatient ancillary and for outpatient services, respectively. If the charges on Worksheet C do not include the professional component of provider-based physician remuneration, obtain the amount to be entered on line 11 from the appropriate Worksheet D, Part I, column 2, line 100 and obtain the amount to be entered on line 13 from the appropriate Worksheet D, Part I, column 3, line 100.

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

Line 11.--For titles V or XIX, enter the total charges for inpatient ancillary services from Worksheet D, Part I, column 2, line 100 net of professional component.

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

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

The amount on this line includes covered late charges which have been billed to the program where the patient's medical condition is the cause of the extended stay. In addition, these charges include the charges for semi-private accommodations of inpatients which workmen's compensation and other primary payers paid at the ward rate. Adjust these charges on line 14 in determining final settlement.

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

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

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

#### Computation of Reimbursement Settlement

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

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

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

Line 24.--Enter the coinsurance billed to beneficiaries. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

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

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

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

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

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

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

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

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

**NOTE:** Section 1861 (v) (1) (O) sets a limit on the valuation of a depreciable asset that may be recognized in establishing an appropriate allowance for depreciation, and for interest on capital indebtedness after a change of ownership that occurs on or after December 1, 1997.

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

Line 33.--Enter interim payments from Worksheet E-1, column 2, line 4.

Line 34.-- Enter a negative amount in parentheses ( ). Transfer the amount on this line to Worksheet S, Part III, line 1, columns 1 or 4, as applicable. Transfer titles V and XIX NF amounts to Worksheet S, Part III, line 2, columns 1 or 4, respectively. Transfer title XIX ICF/MR amounts to Worksheet S, Part III, line 3, column 4.