

Medicare Cost Report Preparation

2552-10 Cost Report

February 25, 2015



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Medicare Cost Report Instructions

- A complete set of forms and instructions are available on the CMS website

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R4P240.pdf>

Select Chapter 40 (T5)

Filing Requirements

- All providers are required to submit a cost report to their Fiscal Intermediary (FI)/Medicare Administrative Contractor (MAC) within five (5) months of the cost reporting fiscal year end, or 30 days after a valid PS&R is available, whichever is later.
- Filing deadlines:
 - 6/30 year end is 11/30
 - 9/30 year end is 2/28
 - 12/31 year end is 5/31

Cost Report Data Request List

- **General**

- Audited Financial Statements
- Internal Financial Statements
- Income Statement including sub-account summary
- Balance Sheet including sub-account summary
- Trial Balance - Detail by subaccount and department of all accounts
- Transaction summary report for the following sub-accounts
 - Physicians Fees
 - Professional Fees
 - Contracted labor
 - Purchased Services
 - Resident Fees
- A/P Distribution
- Invoices for all contract services related to A& G and patient care for wage index

Cost Report Data Request List

- **General Continued..**

- Internal statistic report by unit
- Maintained bed report
- Bed license
- Labor distribution/payroll report, hours and dollars by cost center, by position
- Revenue and Usage report
- Current charge master to identify charges by UB code to properly map PS&R charges
- Employee self insurance charges report, IP and OP report by patient with UB revenue code detail, if applicable
- IP Medicare bad debt listing and OP Medicare bad debt listing
- IP Medicare dual eligible listing and OP Medicare dual eligible listing
- IP Medicare bad debt recovery listing and OP Medicare bad debt recovery listing
- IP Medicare charity care listing and OP Medicare charity care listing
- Disproportionate share reports (DSH)

Cost Report Data Request List

- **Statistics from departments**
 - Square footage
 - MME depreciation by department (plant ledger)
 - Debt Schedule
 - Dietary patient meals by unit
 - Cafeteria Meals
 - Social service time spent by department
 - Housekeeping hours spent by department
 - Laundry and linen pounds by department
 - Medical records time spent
 - School of Nursing time spent, if applicable
 - Interns & Residents time spent, if applicable
- **Physician Data**
 - List of Physicians employed and contracted
 - Contracts and/or time studies
 - Invoices for all contract physician services

Cost Report Data Request List

- **S-10 Data**

- Bad debt Listing for S-10 all payers
- Charity care Listing for S-10 all payers
- Medicaid listing of charges and payments for traditional and managed care patients

- **Interns and Residents Data**

- Rotation schedules for all programs
- Residents contracts
- ECFMG's for new residents
- Medical school invoices, if applicable
- Per resident amounts (PRA) - obtained from Intermediary

Cost Report Data Request List

- **Medicare**

- Medicare PS&R for hospital and all sub-units
- Medicare PIP payment schedule, if applicable
- Medicare pass-through schedule

- **Medicaid**

- Medicaid Settlement Data for hospital and all sub-units
- Medicaid Target Amounts for hospital and psych
- Contact: mary.nickles@dhs.state.nj.us

Cost Report Preparation

Worksheet S Part II Certification

Purpose: Certification of the cost report by an officer or administrator of the provider(s).

Data Sources:

- Signature of an officer or administrator of the provider after cost report preparation is completed.

Worksheet S Part III Settlement Summary

Purpose: Includes the balance due to or due from applicable program for each provider/sub-provider

Cost Report Data Flow:

- Medicare Hospital
 - I/P: W/S E Pt. A
 - O/P: W/S E Pt. B
 - HIT: W/S E-1 Pt. II
- Medicare Psych
 - I/P: W/S E-3 Pt. II
- Medicare Rehab
 - I/P: W/S E-3 Pt. III
- Medicaid Hospital & Sub-provider Settlement
 - I/P & O/P: W/S E-3 Pt. VII

Worksheet S-2, Parts I & II

Identification Data

Purpose: To provide information necessary to identify the provider/sub-provider to provide information specific to both Medicare and Medicaid reimbursement.

Data Sources:

- General information regarding the provider(s) and sub-provider(s). For example, name, address, provider #, type of facility, teaching status, types of services provided, etc.
- **Note: The revised S-2 includes all former questions from Form 339 and also includes new additional questions. The answers on this worksheet will determine the flow of reimbursable cost. It is important that all questions are answered correctly.**

Worksheet S-3 Part I

Statistical Data

Purpose: To collect statistical data regarding beds, patient days, discharges, and FTEs.

Data Sources:

- Internal Statistical Reports
 - Maintained Beds
 - Patient Days
 - Employee Patient Days
 - Discharges
 - Ambulance trips
 - Observation Days
 - Labor and Delivery Days
- Labor Distribution/Payroll Report (Total FTE's)
- Intern & Resident FTE's from Medical Education Dept.

Worksheet S-3, Part I

Non Distinct Observation Days

- Only non-distinct observation days are included
- Distinct observation days are not included on this schedule
- Distinct observation unit is included as a separate outpatient cost center

Labor and Delivery Days

- Effective for cost reporting periods beginning on or after 10/1/09, CMS has changed its policy regarding patient days associated with patients occupying labor and delivery beds in the disproportionate patient percentage of the Medicare DSH adjustment
- Any data reported on WS S-3, Part I, Line 32, Columns 7 and 8 will be included in both the numerator and denominator of the Medicare DSH calculation (Medicaid proxy portion)
- Do not double count the labor and delivery days, they should not be included in existing Medicaid days or total days already reported on WS S-3, Part I

S-3 Days input on S-2

- Medicaid Days reported on worksheet S-3 Part I will flow to worksheet S-2 Part I line 24 for Hospital, line 25 for Rehab facility
- The sample cost report is incorrect S-2 Part I, Column 1, Line 24 should be 15,032.

Line		In State XIX Paid	In State XIX Eligible	Out of State XIX Paid	Out of State XIX Eligible	XIX HMO	Other XIX
24	Medicaid Days	14,645	886	100	101	135	65

Worksheet A

Expenses

Purpose: To determine Medicare allowable costs by cost center and to insure proper mapping of expenses to the appropriate cost center. If there are new departments, determine correct inclusion in a cost center based on department description.

Data Sources:

- Trial Balance – Year-end Salary and Other Expenses
- Financial Statements

Cost Report Data Flow:

- Expense Reclassifications from W/S A-6
- Adjustments to Expenses from W/S A-8
- Net Expenses to W/S B Pt. I

Worksheet A-6

Expense Reclassifications

Purpose: Reclassification of certain costs for proper cost allocation. Review the trial balance subaccounts and new cost centers to insure proper classification of expenses.

Data Sources:

- General Ledger
- Debt schedules
- Internal Statistical Reports and time studies

Cost Report Data Flow:

- All expense reclassifications to W/S A
- Salary reclassifications to W/S S-3 Pt. II & III

Worksheet A-7 Parts I, II, III

Analysis of Capital Assets

Purpose: To provide an analysis of the hospital's capital assets

Data Sources:

- Plant Ledger
- Capital expenses (Insurance, Taxes, Other Capital related expenses)

Note: If you acquired certified HIT assets and are an EHR technology meaningful user, complete Part I, Line 7, "HIT-Designated Assets".

Worksheet A-8

Adjustments to Expenses

Purpose: To adjust operating expenses for amounts that are non-reimbursable under the Medicare principles of reimbursement. Review all subaccounts included in Worksheet A reimbursable costs to determine if an adjustment needs to be made for non-reimbursable costs.

Data Sources:

- General Ledger detail of Other Income and Non-Operating Income
- Cost Studies

Cost Report Data Flow:

- Related Organization Transactions Adj. from W/S A-8-1
- Provider Based Physician Adjustment from W/S A-8-2
- Adjustments to W/S A

Worksheet A-8-1

Costs of Services from Related Org. & Home Office Costs

Purpose: To adjust costs applicable to services, facilities and supplies furnished by a related organization or a home office to allowable cost.

Data Sources:

- Home Office Cost Report
- Other Related Parties Provider Cost Reports
- General Ledger

Cost Report Data Flow:

- Net Adjustment to W/S A-8

Worksheet A-8-2

Provider Based Physician Adjustment

Purpose: To adjust provider-based physician costs for time spent performing professional services.

Data Sources:

- Payroll Reports
- General Ledger
- Accounts Payable/Invoices
- Physicians Contracts
- Physician Time Studies
- RCE Limits from the Federal Register

Cost Report Data Flow:

- Adjustment to W/S A-8
- **Note:** It is important to have supporting documentation for salary and hours and contracted physician expenses and hours for the completion of the wage index.

Worksheet B-1

Cost Allocation – Statistical Basis

Purpose: To provide the statistical basis for allocation of the general service and capital related costs to the cost centers that receive the services.

Data Sources:

- Square Footage Report/Blue Prints
- Plant Ledger
- Departmental Statistics
- Time Studies
- General Ledger (Salaries, Medical Supplies, Drugs charged)
- Labor Distribution/Payroll Report

Cost Report Data Flow:

- Unit Cost Multiplier to W/S B Pt. I & II
- **Note:** Insure there is auditable documentation for statistics, information should be updated annually. Insure mapping consistency with worksheet A and properly adjust statistics if reclassifications were made.

Worksheet B-1

Cost Allocation – Statistical Basis

Indirect Costs allocated by CMS Approved Statistical Basis:

- Square Footage: Capital Buildings & MME, Maintenance & Repairs, Operation of Plant
- Asset Dollar Value: Capital Major Moveable Equipment
- Salaries: Employee Benefits
- Accumulated Costs: A&G
- Hours of Service or Square Footage: Housekeeping
- Pounds of Laundry: Laundry & Linen
- Patient Days or Meals by Department: Dietary

Worksheet B-1

Cost Allocation – Statistical Basis

- FTE's, Hours or Salaries: Cafeteria
- Nursing Admin. Salaries: Nursing Administration
- Costed Requisitions: Central Sterile Supplies and Pharmacy
- Time Spent or Patient Days: Social Services
- Time Spent or Gross Patient Revenue: Medical Records
- Assigned Time: Nursing School, Interns & Residents, Paramedical Education
- Unit Cost Multiplier: Costs to be allocated on Worksheet B, Part I based on Statistics on Worksheet B-1

Worksheet B Part I

Cost Allocation-General Service Costs

Purpose: Step down of general service costs to those cost centers that use the provided services.
Review the B Part I to insure indirect expenses are properly being allocated to utilizing cost centers.

Cost Report Data Flow:

- Net Expenses from W/S A
- Unit Cost Multiplier from W/S B-1

Worksheet B Part I

Cost Allocation-General Service Costs

- General Service Cost Centers – Worksheet A Lines 1-23 which include Capital, A&G, Plant Operations, Housekeeping, Laundry, Medical Supplies, Pharmacy and other General Areas
- Worksheet A column 7 is also Worksheet B, Part I column 0 which is the beginning point of the allocation
- Also called allocation of INDIRECT COSTS

Worksheet B Part I

Cost Allocation-General Service Costs

- The allocated lines are allocated by CMS approved Statistics
- These statistics move the allocated costs or indirect costs into the following Medicare Cost Centers based on B-1 Statistics:
 - Inpatient Routine (lines 30-46)
 - Ancillaries (lines 50-76)
 - Outpatient (lines 88-93)
 - Other Reimbursable (94-101)
 - Special Purpose (105-117)
 - Non-Reimbursable (190-194)

Worksheet B Part I

Cost Allocation-General Service Costs

- Columns 1 – 23: Allocated based on Worksheet B-1 Statistics
- Column 24: Subtotal column
- Column 25: Interns & Residents Post Step-down Adjustment - automatically calculated - is = to the line amounts in columns 21 and column 22;
Direct and Indirect Graduate Medical Education Costs are reimbursed based on GME and IME calculations
- Column 26: All costs now allocated to the remaining cost centers.
Allowable Medicare Costs (Lines 30 – 117) are then mapped to Worksheet C, Part 1, Column 1

Worksheet B Part II

Allocation of Capital Related Costs

Purpose: To step-down direct and indirect capital-related costs to those cost centers that receive the services.

Data Sources:

- Directly assigned costs for Capital, if applicable

Cost Report Data Flow:

- Capital Related Costs from W/S B Pt. I
- Unit Cost Multiplier from W/S B-1

Worksheet B Part II

Allocation of Capital Related Costs

- Directly Assigned Capital Related costs on Worksheet B Pt. II, column 0:
- Report all capital related costs (such as capitalized leases or depreciation from a related organization) in this column
- Transfer Worksheet B Part II, col. 26 costs:
 - Routine lines 30-46 to Worksheet D, Pt. I
 - All other lines 50-101 to Worksheet D, Pt. II

B-Series Example

Cost Allocation – Statistical Basis

Example: Employee Benefits Step Down to Operating Room

Allocation Base:

Gross Salaries

		<u>Cost Report</u>			
		<u>Cost Report Source</u>	<u>Line</u>	<u>Amount</u>	<u>Calculation</u>
A.	Net Expenses to be Allocated:	Wkst A Col 7	4	750,000	
B.	Allocation of Capital Related Costs	Wkst B Part II Col. 1-3	4	5,812	
C.	Total Expenses to be Allocated	Wkst B-1 Col 4	202	755,812	A+B
D.	Total Gross Salaries	Wkst B-1 Col 4	4	22,164,726	
E.	Unit Cost Multiplier Worksheet B Part I	Wkst B-1 Col 4	203	0.034100	C/D
F.	Unit Cost Multiplier Worksheet B Part II	Wkst B-1 Col 4	205	0.000262	B/D
G.	Operating Room Gross Salaries	Wkst B-1 Col 4	50	1,207,551	
H.	Cost Allocation - General Service Costs	Wkst B Part I Col 4	50	41,177	E*G
I.	Allocation of Capital Related Costs	Wkst B Part II Col 4	50	316	F*G

Worksheet C Parts I & II

Calculation of Cost to Charge Ratios

Purpose: To calculate the ratio of cost to charges for inpatient services and, for providers not subject to the outpatient capital reduction, the outpatient ratio of cost to charges

Data Sources:

- Inpatient & Outpatient Gross Charges by Department
- Gross Inpatient and Outpatient Charges by UB revenue code by department
- Professional Charges
- Self Insurance Charges

Worksheet C Parts I & II

Calculation of Cost to Charge Ratios (continued)

Cost Report Data Flow:

- Total Cost from W/S B Pt. I
- RCE Disallowances from W/S A-8-2
- Observation Bed Pass Through Cost from W/S D-1 Pt. IV
- Total Charges to W/S D Pt. IV
- Inpatient Routine Service Costs to W/S D-1 Pt. I & II

- **Note:** Insure proper mapping of revenues consistent with expenses on Worksheet A

Mapping Consistency and Comparability

- Worksheet A grouping of expenses should match the revenue grouping on worksheet C
- Medicare Charges by UB code from PS&R should match the revenue groupings on worksheet C
 - W/S A costs come from the GL and are grouped by department by Medicare line number
 - W/S C gross charges by department are matched to the corresponding Medicare line where the expenses are recorded
 - Total charges and Medicare Charges by department should also be run by UB revenue code to identify where the Medicare revenues from the PS&R should be reported on W/S D's
 - Review Cost to Charge ratios on W/S C investigate cost centers where there is a material variance

Worksheet C Part I & II

Calculation of Cost to Charge Ratios

- Medicare Cost to Charge Ratio:

Line 50 Operating Room

Total Costs	Total Charges	Cost/Charge Ratio
<u>col. 5</u>	<u>col. 8</u>	<u>col. 9</u>
2,437,145	3,367,683	.723686

Worksheet D Part I

Apportionment of Inpatient Routine Service Capital Costs

Purpose: To calculate the amount of capital-related costs applicable to hospital inpatient routine service costs.

Data Sources:

- Automatically flows

Cost Report Data Flow:

- Capital Cost from W/S B Pt. II
- Patient Days from W/S S-3 Pt. I

Worksheet D Part II

Apportionment of Inpatient Ancillary Service Capital Costs

Purpose: To calculate the amount of capital-related costs applicable to hospital inpatient ancillary service costs.

Data Sources:

- Automatically flows

Cost Report Data Flow:

- Capital Cost from W/S B Pt. II
- Total Charges from W/S C Pt. I
- Observation Bed Pass Through Cost from D-1 Pt. IV
- Program Charges from W/S D-3

Worksheet D Part III

Apportionment of Inpatient Routine Service Other Pass Through Costs

Purpose: To calculate the amount of pass through costs other than capital applicable to hospital inpatient routine service costs.

Data Sources:

- Automatically flows

Cost Report Data Flow:

- Nursing School Cost from W/S B Pt. I
- Patient Days from W/S S-3 Pt. I

Worksheet D Part IV

Apportionment of Inpatient Ancillary Service Other Pass Through Costs

Purpose: To calculate the amount of pass through costs other than capital applicable to hospital inpatient ancillary service costs.

Data Sources:

- Automatically flows

Cost Report Data Flow:

- Direct Medical Education Cost for each Cost Center from W/S B Pt. I
- Total Charges from W/S C Pt. I
- Inpatient Program Charges from W/S D-3
- Outpatient Program Charges from W/S D Pt. V
- Total Program Pass Through Costs to W/S D-1 Pt. II and W/S E Pt. A

Worksheet D Part V

Apportionment of Medical and Other Health Costs

Purpose: To calculate the program cost applicable to hospital outpatient services

Data Sources:

- Medicare PS&R
- Medicaid Settlement Data

Cost Report Data Flow:

- Cost to Charge Ratio from W/S C Pt. I
- Medicare Program Costs to W/S E Pt. B

Worksheet D-1 Part I and II

Computation of Inpatient Operating Cost

Purpose: To calculate the hospital inpatient operating cost

Data Sources:

- Private Room Days
- TEFRA Target Rate
- Revenue Report

Cost Report Data Flow:

- Patient Days & Discharges from W/S S-3 Pt. I
- Cost from W/S C Pt. I
- Inpatient Ancillary Service Cost from W/S D-3
- Capital Related Inpatient Routine Cost from W/S D Pt. I
- Other Pass Through Costs from W/S D Pt. III
- Capital Related Inpatient Ancillary Costs from W/S D Pt. II

Worksheet D-3

Inpatient Ancillary Service Cost Apportionment

Purpose: To calculate the reimbursable cost applicable to hospital inpatient services.

Data Sources:

- Medicare PS&R
- Medicaid Settlement Data

Cost Report Data Flow:

- Cost to Charge Ratios from W/S C Pt. I
- Inpatient Program Cost to W/S D-1 Pt. II
- **Note:** Insure proper matching of Medicare charges from PS&R to the charges on Worksheet C.

Medicare Graduate Medical Education Reimbursement

Medicare Makes Two Types of Payments for Medical Education

- **Direct GME Payments (DGME)**

- Compensates for the Medicare direct portion of intern and resident education costs.
 - Hospital and Subproviders – Worksheet E-4

- **Indirect Medical Education Payments (IME)**

- Compensates for the Medicare indirect portion of the higher patient care costs due to the presence of teaching programs.
 - Hospital – Worksheet E Part A and E-4 and S-3 Part I
 - Psychiatric and Rehabilitation Subproviders – Worksheet E-3 Part II, E-3 Part III and S-3 Part I

Residents must be in approved programs.

Direct Graduate Medical Education (DGME)

- Compensates teaching hospitals for the direct costs related to the teaching programs, which includes:
 - Residents' salaries and fringe benefits
 - Teaching physicians' salaries and fringe benefits
 - Other direct costs such as resident travel and lodging
 - Allocated overhead costs
- A Medicare payment separate from the DRG payment (known as "pass-through" payment).
- Payment is based on a formula that reflects each hospital's per resident costs (Per Resident Amount or "PRA") in a base year (generally 1984) which, in general, has been updated for inflation.

Direct Graduate Medical Education (DGME)

- Three PRA categories – PRAs differ for primary care residents and non-primary care residents due to a congressional freeze on inflation updates to the non-primary care residents in 1994 and 1995.
 - Primary Care - Residents enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, OB/GYN, geriatric medicine or osteopathic general practice.
 - Non-Primary Care – Residents enrolled in an approved medical residency training program in all other specialties.
 - Locality adjusted national PRA
- PRAs can be obtained from your FI/MAC.

Note: Enter hospital specific PRA data on E-4, line 18, columns 1 & 2. Enter locality adjusted national PRA on E-4, line 23, column 1

Indirect Graduate Medical Education (IME)

- Compensates hospitals for the additional costs incurred due to:
 - Increased testing
 - Severity of Illness
 - Other indirect costs
- Payment is an add-on to the hospital specific Medicare DRG payment, which is based on a statistical analysis using intern and resident-to-bed ratios (IRB).
- IME FTE count is NOT weighted like DGME.
- Formula is set by statute:
 - Multiplier X $((1 + \text{Intern \& Resident Bed Ratio (IRB)})^{0.405} - 1)$
 - For Federal FY 2008 and beyond, the multiplier is 1.35

DGME and IME Resident FTE Counts

- The resident FTE count is one of the main driving factors in both the DGME and IME payment.
- No resident can ever be count more than a 1.0 FTE.
- Per CMS - A rotation schedule is the primary documentation that can be used to support the direct GME and IME resident counts, but other similar documentation may be acceptable (Federal Register Vol. 71, No. 160, dated August 18, 2006, page 48077).
- See your Medical Education Program Directors for rotation schedules and explanations of rotations.
- The resident FTE count can be maintained throughout the year (if done manually) if hospital maintains monthly or more detailed rotation schedules.

DGME and IME Resident FTE Counts

- **DGME**

- **Inhouse** – All patient care and non-patient care activities within the hospital complex may be counted for DGME.
- **Non-provider Sites** – Patient care activities as defined in CFR §413.75(b)(“the care and treatment of particular patients,” with residents providing “services for which a physician or other practitioner may bill and orientation activities”), didactic activities at a non-provider setting that is “primarily engaged in furnishing patient care”, and vacation, sick leave, or other approved leave that does not prolong the total time of a resident in the approved program beyond the normal duration of the program may be counted toward DGME if other required criteria are met. The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable.

Note: Enter current year DGME FTE on E-4, lines 8 & 10, columns 1 & 2

DGME and IME Resident FTE Counts

- **IME**

- **Inhouse** – Patient care activities as defined in CFR §413.75(b), non-patient care activities such as didactic conferences and seminars, vacation, sick leave, or other approved leave that does not prolong the total time of a resident in the approved program beyond the normal duration of the program is countable. The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable.
- **Non-provider Sites** – Patient care related activities as defined in CFR §413.75(b) and vacation, sick leave, or other approved leave that does not prolong the total time of a resident in the approved program beyond the normal duration of the program may be counted toward IME if other required criteria are met.

Note: Enter current year hospital IME FTEs on E Part A, lines 10 & 11, IPF IME FTEs on E-3 Part II, line 6, IRP IME FTEs on E-3 Part III, line 7

DGME and IME Resident FTE Counts

- **Inhouse Defined**

- For DGME “Inhouse” is defined as all areas of the hospital complex and any off-site hospital-based department.
- For IME, “Inhouse” is defined as all areas of the hospital subject to the inpatient prospective payment system and outpatient departments of the hospital (including off-site hospital-based departments), inpatient distinct part psychiatric and rehabilitation units (psychiatric & rehabilitation units need to be recorded separately).

- **Non-provider Sites Defined**

- Non-provider settings include, but are not limited to, freestanding clinics, nursing homes (no Medicare certification), and physician offices.

Note: Physicians renting space within the hospital complex to see their private patients should be considered as a non-provider site, not “Inhouse”.

DGME and IME Resident FTE Counts – Non-Hospital Providers

- Other “provider site” rotations that a hospital can count towards its FTE count if certain criteria are met:
 - Federally Qualified Health Centers
 - Rural Health Clinics
 - Medicare + Choice organizations
- Other “provider site” rotations that a hospital can not count towards its FTE count because they may receive DGME payments directly:
 - SNFs
 - HHAs
 - Other hospitals

Note: Although a hospice is a provider, it cannot directly receive payments for GME costs incurred, as can the providers mentioned above. Therefore, if a hospital incurs the cost of the training at a hospice, the hospital can claim that FTE time.

Sample Rotation Schedules

Obstetrics & Gynecology Resident Rotation Schedule 2012-2013

04/09/12

Resident	Status	Block 1 Jul 1 - Jul 29	Block 2 July 30 - Aug 26	Block 3 Aug 27 - Sep 23	Block 4 Sep 24 - Oct 22	Block 5 Oct 23 - Nov 18	Block 6 Nov 19 - Dec 16	Block 7 Dec 17 - Jan 13	Block 8 Jan 14 - Feb 10	Block 9 Feb 11 - Mar 10	Block 10 Mar 11 - Apr 7	Block 11 Apr 8 - May 5	Block 12 May 6 - Jun 2	Block 13 Jun 3 - Jun 30
Yates, Angie	Pgy 1	OB	NF	GYN	OB	MICU	GYN	OB/GYN	ONC	ER	US	NF	OB/GYN	OB
Fernandez, Noelle	Pgy 1	OB/GYN	US	NF	GYN	OB	MICU	OB/GYN	OB	ONC	NF	ER	OB	GYN
Evors, Laura Jane	Pgy 1	GYN	OB	MICU	NF	ONC	OB	OB/GYN	OB/GYN	GYN	OB	US	ER	NF
Trussell, John	Pgy 1	US	GYN	OB	MICU	NF	ONC	OB/GYN	ER	OB	OB/GYN	GYN	NF	OB
Brown, Suzanne	Pgy 2	ONC	Gyn	OB	REI	OB	NF	OB/GYN	GYN	URO	ONC	OB	GYN	US/CL
Trimble, Hayley	Pgy 2	NF	ONC	GYN	OB	USG/CL	GYN	OB/GYN	OB	GYN	URO	ONC	OB	REI
Connor, Shae	Pgy 2	OB	REI	ONC	GYN	OB	URO	OB/GYN	NF	US	GYN	OB	ONC	GYN
Rooney Thompson, Megan	Pgy 2	Gyn	OB	REI	ONC	GYN	OB	OB/GYN	URO	NF	OB	GYN	US/CL	ONC
Onwuchuruba, Cheryl	Pgy 3	ONC	GYN	OB	NF	GYN	GYN	OB/GYN	NF	OB	GYN	NF	REI	OB
Dizon, Mitch	Pgy 3	OB	ONC	GYN	OB	NF	REI	OB/GYN	GYN	NF	OB	GYN	NF	GYN
Fields, Meredith	Pgy 3	GYN*	OB	ONC	GYN	OB*	NF	OB/GYN	REI	GYN	NF	OB	GYN	NF
Visconti, Kevin	Pgy 4	NF	OB	GYN	OB	GYN	ONC	OB/GYN	GYN	REI	ONC	OB	URO	GYN
Barry, Audrey	Pgy 4	GYN	NF	OB	GYN	ONC	GYN	OB/GYN	OB	ONC	REI	URO	OB	GYN
Hopkins, Kim	Pgy 4	OB	GYN	NF	ONC	URO*	OB*	OB/GYN	ONC	OB	GYN	REI	GYN	GYN

GYN

OB

NF = Night Float

ONC = Oncology

REI = Reproductive Endocrinology & Infertility UT and Dr. Keenan's office and Dr. Harris' office

ER = Emergency Medicine

URO = Urogynecology

MICU = Medicine ICU with critical care physicians in Department of Medicine

USG = Ultrasound

USG/CL = Ultrasound/op clinic

Sample Rotation Schedules

UTHSCH Neurosurgery Resident Rotation Schedule

Year	July to December	January to June	
PGY-1	General Surgery	Neurology ICU	Neurosurgery ICU
PGY-2 (NS1)	Junior Resident at Memorial Hermann Hospital	Junior Resident at Memorial Hermann Hospital	
PGY-3 (NS2)	Pediatric Neurosurgery at Children's Memorial Hermann Hospital	Neurosurgery at Memorial Hermann Hospital	
PGY-4 (NS3)	Research	Research	
PGY-5 (NS4)	Research	3 months Endovascular Surgery	3 months Radiosurgery
PGY-6 (NS5)	Senior Resident at Memorial Hermann Hospital	Senior Resident at Memorial Hermann Hospital	
PGY-7 For 6 year programs	Chief Resident at Memorial Hermann Hospital	Chief Resident at Memorial Hermann Hospital	

During the Research Rotations, the residents will also get training in Neuropathology, Neuroradiology, Neuroanatomy, and Neurophysiology. Rotations in Endovascular Surgery and Radiosurgery are elective; they can be requested by the resident and will be approved on an individual basis.

Interns and Resident Information System (IRIS)

- All resident information is entered into the Interns and Resident Information System (IRIS), in addition the Medicare Cost Report.
- Used to determine Medicare payments for both IME and DGME.
- Is required as part of the Medicare Cost Report submission.
- Software can be downloaded for free from CMS or FI/MAC websites.
- Other software packages available to purchase.

Required Resident for IRIS

- In addition to the FTE/rotation information, the following information is needed on each resident and will be entered into the IRIS software:
 - Full Name
 - Social Security Number
 - Graduated Medical School
 - Graduation Date
 - Initial Specialty

Foreign residents require

- Test ID
- Foreign Certification Date

IRIS Screen Shot

The screenshot displays the Microsoft Access application window titled "Graduate Medical Education - Microsoft Access". The interface includes a ribbon with tabs for File, Home, Create, External Data, Database Tools, Add-Ins, Acrobat, and Datasheet. The "Form Tools" tab is active, showing a menu with File, Tools, Edit, Reports, IRIS, and Help, along with a custom toolbar. The main form area contains several input fields: SSN, Last, First, Mid, Suffix, Created (2/3/2014), School (dropdown), Grad Date, Init Specialty (dropdown), Yrs Allowed (?), Extra Yrs Geriatrics/Prevent? (checkbox), Foreign (dropdown), Test ID, and Foreign Certification Date. There are "More" and "Error" buttons. Below the form is a data table with the following columns: Re, Beg Date, End Date, Provider, FYE, GME, IME %, Years, <Overlap, FYB, F/P %, GME FTE, Wt Fact, IME FTE, Paying Institutio, Current Specialt, Primary_Description, Nonprovider Site, Hospital Department, Init Residency P, and Ente. The first row of data shows a yellow asterisk in the "Re" column and "No" in the "<Overlap" column.

Re	Beg Date	End Date	Provider	FYE	GME	IME %	Years	<Overlap	FYB	F/P %	GME FTE	Wt Fact	IME FTE	Paying Institutio	Current Specialt	Primary_Description	Nonprovider Site	Hospital Department	Init Residency P	Ente
*								No												

IRIS Summary Report

GME and IME FTE Report
 Provider: 110899 FYE: 9/30/2013

Statistics							
Resident Rotations	12,442						
Number of Residents	166						
Graduates of Foreign Schools	0						
	GME - E4				IME -E, Part A		
	Primary Care			Non-Primary Care			Total
Allopathic /Osteopathic	130.00			20.00			150.00
Allopathic /Osteopathic Overlap	0.00			0.00			0.00
	Line 8			Line 8			
Audited Allopathic / Osteopathic Total	Col 1 130.00			Col 2 20.00			150.00
Dental / Podiatric	0.00			16.00			16.00
Dental / Podiatric Overlap	0.00			0.00			0.00
					Line 10 Col 2		
Audited Dental /Podiatric Total	0.00			16.00	2		16.00
Weighted FTE Total	130.00			36.00			166.00
Overlap FTE Total	0.00			0.00			0.00
Audited FTE Total	130.00			36.00			166.00
Unweighted FTE Allopathic / Osteopathic	130.00			25.00			155.00
Unweighted FTE Allo / Osteo Overlap	0.00			0.00			0.00
					Line 6 Col 1		155.00
Audited Unweighted FTE Allo / Osteo	130.00			25.00			155.00
Unweighted FTE Dental / Podiatric	0.00			16.00			16.00
Unweighted FTE Total	130.00			41.00			171.00
Total Resident Rotations	11,960			482			12,442
				Overlap FTE for:			
				Allopathic / Osteopathic			0.00
				Dental / Podiatric			0.00
				Unweighted FTE Allopathic / Osteopathic			0.00
				Unweighted FTE Dental / Podiatric			0.00
Total Days: 7363							



Medicare Resident Limits (“Caps”)

- In general, for cost reporting periods beginning on or after October 1, 1997, a hospital’s allopathic and osteopathic resident level (but not dental and podiatry) may not exceed the hospital’s unweighted FTE count for the most recent cost reporting period ending on or before December 31, 1996 (“1996 cap” or “historic limit”).
 - There are separate limits for DGME and IME. In 1996, residents training in nonhospital locations and PPS exempt units could be counted for DGME but not for IME. Enter 1996 DGME cap on E-4, line 1, the hospital IME on W/S E Part A, Line 5, IPF IME on W/S E-3 Part II, line 4 and IRP IME on W/S E-3 Part III, line 5

Exceptions:

- Rural Teaching Hospitals
- Rural Training Track Programs
- New Teaching Hospitals
 - DGME – E-4, line 2
 - IME – E Part A, line 6
- Temporary Adjustment Associated with Closed Hospitals or Programs
 - DGME – E-4, line 16
 - IME – E Part A, line 17

Medicare Resident Limits (“Caps”)

- Exceptions Continued....
 - Affiliation Agreements Between Hospitals
 - DGME – E-4, line 4
 - IME – E Part A, line 8
 - Redistribution of “Unused Resident Cap Slots” as per MMA Sec. 422
 - DGME – E-4, lines 3 & 20
 - IME – E Part A, lines 7 & 23
 - ACA Section 5503 redistribution
 - DGME – E-4, lines 3.01 & 4.01
 - IME – E Part A, lines 7.01 & 8.01
 - ACA Section 5506 FTE increase for closed teaching hospitals
 - DGME – E-4, line 4.02
 - IME – E Part A, line 8.02

Medicare Resident Limits (“Caps”)

- In addition to the resident cap, a hospital’s FTE count in a cost-reporting period is based on a 3-year rolling average – the current year and the two prior years.
- Rolling average works in conjunction with historic resident cap. If your FTE count is over your cap in a given year, you will be limited to your cap in that year for the purposes of computing the rolling average.
- Unlike your resident cap, the rolling average applies to dental and podiatry residents, in addition to your residents training in allopathic and osteopathic programs.

Note: If you are at your cap in the current year, but under your cap in either of the other two years, your rolling average for the current will be less than your cap. Enter prior years’ DGME FTEs on E-4, lines 12 & 13, columns 1 & 2. Enter prior years’ IME FTEs on W/S E Part A, lines 13 & 14.

Worksheet E Part A

Operating Indirect Medical Education Payment

Purpose: To calculate the hospital's allowable inpatient operating indirect medical education cost under Medicare

Data Sources:

- Medicare Payments from the Medicare Provider Statistical and Reimbursement System Summary Report (PS&R)
- Hospital's Maintained Beds
- Intern & Resident FTE Caps (from Fiscal Intermediary)
- Current Year Intern & Resident Allowable FTE Counts
- Prior Years Intern & Resident FTE Count
- Prior Year's Intern-to-Bed Ratio (from prior year cost report)

Worksheet E Part A

Operating Indirect Medical Education Payment

- Line 4 – Bed days available
- Lines 5 – 8 - Hospital specific unweighted IME resident FTE cap information
- Line 9 – Hospital's adjusted FTE cap
- Line 10 – Current year unweighted IME FTE count (less dental and podiatry)
- Line 11 – Current year FTE count for dental and podiatry residents
- Line 12 – Lessor of line 9 (cap) or line 10 (current year actual), added to line 11

Worksheet E Part A

Operating Indirect Medical Education Payment

- Lines 13 – Prior year's allowable FTE count (prior year cost report, line 12)
- Line 14 – Penultimate year's allowable FTE count (second to last cost report, line 12)
- Line 15 – Sum of line 12 through 14, divided by 3
- Line 16 – Current year FTE count that meets the exception to the rolling average rules (i.e., new teaching hospitals)
- Line 17 – Current year FTE count for residents that were displaced by a hospital or program closure

Worksheet E Part A

Operating Indirect Medical Education Payment

- Line 18 – Adjusted rolling average FTE count
- Line 19 – Current year resident-to-bed ratio (line 18 divided by line 4)
- Line 20 – Prior year resident-to-bed ratio (prior year cost report, line 12 divided by line 4)
- Line 21 – Lessor of line 19 or 20
- Line 22 – Medicare IME payment – $1.35 \times \left\{ \left((1 + \text{line 21}) \right)^{.405} - 1 \right\} \times \left\{ \text{sum of line 1} + \text{line 3} \right\}$

Worksheet E Part A

Operating Indirect Medical Education Payment

- Line 23 – Additional FTE slots received under Section 422 of the Medicare Modernization Act
- Lines 24–28 – Calculation of IME payment attributable to the additional slots received under Section 422 of the MMA
- Line 29 – Total Medicare IME payment – Line 22 plus line 28)

Worksheet L

Capital Indirect Medical Education Payment

- Line 3 – Patient days divided by the total days in the cost reporting period
- Line 4 – FTE counts from Worksheet E, Part A, lines 18 and 25
- Line 5 – Capital IME percentage – $\{e.2822 \times \text{line 4}/\text{line 3}\} - 1$ where $e = 2.71828$
- Line 6 – Capital IME payment – line 5 x line 1 (Federal rate portion of the capital DRG payments obtained from you PS&R)

Worksheet E-4

Direct Medical Education

Purpose: To calculate each programs payment for direct graduate medical education (GME) cost applicable to interns and residents in approved teaching programs.

Data Sources:

- Intern & Resident FTEs by program type total and weighted
- Prior year FTE count and penultimate year FTE count
- Hospital specific per resident amount
- Locality adjusted national average per resident amount
- 1996 FTE Cap
- Section 422 of MMA cap reduction and/or increase
- ACA §5503 DGME cap reduction and/or cap increase
- Affiliation agreements
- ACA §5506 DGME cap increase amount

Worksheet E-4

Direct Graduate Medical Education

- Lines 1 – 5 – Hospital specific unweighted DGME resident FTE cap information
- Line 6 – Hospital's current year unweighted FTE count (excludes dental and podiatry)
- Line 7 – Lessor of line 5 or line 6
- Line 8 – Current year weighted FTE counts from your IRIS summary report (excluded dental and podiatry)
- Line 9 – Calculated allowable FTE count (excluded dental and podiatry)
- Line 10 – Current year weighted dental and podiatry FTE counts
- Line 11 – Total current year allowable weighted FTE count

Worksheet E-4

Direct Graduate Medical Education

- Line 12 – Total weighted resident FTE count for the prior cost reporting year
- Line 13 – Total weighted resident FTE count for the penultimate cost reporting year
- Line 14 – Calculated 3-year rolling average
- Line 15 – Adjustment for residents in initial years of new programs
- Line 16 – Adjustment for residents displaced by program or hospital closure
- Line 17 – Adjusted rolling average FTE count
- Line 18 – Per Resident Amount obtained from Fiscal Intermediary

Worksheet E-4

Direct Graduate Medical Education

- Line 19 – Represents the total I&R cost for the hospital before add-on for additional resident slots awarded under Section 422 of the Medicare Modernization Act
- Lines 20 – 24 – Represents the total hospital I&R cost for slots awarded under Section 422 of the Medicare Modernization Act
- Line 25 – Represents the total hospital direct GME cost
- Lines 26 – 29 – Calculates Medicare’s portion of the total cost
- Line 30 – Reduction in direct GME payments to cover additional payments for nursing and allied health education associated with Medicare managed care enrollees to hospitals that operate nursing or allied health education programs as directed in section 1886(h)(3)(D) of the Act and amended by section 541(b) of Public Law 106-113.
- Line 31 – Net Medicare direct GME amount (line 29, columns 1 and 2, less amount in column 2, line 30)

Documentation is the Key!

- Rotation schedules
- FTE summary report
 - Name and SS #
 - Type of program
 - Number of years the resident has completed in all programs
 - Medical school from which the resident graduated
 - Resident's employer
 - Rotation dates
- Accreditation letter for each program from accrediting body
- ECFMG Certificates, if applicable
- Resident Contracts
- Affiliation agreements, if applicable
- Non-hospital site agreements, if applicable
- Medical school invoices, if applicable
- Simultaneous match documentation, if applicable

Documentation is the Key!

- Why have we stressed documentation?
 - – Increasing Complexity
 - – Time Lag between Preparation and Audit
 - – Staff Turnover
 - – Accuracy, Efficiency and Consistency

DGME and IME Audit Issues

- Audit Issues

- Most audit issues relate to the hospital's submitted FTE counts.
 - Lack of or inaccurate documentation
 - Failure to support when and where the training took place (on-site or off-site).
 - Residents' evaluations do not support the rotation noted on the resident rotation schedules.
 - Missing residents' ECFMG certificates (Educational Commission for Foreign Medical Graduates).
 - Inaccurately reporting the number of years a resident has completed in all types of residency programs.
 - Including non-allowable time in IME count.
 - Counting residents that are not in an approved program.

Graduate Medical Education – Code of Federal Regulations

Regulation	Subject
412.105	IME - General Indirect Medical Education Requirements
413.75	DGME - General Requirements/Definitions
413.76	DGME - Calculation of payments for GME costs
413.77	DGME - Per resident amounts (PRAs)
413.78	DGME - Determination of the total number of FTE residents
413.79	DGME - Determination of the weighted number of FTE residents
413.80	DGME - Weighting factors for foreign medical graduates
413.81	DGME - Community support and redistribution of costs in determining FTE resident counts
413.82	DGME - Special Rules for States that formerly had a waiver from Medicare reimbursement principles
413.83	DGME - Adjustment of a hospital's target amount or prospective payment hospital-specific rate

Disproportionate Share Adjustment & Uncompensated Care

Disproportionate Share Adjustment

- Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on Worksheet E Part A lines 30 through 34. Complete this portion only if you are an IPPS hospital and answered yes to Worksheet S-2, Part I, line 22, column .
- Qualifying for DSH Payments
 - The Statutory Formula
 - Pickle Method

Disproportionate Share Adjustment

- **The Medicare Fraction (Medicare Proxy)**

The Medicare Fraction is computed by dividing the number of patient days that are furnished to patients who are entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the total number of patient days furnished to patients entitled to benefits under Medicare Part A. This percentage is supplied to providers by CMS and is determined on the federal fiscal year. If a hospital prefers, it may request that CMS calculate the Medicare fraction based upon their cost reporting period, rather than the federal fiscal year. Instructions for requesting this recalculation can be found at [42 CFR 412.106\(b\)\(3\)](#)* (*scroll to section (b) then to number (3)*).

Disproportionate Share Adjustment

- Line 30--Enter the percentage of SSI recipient patient days to Medicare Part A patient days.
- Link to the Published SSI Percentages – IPPS <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html>
 - Sample Cost Report SSI% **0.2555**

Disproportionate Share Adjustment

- **The Medicaid Fraction (Medicaid Proxy)**

The Medicaid Fraction is computed by dividing the number of patient days furnished to patients who, for those days, were eligible for Medicaid, but were not entitled to benefits under Medicare Part A by the number of total hospital patient days in the same period. For purposes of counting patient days, as indicated in [PRM 15-2 § 3605.1*](#) (*select chapter 36 then select file pr2_3600_to_3609.3.doc and then scroll to section 3605.1 at page 32*) providers should report days in the cost reporting period in which the discharge is reported.

Disproportionate Share Adjustment

- Line 31--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-2, Part I, columns 1 through 6, line 24) to total days reported on Worksheet S-3, Part I, column 8, line 14, plus column 8, line 32, minus the sum of lines 5 and 6, plus employee discount days reported on Worksheet S-3, Part I, column 8, line 30.
 - Sample cost report error
 - Error on worksheet S-2: Medicaid % calculated incorrectly
 - S-2, line 24 column 1 should be 15,032
 - Medicaid % $(15,032+886+100+101+135+65)/(124,862+135-156-250+100) = 16,319/124,691 = \mathbf{0.1309}$
- Line 32--Add lines 30 and 31 to equal the hospital's DSH patient percentage.
 - Error on sample cost report Line 32 should equal **0.3864**.

Disproportionate Share Adjustment

- Line 33--Compare the percentage on line 32 with the criteria described in 42 CFR 412.106(c) and (d). Enter the payment adjustment factor calculated in accordance with 42 CFR 412.106(d). Hospitals qualifying for DSH, in accordance with 42 CFR 412.106(c)(2) (Pickle Amendment hospitals), if Worksheet S-2, Part I, line 22, column 2 is "Y" for yes, enter 35.00 percent on line 33.
 - **Line 33 should be 0.2109**
- Line 34--Multiply line 33 by line 1.
 - **Line 34 should be \$1,316,605**

Patient Protection and Affordable Care Act (PPACA) or (ACA)

- Beginning 10/1/2013 (FFY 2014) hospitals that qualify for DSH (standard or Pickle) will receive two separate payments.
- 25% of the hospitals DSH payment will come from the current statutory calculation “Empirically Justified Medicare DSH Payment”
- The remaining 75% of the DSH payment will be placed into a pool and divided among all qualifying DSH hospitals in the USA and Puerto Rico. “Uncompensated Care Payment”

ACA Impact on DSH

- The uncompensated care payment for a hospital is calculated using three factors
 - Factor 1 is a pool of the 75% of empirical DSH payment for all DSH hospitals nationally
 - Factor 2 is (1-the % reduction in the uninsured) - 0.1 percentage point.
 - Factor 3 is the hospital-specific amount of uncompensated care divided by the amount of uncompensated care for all DSH hospitals.
- For FFY 2015 factor three of the uncompensated care payment is derived using Hospital specific insured low income days/total insured low income days for all DSH providers. (Medicaid days off worksheet S-3)

Worksheet S-10

Hospital Uncompensated Care Data

Purpose: To provide charges and payments for uncompensated care and indigent care to calculate the associated cost for providing patient care services for which the hospital is not compensated.

Data Sources:

- Uncompensated Care Policies
- Bad debt listing by write-off date applicable to cost reporting period
- Charity care listing based on service date with the cost reporting period
- Medicaid traditional and managed care listing, including patient charges and payments
- Documentation to support DSH or supplemental payments for Medicaid (i.e., Hospital Relief Fund, Medicaid GME)

Major Components of Worksheet S-10

- **Medicaid**
- **SCHIP**
- **State & Local Indigent Care**
- **Uncompensated Care**
- **Bad Debt**

Worksheet L

Calculation of Capital Payment

Purpose: To calculate capital settlement under the fully prospective method.

Note: Percentage of SSI recipient patient days must be entered to calculate capital DSH.

Data Sources:

- Medicare PS&R
- Published SSI Percentages

Cost Report Data Flow:

- W/S S-3 Part I
- Number of Interns & Residents from W/S E Pt. A & W/S E-4
- Prospective Capital payments to W/S E Pt. A for Title XVIII and to W/S E-3 Pt. VII for XIX

Worksheet L

Calculation of Capital Payment

- Variance of Reimbursement of capital settlement under the fully prospective method will be due to the following:
 - Medicare PS&R
 - Hospital SSI Percentage
 - Capital DSH Payment
 - Capital IME Payment

Note: All hospitals (100 beds or more) receive capital DSH even if not receiving operating DSH

Worksheet L

Calculation of Capital DSH Payment

- Line 7 --Enter the percentage of SSI recipient patient days to Medicare Part A patient days.
- Line 8--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-2, Part I, columns 1 through 6, line 24) to total days reported on Worksheet S-3, Part I, column 8, line 14, plus column 8, line 32, minus the sum of lines 5 and 6, plus employee discount days reported on Worksheet S-3, Part I, column 8, line 30.
 - **Sample cost report error on worksheet S-2: Medicaid % calculated incorrectly**
 - **S-2, line 24 column 1 should be 15,032**
 - Medicaid % $(15,032+886+100+101+135+65)/(124,862+135-156-250+100) = 16,319/124,691 = .1309$

Worksheet L

Calculation of Capital DSH Payment

- Line 9--Add lines 7 and 8 to equal the hospital's DSH patient percentage.
 - Error on sample cost report Line 9 should equal .3864.
- Line 10--Enter the percentage that results from the following calculation: $(e.2025 \times \text{line 9}) - 1$ where e equals 2.71828. If Worksheet S-2, Part I, line 22, column 2 is "Y" (Pickle amendment hospital), enter 11.89 percent.
 - Line 10 should be .0814
- Line 11--Multiply line 10 by line 1
 - Line 11 should be \$10,255

DSH Calculation Example

Description	Calculation	Source	Formula
Medicaid Days	7,154	S-2 Part I Line 24 Col. 1-6	A
Total Days	48,368	S-3 Part I Col. 8 Line 14, 30, 32 less 5 & 6	B
DSH Percentage	14.79%	Calc.	$C=A/B$
SSI Percentage	3.02%	CMS Published SSI Percentages	D
DSH Day %	17.81%	Calc.	$E=C+D$
<u>Operating DSH Entitlement</u>			
use if D.S.H. % is over 20.2%	0.00%	Calc.	$F=IF(E>0.202,((B12-0.202)*0.825+0.0588),0)$
use if D.S.H. % is > 15% and< 20.2%	4.33%	Calc.	$F=IF(B12>0.15,IF(B12<0.202,((B12-0.15)*0.65+0.025),0))$
DSH Factor	4.33%	Calc.	G
Inlier	\$24,035,673	E Part A Line 1	H
Operating DSH Entitlement	\$260,045	Calc.	$I=G*H*.25$
<u>Capital DSH Entitlement</u>			
DSH Factor	3.67%	Calc.	$J=EXP(0.2025*B12)-1$
Capital Payments	\$4,173,349	L Part I Line 1	K
Capital DSH Entitlement	\$153,275	Calc.	$L=J*K$
Total DSH Entitlement	\$413,320		$M=I+L$

Settlement

Worksheet S Part I

Certification and Worksheet S Part II Settlement Summary

- Before obtaining the Certification of the cost report by an officer or administrator of the provider(s), review the balance due to or due from applicable program for each provider/sub-provider on the S part II and the detail on the following schedules:
 - Medicare Hospital & Sub-provider Settlement from:
 - I/P: W/S E Pt. A and/or W/S E-3, if applicable
 - O/P: W/S E Pt. B
- A letter detailing any changes from how the cost report was submitted in the PY should accompany the cost report submission.

Worksheet E Part A

Calculation of Inpatient Hospital Services Under PPS Settlement

Purpose: To calculate the settlement for inpatient hospital services reimbursable under Medicare

Data Sources:

- Medicare PS&R
- Prior Years Intern & Resident FTE Count
- Intern & Resident Allowable FTE Counts
- % of SSI recipient patient days to Medicare Part A days (CMS published)
- Reimbursable Bad Debt Listing (Including Recoveries)
- Protested Amounts
- Calculation of Nursing Allied Health managed care payment, if applicable

Worksheet E Part A

Calculation of Inpatient Hospital Services Under PPS Settlement

Cost Report Data Flow:

- Bed Days Available from W/S S-3 Pt. I
- Medicaid Patient Days W/S S-3 Pt. I
- Inpatient Program Capital from W/S L
- Direct Graduate Medical Education Payment from W/S E-4
- Routine Service Other Pass Through Costs from W/S D Pt. III
- Ancillary Service Other Pass Through Costs from W/S D Pt. IV
- Interim Payments from W/S E-1
- Amount Due To/(From) Provider to W/S S Pt. III

Worksheet E Part A

Calculation of Inpatient Hospital Services Under PPS Settlement

Amount due to/(from) at CR submission will come from variances in calculated reimbursement and payment for the following:

- Federal Payments from PS&R:
 - PIP providers could have a receivable/(payable)
- IME Reimbursement:
 - Federal Payments and Federal Payments for Medicare Managed Care patients
 - Bed Days Available
 - Number of Interns & Residents
 - Prior Year and Penultimate Year FTE counts
 - PY Interns to Bed Ratio

Worksheet E Part A

Calculation of Inpatient Hospital Services Under PPS Settlement

- **DSH Reimbursement:**
 - Medicaid Patient Days and Medicaid Managed Care Days
 - SSI percentage (CMS published)
- **Inpatient Program Capital**
- **Direct Graduate Medical Education Payment**
- **Pass Thru Costs:**
 - Routine Service Other Pass Through Costs
 - Ancillary Service Other Pass Through Costs
 - Managed Care Pass Thru Costs (does not flow from another worksheet, it must be calculated and entered)
 - Organ Acquisition Cost
- **Reimbursable Bad Debt**

Worksheet E Part B

Calculation of Outpatient Hospital Services Under PPS Settlement

Purpose: To calculate the settlement for outpatient hospital services reimbursable under Medicare

Data Sources:

- Medicare PS&R
- Reimbursable Bad Debt Listing (Reduced by Recovery Listing)
- Protested Amounts

Cost Report Data Flow:

- Cost of Medical and Other Health Services from W/S D Pt. V
- Pass Through Costs from W/S D Pt. IV
- Charges from W/S D Pt. IV and V
- Graduate Medical Education Payments from W/S E-4
- Interim Payments from W/S E-1
- Amount Due To/(From) Provider to W/S S Pt. III

Worksheet E Part B

Calculation of Outpatient Hospital Services Under PPS Settlement

Amount due to/(from) at CR submission will come from variances in calculated reimbursement and payment for the following:

- Cost of Medical and Other Health Services from W/S D Pt. V
- Pass Through Costs from W/S D Pt. IV
- Graduate Medical Education Payments from W/S E-4
- Reimbursable Bad Debt

Worksheet E-1 Part I

Analysis of Payments to Providers for Services Rendered

Purpose: To report Medicare interim payments paid to the provider for services rendered during the cost report period

Data Sources:

- Medicare PS&R
- PIP Payment Schedule, if applicable
- Pass-Through Payment Schedule

Cost Report Data Flow:

- Inpatient (Part A) Payments to W/S E Pt. A
- Outpatient (Part B) Payments to W/S E Pt. B

Note: A separate E-1 is required for each sub-provider

Worksheet E-1 Part II

Calculation of Reimbursement Settlement for HIT

Purpose: To collect data for the HIT payment calculation

Data Sources:

- HIT Interim Payment

Cost Report Data Flow:

- S-3 Part I
- S-10
- W/S C

Wage Index

Worksheet S-3, Part II

Hospital Wage Index Information

Purpose: To provide hospital wage data to determine the hospital's wage factor to be applied to the labor-related portion of the national average standardized amounts of the prospective payment system.

Data Sources:

- Labor Distribution/Payroll Report
- Trial Balance
- W/S A-8-2 Documentation
- A/P Distribution
- Invoices
- Home Office Cost Report, including hours documentation, if applicable

Cost Report Data Flow:

- Salaries for W/S A and W/S A-6

Worksheet S-3, Part IV

Purpose: To document wage related cost formerly reported on the questionnaire CMS Form 339

Data Sources:

- Trial Balance

Cost Report Data Flow:

- N/A

Worksheet S-3, Part V

Contract Labor and Benefit Cost

Purpose: To capture all contract labor and benefit cost for the hospital and all sub-providers

Data Sources:

- A/P Distribution
- Invoices

Cost Report Data Flow:

- N/A

Hospital Wage Index Development Timetable

- Allows providers to review their submitted wage index data one last time before it is audited and used by the FI/MAC

FY 2016 Timetable

- **February 13, 2015** - Release of revised FY 2016 wage index and occupational mix PUFs on the CMS Web site. These data are been desk reviewed and verified by the MACs before being published. Also, a file including each urban and rural area's average hourly wages for the FYs 2015 (final) and 2016 (preliminary) wage indexes will be provided on the CMS web site.
- **March 2, 2015** - Deadline for hospitals to submit requests for corrections to errors in Feb. PUFs or revisions of desk review adjustments to their wage index data, as included in Feb. PUFs.

Hospital Wage Index Development Timetable (cont.)

- **April/May 2015** – Proposed rule published including proposed wage index data
- **April 8, 2015** – Deadline for FI/MACs to transmit final revised wage index data for inclusion in the final wage index.
- **April 15, 2015** – Deadline for hospitals to appeal FI/MAC determinations and request CMS' intervention in cases where the hospital disagrees with FI/MACs determination.
- **May 1, 2015** – Final FY 2016 wage index data released on CMS site
- **June 1, 2015** – Deadline for hospitals to submit correction requests to both CMS and their FI/MAC to corrects errors due to mishandling of the final wage.
- **August 1, 2015** – Approximate date for publication of the FY 2016 Final Rule; wage index includes final wage index data corrections
- **October 1, 2015** – Effective date of FY 2016 Wage Index

Cost Report Processing Timeline

- Tentative Settlements
- Desk Review, Field Audits & Final Settlements
- Re-openings
- Appeals

Questions

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