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

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

Line Descriptions

Line 1.--Enter the cost of ancillary services furnished to inpatients for titles V, and XIX. Transfer these amounts from Worksheet D, Part I, column 4, lines 40 through 52.

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

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

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

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

Line 7.--Enter the applicable charge differential between semi-private and less than semi-private accommodations. The amount of the differential is the difference between the customary charge for semi-private accommodations and the customary charge for the less than semi-private accommodations furnished for all program patient days when the accommodations provided were not medically necessary.

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

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

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

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

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

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

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

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

Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-1, §2104.3).

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

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

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

Line 13.--Enter the program inpatient routine service charges from your records for the applicable component.

The amount on this line includes covered late charges which have been billed to the program where the patient’s medical condition is the cause of the extended stay. In addition, these charges include the charges for semi-private accommodations of inpatients which workmen’s compensation and other primary payers paid. Adjust these charges on line 13 in determining final settlement.

Line 14.--If the amount entered on line 12 has not been adjusted to take into consideration the differential between semi-private room charges and charges for less than semi-private accommodations. Enter the amount from line 7.

Line 15.--Enter the sum of lines 11 through 13 minus line 14.

Lines 16 through 19.--These lines provide for the reduction of program charges when the provider does not actually impose such charges in the case of most patients liable for payment for services on a charge basis or fails to make reasonable efforts to collect such charges from those patients. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 16 through 18 but instead enter on line 19 the amount from line 15. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 19 exceed the actual charge on line 15.

Computation of Reimbursement Settlement

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

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

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

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

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

Line 25.--Enter program allowable bad debts net of bad debt recoveries for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services.

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

Line 27.--If your cost limit is raised as a result of your request for review, amounts which were erroneously collected on the basis of the initial cost limit 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.

Line 28.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination from the program or a decrease in program utilization. (See CMS Pub. 15-1, §§136 - 136.16.)

Line 29.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from a cash basis to an accrual basis. (See CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

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

Line 30.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss from the disposition of depreciable assets. (See CMS Pub. 15-1, §§132-132.4.) Enter in parentheses ( ) the amount of any excess depreciation taken

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

Line 31.--Enter the sum of the amounts on line 26, plus or minus lines 29 and 30, minus lines 27 and 28.

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

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