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Provider Reimbursement Manual - Part 1
Chapter 22, Determination of Cost of Services to Beneficiaries

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2231 – 2231 (Cont.)		

NEW/REVISED MATERIAL--*EFFECTIVE DATE: For services furnished on or after January 1, 2020*

Section 2231, Regional Medicare Swing-Bed-Rates, updates the language in the initial paragraph of this section and adds Table 31 to update the Medicare Payment Rates for routine SNF-type services provided by swing-bed hospitals during calendar year 2020. These rates should be used to carve out swing-bed costs on the hospital cost report.

DISCLAIMER: The revision date and transmittal number apply to the redlined *italicized material* only. Any other material was previously published and remains unchanged.

CHAPTER 22

DETERMINATION OF COST OF SERVICES TO BENEFICIARIES

DETERMINATION OF COST OF SERVICES
TO BENEFICIARIES

Cost Apportionment

Cost Apportionment - Part B Services

Special Care Units Providing General Care

2200. PRINCIPLES

2200.1 Principle of Cost Apportionment.--Total allowable costs of a provider are apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. The methods of apportionment are defined as follows:

A. Departmental Method.--The ratio of covered beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department. Added to this amount is the cost of routine services for program beneficiaries, determined on the basis of a separate average cost per diem for all patients for general routine patient care areas. In hospitals, another factor to be considered is a separate average cost per diem for each intensive care unit, coronary care unit, and other special care inpatient hospital units.

B. Combination Method.--The cost of routine services for program beneficiaries is determined on the basis of a separate average cost per diem for all patients for general routine patient care areas. An additional factor to be considered is, to the extent pertinent, in hospitals, a separate average cost per diem for the aggregate of intensive care, coronary care, and other special care inpatient hospital units. Added to this amount is the cost of ancillary services used by beneficiaries, determined by apportioning the total cost of ancillary services, excluding delivery and labor room costs, on the basis of the ratio of total covered beneficiary charges for ancillary services to total patient charges for such services, excluding charges for delivery and labor rooms.

C. Carve-Out Method.--Use the carve-out method to allocate general routine inpatient service costs in small, rural hospitals that elect to be reimbursed as a swing-bed hospital. Under the carve-out method, total inpatient general routine service costs are reduced by the total routine service costs attributable to SNF-type, ICF-type (prior to October 1, 1990) and nursing facility type (NF) (on or after October 1, 1990) services furnished to all classes of patients, before computing the average cost per diem for general routine hospital care. Costs other than general inpatient routine service costs are determined using the departmental method of apportionment. (See §2230ff.)

2200.2 Availability of Apportionment Methods for Cost Reporting Periods Starting After December 31, 1971, But Before July 1, 1979.--Use the applicable apportionment method indicated as follows:

A. For cost reporting periods starting after December 31, 1971, but before January 1, 1978, any hospital having less than 100 beds, certified and noncertified, on the first day of its cost reporting period and SNFs, regardless of bed size, must use the combination method of apportionment. Where the combined bed capacity of a hospital-skilled nursing facility complex is less than 100 beds, both components use the combination method.

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B. For cost reporting periods starting on or after January 1, 1978, but before July 1, 1979, any hospital or hospital-skilled nursing facility complex having less than 100 beds, certified and noncertified, on the first day of its cost reporting period and SNFs, regardless of bed size, have the option of using either the departmental method or combination method of cost apportionment. If the provider elects to use the departmental method of cost apportionment for any cost reporting period beginning on or after January 1, 1978, the combination method may not be used for any subsequent cost reporting period.

C. Any hospital or hospital-skilled nursing facility complex having 100 or more beds, certified and noncertified, on the first day of its cost reporting period must use the departmental method of apportionment.

With regard to the 100-bed rule for hospitals and hospital-skilled nursing facility complexes, a bed means an adult or pediatric bed (exclusive of a newborn bed whether in the nursery, in the mother's accommodation, or in a premature nursery) permanently maintained for lodging inpatients in acute, long term, or domiciliary areas of the hospital, as well as in subprovider components, hospital-based skilled nursing facilities, or in any noncertified inpatient area of the facility. "Permanently maintained" means that the beds must be immediately available for use by patients and housed in patient rooms or wards (i.e., not in corridors or as temporary beds) and does not refer to the licensed beds of the hospital, skilled nursing facility, or complex. Beds in labor rooms, postanesthesia and postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses and other staff residences, and other such areas, which are regularly maintained and utilized for only a portion of the stay of patients, primarily for special procedures or not for inpatient lodging, are not termed a bed for these purposes.

2200.3 Availability of Apportionment Method for Cost Reporting Periods Starting On or After July 1, 1979.--For cost reporting periods starting on or after July 1, 1979, any hospital, hospital-skilled nursing facility complex, or skilled nursing facility (including distinct-part skilled nursing facilities) regardless of bed size, must use the departmental method of apportionment.

2200.4 Availability of Carve-Out Method.--The carve-out method is available to a swing-bed hospital on or after July 20, 1982, and must be used as of the date a hospital receives swing-bed approval from CMS. (See §2230.1.)

The carve-out method is also available to small rural hospital-SNF complexes that elect the optional reimbursement method. The election to use the carve-out method under the optional reimbursement method is available for cost reporting periods beginning on or after July 20, 1982. (See §2230.9.)

Definitions

2202. DEFINITIONS

2202.l Inpatient.--An inpatient is a person who has been admitted to a hospital or skilled nursing facility for bed occupancy to receive inpatient hospital or skilled nursing services. A person is considered an inpatient if he is formally admitted as an inpatient with the expectation that he will remain at least overnight an occupy a bed even though it later develops that he can be discharged, or is transferred to another hospital and does not actually use a hospital bed overnight. (See Hospital Manual § 210 for exceptions.)

2202.2 Outpatient.--An outpatient is a person who has not been admitted by the provider as an inpatient and who is not lodged in the provider facility while receiving its services. Where a provider uses the category "day patient;" i.e., an individual who receives the facility's services during the day and is not expected to be lodged in the facility at midnight, the individual is classified as an outpatient.

2202.3 Apportionment.--Apportionment means an allocation or distribution of allowable cost between the beneficiaries of the health insurance program and other patients.

2202.4 Charges.--Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions. (See §2206.l for information on accrual of charges and § 2204.l for hospital based physicians charges.)

2202.5 Cost.--Cost refers to reasonable cost as described in § 2102.1.

2202.6 Routine Services.--Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge--sometimes referred to as the "room and board" charge. Routine services are composed of two board components; (l) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care Units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

In recognition of the extraordinary care furnished to intensive care, coronary care, and other special care hospital inpatients, the costs of routine services furnished in these units are separately determined. If the unit does not meet the definition of a special care unit (see § 2202.7), then the cost of such service cannot be included in a separate cost center, but must be included in the general routine service cost center. (See § 2203.l for further discussion of routine services in an SNF.)

2202.7 Special Care Units/Intensive Care type Units.--

I. Special Care Units for Cost Reporting Periods Beginning Prior to October 1, 1980.

A. Requirements to Qualify as an SCU.--To be considered a special care inpatient hospital unit, the following requirements must be met:

1. The unit must be in a hospital.

2. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis. Extraordinary care incorporates extensive lifesaving nursing services of the type generally associated with nursing services provided in burn, coronary care, pulmonary care, trauma, and intensive care units. For this reason, special life-saving equipment should be routinely available in the unit.

3. The unit must be physically identifiable as separate from general care areas and the unit's nursing personnel must not be integrated with the general care nursing personnel.

4. There shall be specific written policies for each of such designated units which include, but are not limited to, burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude postoperative recovery rooms, or maternity labor rooms. The unit's staff must be specially trained to serve in such areas. Segregation of patients to specific areas by type of illness or age, such as psychiatric, neuropsychiatric, geriatric, pediatric, mental health, rehabilitation, etc., does not qualify as special care inpatient hospital units for purposes of apportionment unless the above requirements are met.

NOTE: If a neonatal unit qualifies as an SCU, the days are considered SCU days rather than nursery days (see Part II, Chapter 3, § 304.2, lines 4, 5, 6, paragraph 5). A regular well-baby nursery may not be considered an SCU.

See § 2217 where a hospital places general care patients temporarily in special care units because all available general care beds are occupied.

B. Subintensive Units.--Some hospitals have units which provide more intensive care than that provided in the general care areas yet not sufficiently intensive to permit the unit to meet the requirements to qualify as a special care unit under the definition provided in paragraph A above. These units are typically designated as subintensive, subacute, progressive, or intermediate care units, etc. Such subintensive units are not special care units for purposes of Medicare reimbursement.

There may, however, be cases where a unit is not easily identified as a subintensive or special care unit without further study. In such cases, a review of the written policies of the various units will indicate whether a unit is or is not providing care as defined in paragraph A. If the intermediary determines that such a unit meets the requirements of paragraph A above, then the unit will qualify as a special care unit.

For example, on indication of whether the unit in question meets the requirements specified in §2202.7 I A 2. is the extent of nursing services provided in the unit. If the hours of nursing service per patient day are less than the hours of nursing services provided in an established special care unit, such as an ICU or CCU in that hospital or in other area hospitals if the hospital has not established special care unit, then the unit in question would generally not qualify as a special care unit. Hospitals should maintain such records as are needed to establish the nursing time in such units.

Another example is when the patients in the unit in question are generally transferred there from a qualified special care unit after their condition has improved. This would indicate that the intensity of care required is less than needed to qualify in A.2. above.

C. Special Care Unit Cost Center.--For purposes of reimbursement, hospitals utilizing the departmental method of cost apportionment must determine the average cost per diem for each special care unit. For example:

> A hospital has two physically separate SCU's, an ICU and CCU, serviced by two nursing stations. For settlement purposes, the ICU and CCU would be considered as two distinct SCU's, thus requiring two cost centers.

Where a hospital utilizing the departmental method has a physically combined SCU e.g., ICU-CCU, the combined ICU-CCU would be considered on SCU. For example:

> A hospital gives both ICU and CCU care in one area serviced by one nursing station. For settlement purposes, the combination of the ICU and CCU would be considered as a single SCU, thus requiring a single cost center.

Hospitals utilizing the combination method of cost apportionment must combine all SCU's into one cost center.

II. Intensive Care Type Units for Cost Reporting Periods Beginning on or After October 1, 1980

A. Requirements to Qualify as an Intensive Care Type Unit.--To be considered an intensive care type unit, the unit must furnish services to critically ill patients. A critically ill patient is defined as a person with a serious illness or injury who requires special life-saving techniques and equipment immediately available. The intensive care type unit furnishes services in life-threatening situations and provides a level of care comparable to that which is furnished in intensive care. (Examples of intensive care type units, included, but are not limited to, intensive care units, trauma units, coronary care units, pulmonary care units, and burn units. Excluded as intensive care type units are postoperative recovery room, postanethesia recovery rooms, maternity labor rooms, and subintensive or intermediate care units.) The unit must also meet the following conditions:

1. The unit must be in a hospital.

2. The unit must be physically and identifiably separate from general routine patient care areas, including subintensive or intermediate care units, and ancillary service areas.

Segregation of patients to specific area by type of illness or age, such as psychiatric, neuropsychiatric, geriatric, pediatric, mental costs of care in other general routine areas.

There cannot be a concurrent sharing of nursing staff between an intensive care type unit and units or areas furnishing different levels or types of care. However, two or more intensive care type units that concurrently share nursing staff can be reimbursed as one combined intensive care type unit if all other criteria in this section are met.

Float nurses (nurses who work in different units on an as-needed basis) can be utilized in the intensive care type unit. If a float nurse works in two different units during the same 8-hour shift, then the costs must be allocated to the appropriate units depending upon the time spent in those units. The hospital must maintain adequate records to support the allocation. If such records are not available, then the costs must be allocated to the general routine service cost area.

3. There must be specific written policies that include criteria for admission to, and discharge from, the unit.

4. Registered nursing care must be furnished on a continuous 24-hour basis. At least one registered nurse must be present in the unit at all times.

5. A minimum nurse-patient ratio of one nurse to two patients per patient day must be maintained; i.e., 12 hours of nursing care per patient day. This can be calculated by converting the total number of patient days into patient hours, with this total being divided by the total number of nursing hours. For example, if the total number of patient days is l,000, the number of patient hours is 24,000. Dividing this by the total number of nursing hours give the ratio. Included in the calculation of this nurse-patient ratio are registered nurses, licensed vocational nurses, licensed practical nurses, and nursing assistants who provide patient care. Not included are general support personnel such as ward clerks, custodians and housekeeping personnel.

6. The unit must be equipped, or have available for immediate use, life-saving equipment necessary to treat the critically ill patients for which it is designed. This equipment may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillator, and wall or canister oxygen and compressed air.

NOTE: If a neonatal unit qualifies as an intensive care type unit, the days are considered intensive care type days rather than nursery days. (See Part II, Chapter 3, § 304.2, lines 4, 5, 6.) A regular well baby nursery may not be considered an intensive care type unit.

See § 2217 where a hospital places general care patients temporarily in intensive care type units because all available general care beds are occupied.

B. Subintensive Care Type Units.--Some hospitals have units which provide a level of care between other general routine and intensive care. These units are typically designated as subintensive, subacute, progressive, intermediate care units, etc. Subintensive care type units are considered part of the total spectrum of general routine care and are therefore reimbursed by combining the reasonable costs of the care furnished in the unit with the reasonable costs of care in other general routine areas.

C. Intensive Care Type Unit Cost Center.--For purposes of reimbursement, hospitals must determine the average cost per diem for each intensive care type unit. For example:

> A hospital has two physically separate intensive care type units, an ICU and CCU, serviced by two nursing stations. For settlement purposes, the ICU and CCU would be considered as two distinct intensive care type units, thus requiring two cost centers.

Where a hospital has a physically combined intensive care type unit; e.g., ICU-CCU, the combined ICU-CCU would be considered on intensive care type unit. For example:

> A hospital gives both ICU and CCU care in one area serviced by one nursing station. For settlement purposes, the combination of the ICU and CCU would be considered as a single intensive care type unit, thus requiring a single cost center.

2202.8 Ancillary Services.--Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. (See §2203.1 and §2203.2 for further discussion of ancillary services in an SNF.)

2202.9 Ratio of Beneficiary Charges to Total Charges on a Departmental Basis.--Ration or beneficiary charges to total charges on a department basis, as applied to inpatients, means the ration of covered inpatient charges to beneficiaries of the health insurance program for services of a revenue-producing department or center in the inpatient charges to all inpatients for that center during a cost reporting period. After each revenue-producing center's ratio is determined, the cost of covered services rendered to beneficiaries of the health insurance program is computed by applying the individual ratio for the center to the cost of the related center for the period.

2202.10 Ratio of Beneficiary Charges for Ancillary Services to Total Charges for Ancillary Services Under the Combination Method.--

A. For cost reporting periods starting before January 1, 1972, the ratio of beneficiary charges for ancillary services to total charges for ancillary services, as applied to inpatients, means the ratio of the total inpatient charges for covered ancillary services rendered to beneficiaries of the health insurance program to the total inpatient charges for ancillary services to all patients during a cost reporting period. This ratio is applied to the total allowable inpatient ancillary costs for the period to determine the amount of reimbursement to a provider for the covered ancillary services rendered to beneficiaries.

B. For cost reporting periods starting after December 31, 1971, the ratio of beneficiary charges for ancillary services to total charges for ancillary services, as applied to inpatients, means the ratio of the total inpatient charges for covered ancillary services rendered to beneficiaries of the health insurance program to the total inpatient charges, excluding delivery and labor room charges for ancillary services to all patients during a cost reporting period. This ratio is applied to the total allowable inpatient ancillary costs for the period, excluding delivery and labor room costs, to determine the amount of reimbursement to a provider for the covered ancillary services rendered to beneficiaries.

2202.11 Average Cost Per Diem for Routine Services.--

A. For cost reporting periods starting before January 1, 1972, average cost per diem for routine services means the amount computed by dividing the total allowable inpatient cost for routine services by the total number of inpatient days of care (including intensive care but excluding newborn days where nursery costs are excluded from routine service costs) rendered by the provider in the cost reporting period. (Total number of inpatient days includes any charity and courtesy days of care rendered, and may or may not include employee days in accordance with §332.1.)

B. For cost reporting periods starting after December 31, 1971, average cost per diem for general routine services means the amount computed by dividing the total allowable inpatient cost for routine services (excluding the cost of services provided in intensive care units, coronary care units, and other special care inpatient hospital units as well as nursery costs) by the total number of inpatient days of care (excluding days of care in intensive care units, coronary care units, and other special care inpatient hospital units and newborn days) rendered by the provider in the cost reporting period. (Total number of inpatient days includes any charity and courtesy days of care rendered, and may or may not include employee days in accordance with §332.1.)

C. Average cost per diem under swing-bed reimbursement.--Reimbursement of routine services furnished in a swing-bed hospital is based on separate average per diem costs for routine long-term care services and general routine inpatient hospital services (see §2230.4 A.)

2202.12 Average Cost Per Diem for Hospital Intensive Care Type Units.--Average cost per diem for intensive care units, coronary care units, and other intensive care type inpatient hospital units as defined in §2202.7 means the amount computed by dividing the total allowable costs for routine services in each (see §2200.2A), or the aggregate (see §2200.2B), of these units by the total number of inpatient days of care rendered in each or the aggregate of these units.

2202.13 Year-End Billing.--A year-end billing is a billing which contains the charges not previously billed for all services furnished to a patient through the end of a cost reporting period. Services furnished in the next reporting period should be billed separately as charges for services provided in different cost reporting periods should not be put on the same bill.

2202.14 Outpatient Services.--Outpatient services include services that are diagnostic in nature as well as those services and supplies which are incident to the services of physicians in the treatment of patients. For a specific description of provider covered services refer to the *Medicare Benefit Policy Manual (Pub. 100-02), Chapter 1 (for hospitals), Chapter 7 (for home health agencies), Chapter 8 (for SNFs), and §§220ff. of Chapter 15 (for outpatient physical therapy providers)*.

2202.15 Visit.--See §2302.18 for definition.

2202.16 Outpatient Occasion of Service.--See §2302.13 for definition.

2202.17 Most Prevalent Semiprivate Charge.--The most prevalent charge for semi-private accommodations is the charge which applies to the greatest number of semiprivate beds. It is determined from the following information:

1. type of accommodation;
2. total rooms of each type of each different room rate;
3. total beds found in each type of each room rate;
4. daily charge for the type of room.

The most prevalent charge for semiprivate accommodations is that single rate charge for the largest number of beds determined in 3 above.

EXAMPLE:

(1) Type of Accommodation	(2) Total Rooms of This Type	(3) Total Beds Col. (1) X Col. (2)	(4) Rate Per Day
2 beds	10	20	$30
2 beds	8	16	35
3 beds	2	6	20
4 beds	1	4	15

NOTE: $30 is the most prevalent semiprivate rate.

Provider Charge Structure

2203. PROVIDER CHARGE STRUCTURE AS BASIS FOR APPORTIONMENT

To assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program. Hospitals which have subproviders and hospital-based SNFs must also maintain uniform charges across all payer categories, as well as like charges for like services across each provider setting, in order to properly apportion costs. If like charges for like services are not maintained across provider settings, the cost report must not combine charges when calculating cost-to-charge ratios but must report separately, by department, costs and charges for the hospital, subprovider, and skilled nursing facility. An exception to this requirement is if the provider has the ability to gross-up charges described in §2314.B.

In determining reimbursement for the costs of routine services, providers do not use charges but use patient days for apportionment purposes in a skilled nursing facility (to the extent certified) or in a hospital (with separate computation for each separate care unit). Costs of routine services are determined based on the consideration that all patients in each separate area are receiving similar services.

The cost of those items and services specifically classified as routine in §2202.6 are always considered routine service costs, and the costs of those specifically classified as ancillary in §2202.8 are always considered ancillary service costs for purposes of Medicare reimbursement. A separate ancillary charge for a particular item or service other than those listed as ancillary in §2202.8 is not recognized, and the cost of the item or service is not included in an ancillary cost center, where the common or established practice of providers of the same class (hospital or SNF) in the same State is to include the item or service in the routine service charge. Where there is no

common or established classification of an item or service as routine or ancillary among providers of the same class in the same State, a provider's customary charging practice is recognized so long as it is consistently followed for all patients and does not result in an inequitable apportionment of cost to the program. Ancillary charges for items or services furnished Medicare beneficiaries, including those enumerated in §2202.8, are not recognized by the program if separate charges are not also recorded by the provider for all non-Medicare patients receiving these same items or services directly from the provider.

2203.1 Routine Services in SNFs.--Hospitals and most SNFs differ historically in their charging practices and method of providing services. It is common in nursing homes and other posthospital care facilities, of which SNFs provide the higher level of care, for certain supplies and services to be furnished or purchased for some patients directly by their families or third parties, while the institution furnishes them to other patients and charges for them. In addition, customary charges may not be recorded, as they are for Medicare beneficiaries, for patients for whom other third-party payers reimburse the SNF a flat rate. Such practices may significantly distort allocations in determining departmental costs. To reduce the potential impact of unusual or inconsistent charging practices, the following types of items and services, in addition to room, dietary, medical social services, and psychiatric social services, are always considered routine in an SNF for purposes of Medicare cost apportionment, even if customarily considered ancillary by an SNF:

o All general nursing services, including administration of oxygen and related medications (see §2203.2 for inhalation therapy by an inhalation therapist), handfeeding, incontinency care, tray service, enemas, etc.

o Items which are furnished routinely and relatively uniformly to all patients, e.g., patient gowns, paper tissues, water pitchers, basins, bed pans, deodorants, mouthwashes.

o Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually in small quantities, e.g., alcohol, applicators, cotton balls, bandaids, antacid, aspirin (and other nonlegend drugs ordinarily kept on hand), suppositories, tongue depressors.

o Items which are utilized by individual patients but which are reusable and expected to be available in an institution providing an SNF level of care, e.g., ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, other durable medical equipment (DME) which does not meet the criteria for ancillary services in SNFs under §2203.2 and the requirements for recognition of ancillary charges under §2203. The criteria in §2203.2 explicitly state that items and services may be considered ancillary if they are identifiable items and services tailored to an individual patient's specific medical needs, are furnished at the direction of a physician, and are either not reusable or represent a cost for each preparation. Accordingly, those items of DME which do not meet both the criteria of §2203.2 and the requirements of §2203 for recognition of ancillary charges must be classified as routine. Examples of DME which may qualify as ancillary items are respirators and air fluidized beds.

o Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician, because these supplements have been classified by the Food and Drug Administration as a food rather than a drug.

EXCEPTION: To facilitate accurate and equitable cost apportionment within a single hospital-SNF complex where both components have customarily followed a uniform charging practice, the same classification of items and services as routine or ancillary may continue to be used by a participating hospital-based SNF as is used by the related hospital for Medicare reimbursement purposes.

2203.2 Ancillary Services in SNFs.--Items and services (other than the types classified as routine services in §2203.1) may be considered ancillary in an SNF if charges for them meet the requirements of §2203 for recognition of ancillary charges and if they are:

o Direct identifiable services to individual patients, and

o Not generally furnished to most patients, and

o One of the following:

- Not reusable, e.g., artificial limbs and organs, braces, intravenous fluids or solutions, oxygen (including medications), disposable catheters;

- Represent a cost for each preparation, e.g., catheters and related equipment, colostomy bags, drainage equipment, trays and tubing;

- Complex medical equipment, e.g., ventilators; or

- Support surfaces. The support surfaces which are classified as ancillary are those listed under the Durable Medical Equipment Regional Carrier's (DMERC) level 2 and level 3 support surfaces categories. For example, support surfaces which qualify under DMERC's level 2 support surface criteria are low air loss mattress replacement and overlay systems. An example of support surfaces which qualify under DMERC's level 3 support surface criteria is air fluidized therapy.

NOTE: Items listed in the DMERC level 1 support surface criteria do not qualify for this category because they are inexpensive and common enough to be considered routine services in all cases.

The use of an operating room and the provision of inhalation therapy services by an inhalation therapist are reimbursable skilled nursing facility services only when furnished to the SNF by a hospital with which the SNF has a transfer agreement.

2203.3 Rental of Equipment.--Rental of equipment by a provider from an outside vendor does not in itself give rise to an ancillary charge. Where a provider rents equipment, the reasonable rental charge is includable in allowable costs of the appropriate department and is subject to apportionment in the same way as other costs of the same department.

2204. MEDICARE CHARGES

Medicare charges refer to the regular rates for various covered services which are charged to beneficiaries for inpatient or outpatient services. The Medicare charge for a specific service must be the same as the charge made to non-Medicare patients (including Medicaid, CHAMPUS, private, etc.), must be recorded in the respective income accounts of the facility, and must be related to the cost of the service. (See §2202.4.)

2204.1 Hospital-Based Physicians.--When a provider uses the ratio of Medicare charges to total charges to apportion allowable costs to the program, the provider may either include or exclude the charges for professional services rendered by hospital-based physicians from both total and Medicare charges in determining the ratio. Additionally, when the provider is using the combination method, the inclusion or exclusion of such charges must be uniform for all ancillary departments for both inpatient and outpatient services. (See §2206.1 for information on accrual of charges.) In all cases, a provider must exclude from allowable costs the payment made to hospital-based physicians as compensation for professional services rendered to patients that are reimbursable under the supplementary medical insurance program (Part B of title XVIII of the Act). (See 42 CFR 405.483-405.488 and §§2108-2108.10.)

2204.2 Accommodations.--

A. For cost reporting periods beginning after December 31, 1971, and before October 1, 1982, inpatient routine service costs must be apportioned on an average cost per diem under both the departmental method and the combination method for all providers. Thus, the program pays the same amount for routine services whether the patient has a private room not medically necessary, a private room medically necessary, a semi-private room (two, three, or four bed accommodations), or ward accommodations when consistent with program purposes. (See §2204.3.)

1. If the patient is admitted to a provider having both private and semi-private accommodations, the provider may nevertheless charge the patient a differential for a private room if:

a. The private room is not medically necessary; and

b. The patient (or relative or other person acting on his/her behalf) has requested the private room and the provider informs him/her at the time of the request of the amount of the charge.

The private room charge differential may not exceed the difference between the customary charge for the accommodations furnished and the most prevalent semi-private accommodation rate at the time of the patient's admission. (See §2202.17.)

2. If the patient is admitted to a provider which has only private accommodations, medical necessity is deemed to exist for the accommodations furnished. Beneficiaries may not be subject to an extra charge for a private room in an all-private room provider. Beneficiaries do not have alternative accommodations in such a provider and, therefore, are not requesting service for which an extra charge may be made.

B. For cost reporting periods beginning on or after October 1, 1982, the apportionment methodology for inpatient general routine service costs (see §2207) is revised to include in Medicare costs the difference in cost between semiprivate and private accommodations only when private rooms are furnished to Medicare beneficiaries for medically necessary reasons. As provided in subsection A, you may still collect a private room charge differential from Medicare beneficiaries when private rooms are requested and are not medically necessary. (See also §A210.1 of the Hospital Manual or §A230.2 of the SNF Manual for your responsibilities regarding private rooms.)

Under the swing bed provision, Medicare payment for inpatient general routine hospital services is determined after excluding amounts and days attributable to the routine long term care services provided under the swing bed approval. Since payment rates are specified for the long term days of care, the apportionment methodology described above does not apply to these days of care. However, you may charge a beneficiary a differential for such days which are furnished in a private room as requested by the beneficiary and which are not medically necessary.

2204.3 Accommodation Differential.--When ward accommodations are furnished at the patient's request or for a reason determined to be consistent with the purpose of the health insurance program, payment is made for the reasonable cost of the accommodations furnished.

Where a ward accommodation is furnished by a provider not at the patient's request nor for a reason that the intermediary can approve as consistent with the purposes of the health insurance program, payment is made for the reasonable cost of semiprivate accommodations less an accommodation differential (the difference between the hospital's customary charge for semiprivate accommodations at the most prevalent rate at the time of the patient's admission (see §2202.17) and its customary charge for the ward accommodation actually furnished). (See §210.1F2 of the Hospital Manual or §230.2F2 of the SNF Manual.)

In either situation, the customary charge for the ward accommodation actually furnished is the charge included on the billing form.

It is consistent with the program's purpose to furnish bed and board in less expensive accommodations when semiprivate accommodations are not available. However, the patient must be moved to semiprivate accommodations when they become available. Payment to hospitals which have only ward accommodations is made on the basis of the reasonable cost of the accommodations furnished.

2205. MEDICARE PATIENT DAYS

Only full patient days may be used apportion inpatient routine care service costs (separately for general care and for intensive care) to the Medicare program. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method must be used even if you use a different definition of a patient day for your statistical or other purposes.

An inpatient at midnight is included in the census of your inpatient routine (general or intensive) care area regardless of the patient's location at midnight (whether in a routine bed, in an ancillary area, etc.), including a patient who has not yet occupied a routine care bed since admission. (See exception in §2205.2 regarding maternity patients.) When a patient occupies a bed in more than one routine care area in one day, the inpatient day is counted only in the routine care area in which the patient was located at midnight. In a case where the patient is located in an ancillary area at midnight, an inpatient day is counted in the routine care area in which the patient was located before going to the ancillary area. If the patient was not located in a routine care area since admission, an inpatient day is counted in the routine care area to which the patient was assigned. See §2805 regarding apportionment statistics for providers subject to the prospective payment system.

2205.1 Days of Admission and Discharge.--The day of admission is the day when a person is admitted to a provider for bed occupancy for purposes of receiving inpatient services and counts as a day of inpatient routine care. Except when the day of admission and discharge (or death) are the same, the day of discharge is not counted as a day of inpatient routine care. (However, charges for ancillary services on the day of discharge are included in charges for covered services.) If admission and discharge occur on the same day, the day is considered a day of admission and counts as a day of inpatient routine care. If a patient admitted and discharged on the same day was located only in an ancillary area during the stay, an inpatient day is counted in the routine care area to which the patient was assigned (subject to §2205.2 regarding maternity patients). When a patient is admitted and then transferred from one participating provider to another participating provider before midnight of the same day, a day (except for utilization purposes) is counted at both providers. A day of Medicare utilization is charged only for the admission to the second provider.

2205.2 Counting Patient Days for Maternity Patients.--A maternity patient in the labor/delivery room ancillary area at midnight is included in the census of the inpatient routine (general or intensive) care area only if the patient has occupied an inpatient routine bed at some time since admission. No days of inpatient routine care are counted for a maternity inpatient who is discharged (or dies) without ever occupying an inpatient routine bed. However, once a maternity patient has occupied an inpatient routine bed, at each subsequent census the patient is included in the census of the inpatient routine care area to which assigned even if the patient is located in an ancillary area (labor/delivery room or another ancillary area) at midnight. In some cases, a maternity patient may occupy an inpatient bed only on the day of discharge, where the day of discharge differs from the day of admission. For purposes of apportioning the cost of inpatient routine care, this single day of routine care is counted as the day of admission (to routine care) and discharge and, therefore, is counted as one day of inpatient routine care.

2205.3 Late Discharge.--When a patient continues to occupy his accommodations in a hospital or SNF beyond the check out time for personal reasons (e.g., the patient is not bedridden, and is awaiting transportation to his home), the hospital or SNF may charge the beneficiary for the continued stay. A stay beyond the normal checkout time which is for the comfort or convenience of the patient is not covered under the program. The institution's agreement to participate in the program does not preclude it from charging the patient as a non-covered service. It is expected that providers will not impose late charges unless the beneficiary has been given reasonable advance notice (for example, 24 hours) of his impending discharge.

Where the patient's medical condition is the cause of the stay past the checkout time (e.g., the patient needs further services, is bedridden and awaiting transportation to his home or to a skilled nursing facility, or dies in the institution), the stay beyond the discharge hour is covered under the program and the hospital may not charge the patient. (See § 2206.2.)

Fractional or full days due to late discharges must not be included in total patient days or total Medicare days. Medicare will thus reimburse its share of allowable late discharge costs incurred for medical reasons as part of routine costs on the basis of its share of total patient days.

The Medicare days of care are the cumulative total of "covered days" shown on Item 28 of Form HCFA-1453, Inpatient Hospital and Skilled Nursing Facility Admission and Billing.

2205.4 Leave of Absence Days.--The day on which the patient began a leave of absence is treated as a day of discharge and is not counted as an inpatient day unless he returns to the hospital by midnight of the same day. The day the patient returns to the hospital from a leave of absence is treated as a day of admission and is counted as an inpatient day if he is present at midnight of that day. Providers are not required to go through the actual administrative process of discharging a patient when he begins a leave of absence nor are they required to complete new admission forms when he returns. The number of leave days should be noted on the billing form.

The provider may not charge the beneficiary for leave days. In cases where the provider charges non-Medicare patients for leave days but is precluded from charging Medicare patients, then in apportioning cost to the Medicare program, the provider should eliminate the non-Medicare charges and days from total charges and days so that the result will be the same as if the non-Medicare patients were not charged for these days.

As the program regards the cost of holding a room during a leave of absence as synonymous with standby costs, no exclusion is required for costs representing leave of absence days.

2205.5 Patient Days for Purposes of Swing-Bed Reimbursement.--(See §2230.2.)

2206. TOTAL CHARGES

2206.1 Accrual.--A provider's total charges used in the ratio of beneficiary charges to total charges should include all charges for services rendered during the entire cost reporting period. Where a provider does not record its total actual charges on this basis, an accrual must be established to provide for any unrecorded charges. This would also include delayed billing charges, i.e., those charges recorded in a subsequent cost reporting period but applicable to services rendered in the current cost reporting period. A provider should be consistent in the method which is used to establish accrued charges at the end of each cost reporting period. See §2805 regarding apportionment statistics for providers subject to the prospective payment system (PPS).

Where the costs of nonallowable services (e.g., costs of television and radio services for the entertainment of the patients where the equipment is located in patient accommodations) are excluded from allowable costs on the Medicare statement of reimbursable costs, the charges for such nonallowable services for all patients should also be excluded from total charges. Where a provider chooses to include the charges for professional services rendered by hospital-based physicians in Medicare and total charges, these charges must also be accrued. (See § 2204.l.)

2206.2 Late Discharges.--Where a provider imposes a charge for a late discharge, it should include such charges in its total charges for all patients. This is required in order to effect the proper apportionment of costs in the Medicare cost reimbursement formula based on the ratio of Medicare charges to total charges. (For cost reporting periods beginning before January 1, 1972.) (See 2205.3 for an explanation of late discharges for Medicare beneficiaries.)

2206.3 Accommodation Differential - Difference between Semiprivate and Ward.--See § 2204.3, Accommodation Differential.

Cost Apportionment

2207. METHODS OF COST APPORTIONMENT FOR PART A INPATIENT SERVICES

2207.1 Objective.--The law provides that the costs of services to individuals covered by the health insurance program will not be borne by individuals not so covered, and, conversely, that costs of services to individuals who are not under the program will not be borne by the program.

The two methods of apportionment (departmental and combination) available for use in determining the cost of services rendered to beneficiaries of the program have as their goal the allocation of the total allowable costs between the beneficiaries and other patients in as equitable a manner as possible. Under these methods, if it is found that beneficiaries receive more than the average amount of services, the providers would receive reimbursement greater than the average cost for all patients. Conversely, if the beneficiaries receive less than the average amount of services, the providers would be reimbursed accordingly for the services rendered.

2207.2 Apportionment Methods for Cost Reporting Periods Beginning after December 31, 1971.--For cost reporting periods beginning after December 31, 1971, providers shall use the departmental or combination method of apportionment as indicated in §2200.2 and §2200.3. The carve-out method shall be used by providers approved as swing-bed hospitals on or after July 20, 1982. (See §2200.4).

A. Departmental Method.--The following illustrates the apportionment of costs, using only inpatient data, based on the average cost per diem for general routine services and for each special care unit, and the apportioning of the cost of ancillary services on the ratio of beneficiary charges to total charges applied to cost by department.

Hospital Y

Department	Charges to Program Beneficiaries	Total Charges	Ratio of Beneficiary Charges to Total Charges	Total Cost	Cost of Beneficiary Services
			Percent		
Operating Rooms	$20,000	$70,000	28 4/7	$ 77,000	$22,000
Delivery and Labor Rooms	0	12,000	0	30,000	0
Pharmacy	20,000	60,000	33 1/3	45,000	15,000
X-ray	24,000	100,000	24	75,000	18,000
Laboratory	40,000	140,000	28 4/7	98,000	28,000
Others	6,000	30,000	20	25,000	5,000
Sub-total	$110,000	$412,000	---	$350,000	$88,000

	Total Inpatient Days	Total Cost	Average Cost Per Diem	Program Inpatient Days	Cost of Beneficiary Services
General Routine	30,000	$630,000	$21	8,000	$168,000
Coronary Care Unit	500	20,000	40	200	8,000
Intensive Care Unit	3,000	108,000	36	1,000	36,000
Sub-Total	33,500	$758,000		9,200	$212,000
Total Cost of Beneficiary Services					$300,000

For services rendered on or before September 30, 1982, an inpatient routine nursing salary cost differential adjustment factor is necessary, to the extent pertinent, in determining the cost of general routine services rendered to program beneficiaries. (See §1300.)

B. Combination Method.--The following illustrates the apportionment of costs, using only inpatient data, based on the average cost per diem for general routine services, the average cost per diem for the aggregate of the special care units, and the apportioning of the cost of ancillary services on the basis of the ratio of total beneficiary covered ancillary charges to total patient ancillary charges (excluding delivery room and labor room charges) applied to the total cost of all such ancillary services (excluding delivery and labor room costs).

Hospital Z

Statistical and financial data:

Total inpatient days for all patients - General area	30,000
Total inpatient days for all patients - All special care units	2,500
Inpatient days applicable to program beneficiaries - General area	7,500
Inpatient days applicable to program beneficiaries - All special care units	750
Total allowable costs - General inpatient routine area	$600,000
Total allowable costs - All special care units	$ 95,000
Inpatient ancillary services - Total allowable costs excluding delivery and labor room cost	$320,000
Inpatient ancillary services - Total charges excluding delivery and labor room charges	$400,000
Inpatient ancillary services - Charges for services to program beneficiaries	$ 80,000

Computation of cost applicable to program:

Average cost per diem for general routine services:
$600,000 ÷ 30,000 = $20 per diem

Cost of general routine services (exclusive of any inpatient routine nursing salary cost differential adjustment factor) rendered to program beneficiaries:
$20 per diem x 7,500 days $150,000

Average cost per diem for special care units:
$95,000 ÷ 2,500 = $38 per diem

Cost of services rendered to program beneficiaries in special care units: $38 per diem x 750 days	$ 28,500
Ratio of beneficiary charges to total charges for all ancillary services excluding delivery and labor room charges: $80,000 ÷ $400,000 = 20 percent	
Cost of ancillary services rendered to program beneficiaries: 20 percent x $320,000	$ 64,000
Total cost (exclusive of any inpatient routine nursing salary cost differential adjustment factor) of services rendered to program beneficiaries	$242,500

For services rendered on or before September 30, 1982, an inpatient routine nursing salary cost differential adjustment factor is necessary, to the extent pertinent, in determining the cost of general routine services rendered to program beneficiaries. (See §1300.)

C. Swing-Bed Reimbursement Method.--On or after July 20, 1982, small, rural hospitals that have received CMS approval to use beds interchangeably as either hospital or SNF beds must use the swing-bed reimbursement method. Small, rural hospital-SNF complexes that elect to be reimbursed under the optional reimbursement method must use that method for cost reporting periods beginning on or after July 20, 1982. (See §2230.9.)

2207.3 Cost Reporting Periods Beginning on or After October 1, 1982.--The apportionment methodology for inpatient general routine service costs in hospitals and skilled nursing facilities is revised to include in Medicare costs, the difference in cost between semi-private and private accommodations only when private rooms are furnished to beneficiaries for medically necessary reasons. (See 42 CFR 405.452(b)(1)(iii).) In addition, Medicare no longer shares in the additional cost of private rooms used by non-Medicare patients. Providers may still collect a private room charge differential from Medicare beneficiaries when private rooms are requested and are not medically necessary. (See §2204.2.)

Determine hospital and SNF reimbursement for inpatient general routine service cost as follows.

Step 1a.--Determine the average per diem private room charge differential between a private room patient day and semi-private room patient day by subtracting the average per diem charge for all semi-private room accommodations from the average per diem charge for all private accommodations. The average per diem charge for private room accommodations is determined by dividing the total charges for private room accommodations by the total number of days of care furnished in private room accommodations. The average per diem charge for semi-private accommodations is determined by dividing the total charges for semi-private room accommodations by the total number of days of care furnished in semi-private accommodations.

Step 1b.--Determine the inpatient general routine cost/charge ratio by dividing the total inpatient general routine service costs by the total inpatient general routine service charges.

Step 1c.--Determine the average per diem private room cost differential by multiplying the average per diem private room charge differential determined in step 1a by the inpatient general routine cost/charge ratio determined in step 1b.

Step 2a.--Determine the total private room cost differential by multiplying the average per diem private room cost differential determined in step 1c by the total number of private room patient days.

Step 2b.--Determine the total inpatient general routine service costs net of the total private room cost differential by subtracting the total private room cost differential determined in step 2a from total inpatient general routine service costs.

Step 2c.--Determine the average cost per diem for inpatient general routine services by dividing the total inpatient general routine service costs net of the total private room cost differential determined in step 2b by all inpatient general routine days for all accommodations including private room accommodations.

Step 3.--Determine the total inpatient general routine service cost applicable to Medicare, including the cost of medically necessary private rooms used by Medicare patients, as follows. First, multiply the average cost per diem for inpatient general routine services determined in step 2c by all Medicare inpatient general routine days including Medicare private room days regardless of whether they were medically necessary. Add to this amount the private room cost differential applicable to Medicare inpatient general routine days. This is determined by multiplying the average per diem private room cost differential determined in step 1c by the number of medically necessary private room days of care furnished to Medicare patients.

These steps are restated in the following formula:

1. Average per diem private room cost differential

a. Average Per Diem Private Room Charge Differential = Average Per Diem Private Room Charge - Average Per Diem Semi-Private Room Charge

b. Inpatient General Routine Cost/Charge Ratio = $\frac{\text{Total Inpatient General Routine Service Costs}}{\text{Total Inpatient General Routine Service Charges}}$

c. Average Per Diem Private Room Cost Differential = Average Per Diem Private Room Charge Differential X Inpatient General Routine Cost/ Charge Ratio

2. Average cost per diem for inpatient general routine services

a.	Total Private Room Cost Differential	=	Average Per Diem Private Room Cost Differential	X	Total Private Room Patient Days
b.	Total Inpatient General Routine Service Costs Net of the Private Room Cost Differential	=	Total Inpatient General Routine Service Costs	-	Total Private Room Cost Differential
c.	Average Cost Per Diem for Inpatient General Routine Services	=	Inpatient General Routine Service Costs Net of Private Room Cost Differential / Total Patient Days for All Inpatient General Routine Accommodations		

3. Medicare inpatient general routine service costs

(Average Cost Per Diem for Inpatient General Routine Services	X	All Medicare Inpatient General Routine Days Including Medicare Priv. Rm. Day)
+		
(Average Per Diem Private Room Cost Differential	X	Medicare Medically Necessary Private Room Days)

In light of the small proportion of ward days compared to other inpatient general routine days, this methodology does not distinguish between ward and semi-private accommodations except where semi-private or private days are specifically identified.

Under the swing-bed provision, Medicare reimbursement for inpatient general routine hospital services is determined after amounts and days attributable to the routine long-term care services provided under the swing bed approval are excluded. (See §2230.) The private room methodology discussed in this section is applicable after the long-term care costs and days have been excluded. Since reimbursement rates are specified by statute for the long-term days of care furnished by a swing-bed hospital, the apportionment methodology in this section does not apply to these days of care.

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2208. METHODS OF COST APPORTIONMENT FOR ALL-INCLUSIVE RATE OR NO-CHARGE STRUCTURE PROVIDERS

2208.1 All-Inclusive Rate or No-Charge Structure Hospitals.--The approved methods for apportioning allowable cost between Medicare and non-Medicare patients under the program are not readily adaptable to those hospitals having an all-inclusive rate (one charge covering all services) or a no-charge structure. Therefore, alternative methods of apportionment have been developed for all-inclusive rate or no-charge structure hospitals. These methods are available only to those hospitals which do not have charge structures for individual services rendered. The alternative methods described herein are presented in the order of their preference, A through E.

For cost reporting periods ending before January 1, 1970, the statistical method (Method A) should be used where there are sufficient and usable data available. Alternative Methods B through E are offered to accommodate the varying degrees of data available in these hospitals. The use of Methods B through E must be approved by the intermediary after considering the data available and ascertaining which of the methods that can be applied achieves equity, not merely greater reimbursement, in the allocation of costs for services rendered to Medicare beneficiaries.

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For cost reporting periods ending after December 31, 1969, the statistical method (Method A) shall be considered the permanent method of cost apportionment. Where the permanent method is not used, the intermediary may grant specific permission for a hospital to continue to use--on a temporary basis--a less sophisticated method.

Having used an alternative of higher preference, a hospital may not elect to use an alternative of lower preference in subsequent reporting periods. For example, if a hospital used Method D, Comparative Hospital Data, for its first reporting period, it cannot, thereafter, elect to use alternative Method E. It can, however, use methods A, B, or C. Where the statistical method is not used, the intermediary will add to the cost report a statement explaining why the method selected was used, and why methods of higher priority could not be used.

In the application of these alternatives, cost report forms plus associated instructions and definitions currently in use should be used where applicable.

A. Departmental Statistical Data-Method A.--In the absence of charge data which would permit the use of methods approved under §§ 2200.1-2200.3, this method is to be used where adequate departmental statistics are available. The step-down procedures for cost finding required in § 2306.1 must be used.

Under the statistical method, the cost of routine services are apportioned on the basis of the relative number of patient days for beneficiaries and for other patients, i.e., an average per diem basis. The costs of ancillary services if apportioned departmentally on the basis of the ratio of covered beneficiary inpatient statistics to total inpatient statistics applicable to such costs. Statistics must be weighted to reflect relative values. Since weighting factors may vary among various types of institutions, the intermediary may approve the use of those factors which in its judgment produce the most equitable results in each situation. In any event, the data collected must satisfy audit verification. The amounts computed as the program's share of the provider's routine and ancillary costs are then combined in determining the amount of program reimbursement.

Application.--Hospitals that have maintained a count of services by type rendered to Medicare and non-Medicare patients may apply such statistics in the apportionment of ancillary costs. Hospitals that did not record such statistics during their first Medicare cost reporting period may use statistical sampling techniques where approved by the intermediary. However, hospitals that began to record such statistics during the second cost reporting period may use the statistical data gathered in the second period to apportion costs of the first period. In such cases,

however, the intermediary must have established that procedures followed in gathering data are proper. The statistics must represent an adequate segment of the period in which gathered, preferably 6 months or longer.

Certain ancillary services may not be considered sufficiently significant to justify a separate calculation of costs for Medicare and non-Medicare patients. For example, a provider may have very limited physical therapy services which may represent less than 1 percent of the total direct and indirect costs and therefore a separate cost apportionment is not necessary. Other ancillary services such as regular drugs and medical supplies may be significant but present special difficulties in identifying and measuring usage. For cost reporting period ending before January 1, 1970, the total expenditures for such services can be segregated and assumed to have been incurred by Medicare and non-Medicare patients in equal quantity per patient day. The cost of these ancillary average cost per diem for all patient multiplied by the total number of Medicare patient days. For period ending after December 31, 1969, where such services are significant, adequate procedures must be established for measuring the use of these services by Medicare beneficiaries.

Using the statistical basis the cost settlement shall be determined as follows:

1. Determine total allowable cost using Form SSA-1562, Schedule A through Worksheet B-1-2.

2. Complete Schedule C and C-1 Form SSA-1562 to allocate total allowable costs between inpatient and outpatient services using the ratios of total inpatient charges and total outpatient charges to total combined charges, weighted statistics, occasions of service, or other basis with the intermediary's approval.

3. Multiply the average per diem cost of routine services by the total Medicare days, or apply the ratio of Medicare inpatient charges to total inpatient charges to total inpatient routine services costs to determine Medicare's share of routine service costs.

4. Determine the Medicare portion of ancillary costs by applying departmentally, the statistical ratio of Medicare utilization to total utilization. Such statistical data may be shown on the "Calculation of Reimbursement Settlement, Inpatient Services," Form SSA-1563, page 2, for cost reporting periods ending before April 1, 1968, or Exhibit B, Form SSA-1992 for cost reporting periods ending after March 31, 1968.

5. The statistics used in 4 above should be supported by a supplementary schedule showing how they were developed.

6. The amount determined in 3 above should be inserted on line 16, column 6, page 2 of Form SSA-1563 or line 20, column 6 of Exhibit B, Form SSA-1992.

7. All other pages of Form SSA-1563 or Form SSA-1992 when applicable will be completed in the usual manner. If separate identifiable charges for outpatient services are not available, statistical data or an average cost per occasion of service may be used in the outpatient cost settlement (page 3, Form SSZ-1563 or Exhibit E, Form SSA-1992).

In some cases, a hospital may have an "all-inclusive charge," but for certain specialized services, such as X-ray or laboratory, makes a separate identifiable charge for services rendered in these departments. In such cases, if the same schedule of charges is used for both Medicare and non-Medicare patients, the ratio of charges to charges may be applies to the cost of those departments only when statistics are not available. The statistical method of apportionment should be applied to all other departments.

B. Sliding Scale-Method B.--In the absence of charges or statistical data, a hospital may use the sliding scale method to determine ancillary costs, with routine service costs determined on an average per diem cost basis. Total allowable costs should be allocated between routine and ancillary services through step-down cost finding, or by suing the estimated percentage basis where permitted.

When using the sliding scale method to determine Medicare ancillary costs, the hospital would:

1. determine the average length of stay of all patients;

2. determine the average length of stay for patients 65 years or older;

3. calculate the average per diem allowable ancillary costs for all patients;

4. determine the weighted average percentage of average per diem ancillary costs for Medicare patient in the following manner:

a. multiply the average length of stay for all patient by 100 percent to determine a weighted percentage;

b. the difference in the number of days between the average length of stay for patients 65 years or older and the average length of stay for all patients must be multiplied by 75 percent to determine a weighted percentage;

c. the total of a and b. above will produce a total weighted value for the average length of stay for patients 65 years or older.

This weighted value must be divided by the average length of stay for patients 65 years or older to produce the percentage to be applied to the ancillary average per diem cost.

This percentage can be less than, but cannot exceed, 100 percent of the average ancillary per diem cost. where the average length of stay for Medicare inpatients is less than the average length of stay for all inpatients, the percentage derived under this formula would be 100 percent.

The following example illustrates the computation of the weighted percentages:

Assumed Facts:

Average length of stay, all patients	8 days
Average length of stay, inpatients 65 years of older	13 days

Weighted percentages:

8 days x 100% = 800%
5 days x 75% = 375%
13 1,175%

Total weighted value of 1,175 percent divided by 13 (average length of stay for patients 65 years or older) equals 90.38 percent of the ancillary average per diem cost.

5. Apply the percentage determined in 4 above to the ancillary average per diem cost for patients and multiply the resulting amount by the total number of Medicare inpatient days to determine Medicare's share of ancillary service costs.

The following example illustrates the computation of Medicare ancillary costs under this method:

Assumed Facts:

Total allowable ancillary costs	$200,000
Total inpatient days	10,000
Total Medicare inpatient days	2,500
Average length of stay, all patients	8 days
Average length of stay, patients 65 years or older	13 days

Computed as follows:

a. Average per diem ancillary costs, all patients:
$200,000 10,000 = $20 per day

b. Weighted percentages:

8 days x 100% =	800%
5 days x 75% =	375%
13	1,175%

Total weighted value of 1,175 percent divided by 13 (average length of stay for patients 65 years or older) equals 90.38 percent of the ancillary average per diem cost.

c. $20 per diem x 90.38 percent x 2,500 Medicare inpatient days = Medicare ancillary reimbursement of $45,190

Application.--

1. Determine total allowable cost, using Form SSA-1562, Schedule A through Worksheet B-1-2.

2. Complete Schedules C and C-1 (Form SSA-1562) to allocate total allowable costs between inpatient and outpatient services using the ratios of total inpatient charges and total outpatient charges to total combined charges, weighted statistics, occasions of service, or other basis with the intermediary's approval.

3. Complete line 12, column 4 of page 2, Form SSA-1563, or line 15, column 4 of Exhibit B, Form SSA-1992. Insert in column 6 the amount of Medicare ancillary costs. A separate schedule must be attached to support the calculation of this amount.

4. Medicare's share of routine service costs will be determined when completing the remainder of page 2, Form SSA-1563 or Exhibit B, Form SSA-1992.

5. All other pages of Form SSA-1563 or Form SSA-1992 when applicable will be completed in the usual manner. If separate identifiable charges or statistical data for outpatient services are not available, an average cost per occasion of service may be used in the outpatient cost settlement (page 3, Form SSA-1563 or Exhibit E, Form SSA-1992).

C. Descending Rates of Charges-Method C.--Some providers with all-inclusive rates have established a descending rate charge structure which is applies to the length of patient stay. For example, the average daily

charge established by the hospital may be $30. The hospital would then apply its charges to all patient in the following manner:

Patient Stay	Descending Rate	Average Daily Charge	Charge Per Day
1st-3rd day	120%	$30	$36.00
4th-9th day	100%	$30	$30.00
After 9th day	65%	$30	$19.50

Where the provider has previously established such a rate-charge structure based on cost, the percentage used for establishing the charge per day may be applied to the total allowable average per diem cost to arrive at the Medicare reimbursement.

EXAMPLE:

A Medicare Patient Stay	B Number of Days	C Total Allowable Average Per Diem Cost	D Descending Rate	E Medicare Reimbursement B x C x D
1st-3rd day	1,000	$20	120%	$ 24,000
4th-9th day	3,000	$20	100%	60,000
After 9th day	2,000	$20	65%	26,000
				$110,000

This same approach may be sued with the approval of the intermediary where the provider is using a descending scale of charges which are based on cost.

Application.--

1. The total allowable cost and segregation of cost between inpatient and outpatient services will be shown on Form SSA-1564A, pages 1b and 2b in accordance with related instructions.

2. Insert total inpatient expenses applicable to Medicare inpatients on line 5, page 3b, Form SSA-1574A. This amount must be supported by a separate schedule attached to the cost report, computed on the basis of the provider's descending scale of charges, applied to total allowable average per diem cost. The remainder of page 3b. Form SSA-1564A will be completed in the usual manner. (For cost reporting period ending after March 31, 1968, page 3b, Form SSA-1564A is replaced by Exhibit D, Form SSA-1992).

3. Complete pages 1 (or Exhibit A, Form SSA-1992 for reporting periods ending after March 31, 1968) and 4 through of Form SSA-1563 and Form SSA-1563A in accordance with the instructions for preparation of this form.

4. The Gross RCC Method, statistical data or average cost per occasion of service may be used for the outpatient cost settlement (page 4b, Form SSA-1564A). (For cost reporting periods ending after March 31, 1968, page 4b, Form SSA-1564A is replaced by Exhibit E, Form SSA-1992.)

D. Comparable Hospital Data-Method D.--If the intermediary determines that neither the statistical, sliding scale, or descending rate method can be used, charge data for ancillary services from comparable hospitals may be applied to the ancillary services costs of the all-inclusive or no-charge hospital. When selecting comparable hospital data, the intermediary should consider such factors as size, location, scope of services, type of control, average length of patient stay, and Medicare utilization. The Medicare utilization factor should be consistent among the selected comparable hospitals.

The comparable hospital charge data should include information obtained from 3 or more hospitals, all of which must have facilities and services that are very similar to the all-inclusive hospital. This method is illustrated below.

1. Ancillary charges are determined as follows:

a. Total Medicare Ancillary Charges-All Comparable Hospitals =
Total All Patients Ancillary Charges-All Comparable Hospitals =

$$\frac{\$\ 3{,}000{,}000}{\$12{,}000{,}000} = 25\%$$

b. All-inclusive hospital total ancillary costs = $200,000 x 25%
$50,000 Ancillary Cost Applicable to Medicare

2. The Medicare share of routine care costs will be determined as provided under the Combination Method of apportionment.

3. Application.--

a. Determine total allowable cost, using Form SSA-1562, Schedule A through Worksheet B-1-2.

b. Complete Schedules C and C-1 (Form SSA-1562) to allocate total allowable costs between inpatient and outpatient services using the ratios of total inpatient charges and total outpatient charges to total combined charges, weighted statistics, occasions of service, or other basis with the intermediary's approval.

c. Complete line 12, column 4 of page 2, Form SSA-1563 or line 15, column 4 of Exhibit B, Form SSA-1992. Insert in column 6 the amount representing Medicare ancillary costs. A separate schedule must be attached to support the calculation of this amount as well as a schedule showing the names of the comparable hospitals and the charges used for determining Medicare's share of ancillary service costs.

d. The costs of routine services are apportioned to the program on the relative number of patient days for beneficiaries and for other patients, i.e., an average per diem basis.

e. All other pages of Form SSA-1563 or Form SSA-1992 when applicable will be completed in the usual manner. If separate identifiable charges for outpatient services are not available, comparable hospital data, the hospital's own statistical data, or an average cost per occasion of service may be used for the outpatient cost settlement (page 3, Form SSA-1563 or Exhibit E, Form SSA-1992).

E. Percentage of Per Diem-Method E.--This method of cost apportionment utilizes specified percentages which are applied to average per diem costs for all inpatients as a basis for total Medicare reimbursement. This method may be used where the intermediary is satisfied that the hospital cannot use any of the other methods of apportionment.

The specified percentages are 93 percent for short-term hospitals and 98 percent for long-term hospitals. The distinction between short-term and long-term hospitals is based upon the American Hospitals Association's standard for classifying hospitals (short-term: over 50 percent of all patients admitted stay less than 30 days; long-term: Over 50 percent of all patients stay 30 days or more). All hospitals and separately certified components have been classified accordingly as short-term or long-term (as indicated by the third digit of their provider number).

Application.--Under this method, the hospital must complete pages 1 (or Exhibit A, Form SSA-1992 for reporting periods ending after March 31, 1968) and 4 though 9 of Form SSA-1563. The hospital must also submit cost data on Form SSA-1564 as follows:

1. Determine total allowable costs on pages 1a and 2a, separating inpatient and outpatient expense on a logical basis acceptable to the intermediary.

2. Enter on line 13, column 4, page 3a, Form SSA-1564, 93 percent or 98 percent of the result obtained by multiplying total Medicare patient days by an average per diem rate based on total inpatient allowable costs (SSA-1564, page 1a, line 50, column 4) divided by total inpatient days (SSA-1564, page 3a, line 6, column 4). (For cost reporting periods ending after March 31, 1968, page 3a, Form SSA-1564 is replaced by Exhibit C, Form SSA-1992.)

3. The remainder of Form SSA-1564 will be completed in the usual manner including the calculation of the reimbursement settlement for outpatient services. Where separate identifiable charges for outpatient services are not made, an average cost per occasion of service may be used. (For cost reporting periods ending after March 31, 1968, page 4a, Form SSA-1564 is replaced by Exhibit E, Form SSA-1992.)

2208.2 All-Inclusive Rate or No-Charge Structure Skilled Nursing Facilities.--
The approved methods of apportioning allowable costs between Medicare and non-Medicare patients under the program are not readily adaptable to skilled nursing facilities having an all-inclusive rate (one charge covering all services) or a no-charge rate structure. Therefore, apportionment methods A, D, and E, used by all-inclusive rate or no-charge structure hospitals (§ 2208.1) are to be used by skilled nursing facilities having an all-inclusive rate or no-charge structure, but with minor adaptations being necessary. In the application of these methods, appropriate existing SNF cost reporting forms and instructions are to be used. These methods of apportionment may not be used by SNFs which have a charge structure for individual services rendered.

Method I, described below, is the preferred method and should be used where there is sufficient and usable data available to produce an equitable apportionment of cost. Methods II and III, described below, are considered temporary methods, applicable to cost reporting periods ending before January 1, 1970, and must be approved by the intermediary after considering available data.

A. Departmental Statistical Data-Method I.--This method apportions costs of the various ancillary departments based on statistics which reflect the usage of such services during the reporting period; routine service costs will be apportioned on the basis of inpatient days. Stepdown cost finding techniques are required to be used under this method to determine the respective departmental costs. The cost apportionment for the special service cost centers or ancillary services will be determined by the use of departmental statistical data accumulated through the use of logs or other records. Statistics must be weighted to reflect relative cost values. Since weighting factors may vary among various institutions, the intermediary may approve the use of those factors which in its judgment produce the most equitable results in each situation. Data collected must be reflected to satisfy audit verification. SNFs that did not record such statistics during the first Medicare reporting period may use statistical sampling techniques where approved by the intermediary. However, SNFs that began to record such statistics during the second cost reporting period may use the statistical data gathered in the second period to apportion costs of the first period. In such cases, however, the intermediary must have determined that the procedures followed in gathering the data are proper. Further, the statistics must represent an adequate segment of the period in which gathered, preferably 6 months or longer.

Where the cost of a particular ancillary service is not considered sufficiently significant to treat as a separate cost center, it may be included as a part of routine services. As such, it would be allocated on the basis of an average cost per inpatient day. Where such services are significant, however, adequate procedures must be established for measuring the use of these by Medicare beneficiaries.

An SNF may have an all-inclusive charge structure but for certain specialized services, such as physical therapy or laboratory, may make a separate identifiable charge for services rendered in these departments. Under these circumstances, if the same schedule of charges is used for both Medicare and non-Medicare patients, the ratio of charges to charges may be applied to the cost of those special departments only when statistics are not available. The statistical method of apportionment should be applied to all other departments.

B. Comparable SNF Data-Method II.--This method is the same as stated in §2208.1 under Method D. However, when selecting a comparable SNF, the intermediary should consider the method of providing services (direct or under arrangements) in addition to those mentioned under Method D.

C. Percentage of Average Cost Per Diem-Method III.--Where an intermediary is satisfied that an SNF is unable to use either of the methods of apportionment described above, the intermediary may authorize the SNF to apportion costs on the basis of 98 percent of the average cost per diem based on allowable costs. Under this method total allowable costs should be separated between inpatient and outpatient expenses on a logical basis acceptable to the intermediary. Total allowable expenses applicable to program inpatients is determined by applying 98 percent to the result obtained by multiplying total Medicare patient days by an average per diem rate based on total inpatient allowable costs.

The reimbursement settlement for outpatient services is calculated in the usual manner. Where separate identifiable charges for outpatient services are not made, an average cost per occasion of service may be used.

2208.3 Determining Cost of Inpatient Ancillary Services Covered Under Part B for Medicare Beneficiaries in Hospitals and Skilled Nursing Facilities with All-Inclusive Rate or No-Charge Structure.--The cost of inpatient ancillary services, which are rendered to hospital or skilled nursing facility inpatients and which are covered under Part B when the level of care becomes noncovered or when Part A benefits become exhausted or are otherwise not payable, must be determined in accordance with the provisions of this section. These ancillary services include radiology, pathology, electrocardiology, electroencephalography, physical therapy (effective October 30, 1972), speech pathology (effective January 1, 1973), renal dialysis (effective July 1, 1973), and prosthetic devices, braces and splints covered under the heading of medical supplies.

Section 2208.1, applicable to hospitals, and section 2208.2, applicable to skilled nursing facilities, prescribe the cost apportionment methods for computing the cost of services which are rendered to Medicare inpatients and which are reimbursable under Part A. Accordingly the methodologies to be used in determining reimbursable Part B inpatient ancillary service costs are dependent upon which of the cost apportionment methods available to all-inclusive rate or no-charge structure providers are employed. These methods are described below.

The procedures outlined in this section have not been specifically directed towards the all-inclusive rate and no-charge structure hospital skilled nursing facility complex. Components of these provider complexes should use the apportionment methods which have been approved by the intermediaries within the guidelines of §§ 2208.1-2208.2. In addition, intermediaries shall adapt the procedures outlined in this section to these provider complexes to assure that reimbursement is equitable. In so doing, such providers should use the form SSA-9554 exhibits which are comparable to the exhibits and schedule of forms SSA-1751 cited throughout this section.

A. Departmental Statistical Data-Method A or Method I.--(For use by hospitals or skilled nursing facilities.) Part A ancillary service costs under this apportionment method are determined by use of statistical data accumulated separately for each department.

To determine the Medicare portion of Part B inpatient ancillary service costs, it will be necessary to accumulate Medicare departmental statistical data, using the same bases as those used for the same ancillary services in determining the Part A costs. Such Medicare statistical data will be

applicable to those beneficiaries covered under Part B when Part A benefits are not payable. The ratio of statistics for Medicare Part B inpatients to total statistics for all inpatients, by department, will be applied to the total allowable inpatient cost for that department to determine the cost which is reimbursable under Part B.

Application.--

a. Determine the Medicare portion of allowable inpatient routine and ancillary service costs reimbursable under Part A, as well as outpatient service costs reimbursable under Part B, according to the format outlined for hospitals in § 2208.1 or for skilled nursing facilities in § 2208.2.

b. Use the ratio of Medicare Part B inpatient statistics to total statistics for all inpatients, by department, to determine the Medicare portion for Part B inpatient ancillary costs. Substituting statistics for charges, this determination may be made on Exhibit F of form SSA-1992. Both hospitals and skilled nursing facilities may use Exhibit F.

c. For hospitals, the total amount applicable to Medicare, which is computed on Exhibit F, column 5, line 7, should be inserted on Form SSA-1992, Exhibit E, column 2, line 6a. For skilled nursing facilities, this amount should be added to the amount computed on Form SSA-1751, Schedule D-2, line 5. The caption on this line should be modified to indicate that such costs are included therein. Also, insert the amount computed on Exhibit F, column E, line 7, to the left of the "Part B column" on line 5. Accordingly, the amount appearing in the "Part B column" on line 5 will be the product of line 4 multiplied by line 3, plus the amount entered to left of the "Part B column."

B. Sliding Scale--Method B.--(For use by hospitals only.) Under this method, an adjusted average per diem Part A ancillary cost applicable to Medicare inpatients is determined by applying to the ancillary service average per diem cost a weighted percentage, which takes into account the longer lengths of stay of aged patients.

The following percentages represent the average ratio of inpatient ancillary service costs, which would be reimbursable under Part B when Part A benefits are not available, to total inpatient ancillary service costs.

All Hospitals Except Psychiatric	45%
Psychiatric	48%

The reimbursable Part B ancillary cost applicable to Medicare inpatients shall be the appropriate percentage times the adjusted average per diem Part A ancillary cost for Medicare inpatients.

Assuming the provider is a short-term hospital, the following illustrates this method for computing the Part B inpatient ancillary service:

Total allowable inpatient ancillary costs	$200,000
Total patients days	10,000
Total Medicare Part B inpatients days	500
Average length of stay - all inpatients	8 days
Average length of stay - Medicare inpatients	13 days

(1) Average per diem ancillary cost, all inpatients:
$200,000) 10,000 + $20 per day

(2) Weighted percentage (not to exceed 100%) (see Method B outlined in § 2208.1):

8 days x 100% = 800%
5 days x 75% = 375%
13 1,175%

1,175% (total weighted value) ÷ 13 (average length of stay--Medicare inpatients) = 90.38%

(3) Average per diem ancillary cost reimbursable under Part A for Medicare inpatients: $20 per diem x 90.38% = $18.076

(4) $18.076 per diem x 45% (applicable rate) x 500 Part B inpatient days = $4,067 Medicare Part B inpatient ancillary cost.

Application.--

a. Determine the Medicare portion of allowable inpatient routine and ancillary service costs reimbursable under Part A, as well as outpatient service costs reimbursable under Part B according to the format outlined in § 2208.1.

b. Complete Form SSA-1992, Exhibit E, in the normal manner. The amount to be entered in column 2, line 6.a is to be determined in accordance with the example shown above. A separate schedule must be attached to support the calculation of this amount.

C. Descending Rates of Charges-Method C.--(For use by hospitals only.) Under this method, the total length of stay for each patient is divided into classes, each representing a progressive part of the patient stay. The total Part A days of each class multiplied by the provider's allowable average per diem cost, inclusive of both routine and ancillary service costs. The resulting amounts are then factored by the appropriate descending rates of charges for various length of stay classifications.

With respect to Part B inpatient ancillary services, the same computations will be made, except that Part B inpatient days will be used instead of Part A days. In this computation, the Part B days classified in relation to the total patient stay. For purposes of Part B days classification, the length of stay should not be recomputed to indicate a new length of stay after the patient's Part A days shave been exhausted, i.e., if a patient exhausted his Part A benefits on the 10th day of the stay, the 11th day, when Part B benefits only are available, would also be considered the 11th day of classification purposes. In addition, after completing these computations, the appropriate percentage, furnished below, will be applied to the total amount computed. The resulting amount will represent the Part B inpatient ancillary service cost applicable to Medicare.

The following percentages represent the average of inpatient ancillary service costs, which would be reimbursable under Part B when Part A benefits are not available, to total costs of all inpatient services - ancillary and routine.

All Hospitals Except Psychiatric	16%
Psychiatric	6%

Assuming the provider is a psychiatric hospital, the following illustrates this method:

A	B	C	D	E
Medicare Patient Stay	Number of Part B Days	Total Allowable Average Per Diem Cost	Descending Rate	Total Cost BxCxD
1st - 3rd day	50	$20	120%	$1,200
4th - 9th day	100	$20	100%	2,000
After 9th day	150	$20	65%	1,950
	300			$5,150

$5,150 x 6% (percentage of Part B inpatient ancillary service costs to total cost of all inpatient services for psychiatric hospitals) = $309 Part B inpatient ancillary cost applicable to Medicare.

Application.--

a. Determine the Medicare portion of allowable inpatient routine and ancillary service costs reimbursable under Part A, as well as outpatient service costs reimbursable under Part B, according to the format outlined in §2208.1.

b. Complete Form SSA-1992, Exhibit E, in the normal manner. The amount to be entered in column 2, line 6a, is to be determined in accordance with the example shown above. A separate schedule must be attached to support the calculation of this amount.

D. Comparable Hospital or Skilled Nursing Facility Data-Method D or Method II.--(For use by hospitals or skilled nursing facilities.) Reimbursable Part A ancillary cost applicable to Medicare inpatients is computed by applying the percentage of Medicare Part A ancillary service utilization (based on charges) for all comparable providers to total ancillary service costs.

Similarly, reimbursement for Part B inpatient ancillary services will be determined based on charge data of comparable providers by applying to the provider's allowable inpatient ancillary service costs, the ratio of Medicare Part B inpatient ancillary charges for all comparable providers over total ancillary charges--all inpatients for all comparable providers.

This method is illustrated as follows:

(1) Medicard be modified to indicate that such costs are included therein. Also, insert this amount to the left of the "Part B column" on line 5. Accordingly, the amount appearing in the "Part B column" of line 5 will be the product of line 4 multiplied by line 3 plus the amount entered to the left of the "Part B column."

This method is illustrated as follows:

(1) Medicare Part B Inpatient Ancillary Charges - All Comparable Providers / Total Inpatient Ancillary Charges - All Comparable Providers = $ 240,000 / 12,000,000 = 2%

(2) All-inclusive provider's total inpatient ancillary costs = $200,000

(3) $200,000 x 2% = $4,000 (Part B inpatient ancillary service cost applicable to Medicare)

Application.--

a. Determine the Medicare portion of allowable inpatient routine and ancillary service costs reimbursable under Part A, as well as outpatient service costs reimbursable under Part B, according to the format outlined for hospitals in §2208.1, or as adapted to skilled nursing facilities in §2208.2

b. The amount representing Medicare Part B inpatient ancillary service costs should be inserted on Form SSA-1992, Exhibit E, column 2, line 6. a for hospitals. For skilled nursing facilities, this amount should be added to the amount computed on Form SSA-1751, Schedule D-2, line 5. The c option on this line should be modified to indicate that such costs are included therein. Also, insert this amount to the left of the "Part B column" on line 5. Accordingly, the amount appearing in the "Part B column" of line 5 will be the product of line 4 multiplied by line 3 plus the amount entered to the left of the "Part B column."

c. A separate schedule must be attached to support the calculation of the amount representing Medicare Part B inpatient ancillary service costs, as well as a schedule showing the names of the comparable hospitals Medicare's share of these costs. The comparable hospitals or skilled nursing facilities must be the same ones used in computing Medicare utilization for Part A inpatient ancillary service costs.

E. Percentage of Per Diem--Method E or Method III.--(for use by hospitals or skilled nursing facilities.) Under this method, reimbursable cost applicable to Medicare inpatients under Part A is determined by applying 93 percent (short-term hospitals) or 98 percent (long-term hospitals and all skilled nursing facilities) to the product of the average per diem cost, including routine and ancillary service costs, multiplied by Medicare Part A inpatient days.

The following percentages represent the average ratio of inpatient ancillary service costs, which would be reimbursable under Part B when Part A benefits are not available, to total costs of all inpatient services - ancillary and routine.

All Hospitals Except Psychiatric	16%	
Psychiatric	6%	
Skilled Nursing Facilities	2.5%	(Effective cost reporting periods beginning after July 31, 1977)

Reimbursable Part B ancillary cost applicable to Medicare inpatients may be determined by applying 93 percent (short-term hospitals) or 98 percent (long-term hospitals and all skilled nursing facilities) to the product of the average per diem cost, including routine and ancillary service costs, multiplied by Medicare Part B inpatient days. The applicable percentage of Part B inpatient ancillary service costs to total inpatient costs as set forth above, will be applied to the resulting amount. This will represent the Part B inpatient ancillary service cost applicable to Medicare.

Application.--

a. Determine the Medicare portion of allowable inpatient routine and ancillary service costs reimbursable under Part A, as well as outpatient service costs reimbursable under Part B, according to the format outlined for hospitals in § 2208.1, or as adapted to skilled nursing facilities in § 2208.2.

b. Hospitals should complete Form SSA-1992, Exhibit E, in the normal manner. The amount to be entered in column 2, line 6a is to be determined in accordance with these instructions. A separate schedule must be attached to support the calculation of this amount.

c. For skilled nursing facilities, the Part B inpatient ancillary service cost should be added to the amount computed on Form SSA-1752, Schedule D, line 5. The caption on this line should be modified to indicate that such costs are included therein. Also, insert this amount to the left of the "Part B column" on line 5. Accordingly, the amount appearing in the "Part B column" of line 5 will be the product of line 4 multiplied by line 3, plus the amount entered to the left of the "Part B column." A separate must be attached to support the calculation of this amount.

The percentages employed in the above computations are the same percentages employed in the computation of the inclusive charges for the Part B inpatient ancillary services. The percentages cited under the various apportionment methods are to be used until new percentages are provided. The Health Care Financing Administration will also review the feasibility of using percentages which are related to hospitals classified by average length of stay. Such hospital classifications would be similar to previous program instructions which pertained to the application of the reimbursement provision of renal dialysis and the reasonable cost limits in the all-inclusive rate and no-charge structure provider setting.

The Medicare Part B inpatient days referred to in this section are those days applicable to inpatients who have Part B coverage and who have exhausted or are otherwise not eligible for benefits under Part A.

Any payments made by Medicare beneficiaries to providers for such Part B inpatient ancillary services which are billable to and reimbursable by the Health Insurance Program under these guidelines must be refunded to the beneficiaries.

2209. APPORTIONMENT OF ALLOWABLE RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

The Medicare program provides as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers, an allowance of a reasonable return on equity capital invested and used in the provision of patient care. (See Chapter 12 of definition and application of this return on equity capital.)

Forms.--The following schedules or exhibits shall be used by proprietary providers for the apportionment of the allowable return on equity capital to the health care program.

Type of Providers	Schedule or Exhibit	SSA Form
Hospitals	Page 13	1563
Hospital, Hospital-based Skilled Nursing Facility and Hospital-based Home Health Agency	Exhibit XIII	9554

Instructions for the completion of these schedules and exhibits are included with the forms.

Cost Apportionment - Part B Services

2210. METHOD OF OUTPATIENT COST APPORTIONMENT
(See § 2212, Method of Cost Apportionment for Part B Inpatient Services.) Under this method, the cost of outpatient services used is determined by apportioning the total cost of outpatient services on the basis of the ratio of beneficiary charges for outpatient services to total patient charges for such services.

A. Hospital Outpatient Cost Apportionment for Cost Reporting Periods Ending Before April 1, 1968.--Under the Medicare program prior to April 1, 1968, hospitals provided two distinct types of services to outpatients, namely:

1. services that are diagnostic in nature, and

2. other services which aid the physician in the treatment of his patient.

The outpatient hospital diagnostic services are covered under Part A. All other hospital services provided on an outpatient basis which are incident to physicians' services rendered to outpatients are covered under Part B.

3. Example.--The following illustrates how apportionment based on the ratio of beneficiary charges to total charges applied to cost would be determined for cost reporting periods ending before April 1, 1968, using only outpatient data.

Hospital A

Ratio of charges to charges (gross) applied to cost	Outpatient Services Hospital Plan Part A	Outpatient Services Medical Plan Part B
a. Total amount of outpatient charges (gross) for all outpatients	$100,000	$100,000
b. Total amount of outpatient charges (gross) for health insurance program outpatients	$ 14,000	$ 10,000
c. Percent of health insurance program outpatient charges to total gross charges (Line b ÷ Line a)	14%	10%
d. Total amount of hospital expenses for outpatient services	$ 80,000	$ 80,000
e. Outpatient expenses applicable to health insurance program (Line c x Line d)	$ 11,200	$ 8,000

4. Forms.--The following schedules or exhibits shall be used by hospitals with cost reporting periods ending before April 1, 1968.

Type of Provider	Schedule or Exhibit	SSA Form	Comments
Hospitals	Page 3	1563	For hospitals using Departmental RCC or Combination Method with Cost finding
	Page 4a	1564	For hospitals using Combination Method-Estimated Percentage Basis
	Page 4b	1564A	For hospitals using Gross RCC basis

Instructions for the completion of these exhibits are included with the forms.

B. Hospital Outpatient Cost Apportionment for cost Reporting Periods Ending after March 31, 1968.--Effective April 1, 1968, hospital outpatient diagnostic services are covered under Part B rather than Part A. Thus, all covered outpatient services furnished to Medicare beneficiaries on or after April 1, 1968, are reimbursable under Part B.

1. Example.--The following illustrates how apportionment based on the ratio of beneficiary charges to total charges applied to cost would be determined for cost reporting periods ending after March 31, 1968, using only outpatient data.

Hospital A

Ratio of charges to charges (gross) applied to cost	Outpatient Services Medical Plan Part B
a. Total amount of outpatient charges (gross) for all patients	$200,000
b. Total amount of outpatient charges (gross) for health insurance program outpatients	$ 24,000
c. Percent of health insurance program outpatient charges to total gross charges (Line b ÷ Line a)	12%
d. Total amount of hospital expenses for outpatient services	$160,000
e. Outpatient expenses applicable to health insurance program (Line c x Line b)	$ 19,200

2. Forms.--The following exhibits shall be used by providers with cost reporting periods ending after March 31, 1968.

Type of Provider	Schedule or Exhibit	SSA Form	Comments
Hospitals	Exhibit E	1992	To be used by hospitals in lieu of forms shown in § 22104A above

Hospitals Hospital-based Skilled Nursing Facility and/or hospital-based Home Health Agency	Exhibit III	9554

Instructions for the completion of these exhibits are included with the forms.

C. Skilled Nursing Facility Outpatient Cost Apportionment.--Skilled nursing services provided on an outpatient basis are covered under Part B.

1. Illustration.--See § 2210B1 above.

2. Forms.--The following schedules or exhibits shall be used by skilled nursing facilities:

Type of Provider	Schedule or Exhibit	SSA Form
Skilled Nursing Facilities	Schedule D2	1751
	Schedule D	1752
	Schedule D	1753
Hospital-based Skilled Nursing Facility	Exhibit III-A	9554

Instructions for the completion of these schedules and exhibits are included with the forms.

2211. OUTPATIENT PHYSICAL THERAPY PROVIDER REIMBURSEMENT

Form SSA-2088, Outpatient Physical Therapy Provider Statement of Reimbursable Cost, provides for the determination of allowable outpatient physical therapy costs for services provided on or after July 1, 1968, which are reimbursable under title XVIII, Part B. These schedules are to be used only by rehabilitation agencies, clinics, and public health agencies which have been certified as outpatient physical therapy providers. (See the Outpatient Physical Therapy Provider Manual - HIM-9.)

The cost of services rendered to beneficiaries may be determined under one of three Departmental Methods - using cost finding with cost apportionment based on (1) gross charges; (2) weighted units of services; or (3) number of visits. These methods are described below.

A. The gross charges method is the ratio of health insurance program physical therapy charges total physical charges - all patients - applied to total allowable physical therapy costs.

B. The weighted units of services method is the ratio of health insurance program weighted units of physical therapy service to total weighted physical therapy units of service - all patients - applied to total allowable physical therapy costs. Any method used by the provider to determine the weighted units of physical therapy services rendered Medicare beneficiaries and others must have prior approval of the intermediary/carrier.

C. The number of visits method is the ratio of health insurance program physical therapy patient visits to total physical therapy visits - all patients - applied to total allowable physical therapy costs. (This method may be used only if the intermediary/carrier determines that the data needed for Methods A or B above are not available.)

For cost reporting periods ending after June 30, 1970, one of the above methods of costs apportionment must be used. For periods ending prior to July 1, 1970, if the intermediary/carrier determines that the data needed for Methods A, B, or C above are not available, it may authorize the provider to use an alternative, temporary cost apportionment method (composite cost per visit) which is described in the instructions to cost report Form SSA-2088.

For computing reimbursement settlement, the data applicable to health insurance patients must be the same as the data for all other patients for the same services, i.e., the same schedule of charges, weighted units or visits must be applied to all patients and to health insurance program patients.

2212. METHOD OF COST APPORTIONMENT FOR PART B INPATIENT SERVICES (See § 2210, Method of Outpatient Cost Apportionment.) Effective April 1, 1968, beneficiaries enrolled under Part B of title XVIII who are inpatients of participating hospitals and skilled nursing facilities may receive certain medical and other health services under supplementary medical insurance if the services are not reimbursable on the patient's behalf under the hospital insurance plan (Part A). For example, a participating hospital may be reimbursed, subject to the Part B deductible and coinsurance amounts, for diagnostic laboratory and radiology services, etc., and prosthetic devices braces and splints covered under the heading of Medical Supplies for an inpatient who is not eligible for hospital insurance (Part A) benefits in a spell of illness.

A. Departmental Method.--For those providers using the Departmental RCCAC Method, the following illustrates how apportionment based on the

ratio of covered beneficiary charges to total charges applied to cost on a departmental basis would be determined for cost reporting periods ending after March 31, 1968, using only inpatient data.

Department	(1) Total Inpatient Charges to all Patients	(2) Part B Inpatient Charges to Program Bene-ficiaries	(3) Ratio of Part B Charges to Total Charges Col. 2 + Col. 1	(4) Total Inpatient Expenses	(5) Cost of Part B Inpatient Services Col. 4 x Col. 3
X-ray	$ 73,438	$1,498	2.04%	$ 71,422	$1,457
Laboratory	183,587	2,935	1.60%	150,096	2,402
Medical Supplies	38,696	653	1.69%	58,627	991
Total					$4,850

Forms.--The following schedules or exhibits shall be used by providers electing this method.

Type of Provider	Schedule or Exhibit	SSA Form
Hospitals	Exhibit F	1992
Skilled Nursing Facilities	Exhibit V-A	9554
Hospital and Hospital-based Skilled Nursing Facilities	Exhibits V and V-A	9554

Instructions for the completion of these exhibits are included with the forms.

B. Combination Method.--For those providers using the Combination Method, the following illustrates how apportionment based on the ratio of total covered inpatient charges for Part B ancillary services to beneficiaries to the total inpatient ancillary charges to all inpatients would be determined for cost reporting periods ending after March 31, 1968, using only inpatient data.

1. Using Cost Finding.--

Department	(1) Total Inpatient Charges to all Patients	(2) Part B Inpatient Charges to Program Bene-ficiaries	(3) Ratio of Part B Charges to Total Charges Col. 2 + Col. 1	(4) Total Inpatient Expenses	(5) Cost of Part B Inpatient Services Col. 4 x Col. 3
X-ray	$ 62,238	$1,498	-----	$ 61,400	$------
Laboratory	83,587	2,935	-----	50,096	------
Medical Supplies	38,696	653	-----	58,627	------
Other	111,200	0	-------	110,022	------
Totals	$295,721	$5,086	1.72%	$280,145	$4,818

Forms.--See § 2212A.

2. Using Estimated Percentages.--Where the intermediary determines that a provider is unable to make the unnecessary computations by cost finding methods as indicated in Chapter 23, the intermediary will estimate the appropriate percentage of the provider's allowable costs that represents routine service costs and the appropriate percentage that represents ancillary service costs. These percentages are to be based upon study, analysis, and judgment by the intermediary and designed to approximate the result that a cost-finding method would have produced for the particular provider. This temporary method, estimated percentages, may be used at the option of the provider for cost reporting periods ending before January 1, 1968, and with the approval of the intermediary for cost reporting periods ending after December 31, 1967, but before January 1, 1969. For subsequent periods, ending after December 31, 1968, the use of cost-finding methods as described in Chapter 23 are required for the apportionment of allowable costs.

Financial Data:

a. Estimated amount of inpatient expenses allocable to ancillary services $1,507,827

b. Total gross ancillary charges -
   (1) All inpatients $1,592,701
   (2) Program inpatients-title XVII, Part B 10,618

c. Percent of gross ancillary charges, program inpatients title XVIII, Part B - Line b(2) + Line b(1) .67%

d. Amount of ancillary service expense applicable to program inpatients-title XVIII, Part B Line c x Line a $10,102

Forms.--The following schedules or exhibits shall be used by providers which the intermediary determines are unable to perform cost finding.

Type of Provider	Schedule or Exhibit	SSA Form
Hospitals	Exhibit G (Part 1)	1992
Skilled Nursing Facilities	Page 6	9555
Hospitals and hospital-based Skilled Nursing Facilities	Pages 4 & 6	9555

Instructions for the completion of these exhibits are included with the forms.

C. Temporary Method of Apportionment (Gross RCCAC) for Cost Reporting Periods Ending Before January 1, 1969.--The intermediary may find that a provider is unable to apply either the Departmental Method or the Combination Method employing cost finding or estimated percentages. In such cases, the intermediary can authorize the provider to use, on a temporary basis, an apportionment based on the ratio of beneficiary inpatient charges to total inpatient charges applied to the total cost of all services. This would permit the provider time to establish the records necessary for applying either of the basic alternative methods of apportionment in the next cost reporting period. This method may not, however, be used by hospitals which have all-inclusive rates, or no-charge structure. (See §§ 2208ff.)

In some cases, the intermediary may determine that a provider is unable to employ this temporary method of apportionment based on the ratio of beneficiary inpatient charges total inpatient charges applied to total inpatient cost. In such cases, any other method determined by the intermediary to be reasonable may be used on a temporary basis. Any temporary method of apportionment may not be used to cover cost reporting periods ending on or after January 1, 1969.

Computation of inpatient ancillary services covered by supplementary medical insurance will be made as follows:

Financial Data:

Inpatient Services			
1.	Total allowable inpatient cost		$3,769,568.00
2.	Total inpatient charges	$4,101,584	
3.	Part B charges to program inpatients	10,618	
4.	Percent program inpatient charges to total inpatient charges Line 3 + Line 2		.26%
5.	Amount of cost applicable to Medicare program Line 1 x Line 4		$ 9,801.00

Forms.--The following schedules or exhibits shall be used by providers authorized to use this method.

Type of Provider	Schedule or Exhibit	SSA Form
Hospitals	Exhibit G (Part III)	1992
Skilled Nursing Facilities	Page 6	9556
Hospitals and hospital-based Skilled Nursing Facilities	Pages 4 & 6	9556

Instructions for the completion of these exhibits are included with the forms.

2213. APPORTIONMENT OF REMUNERATION FOR PROFESSIONAL SERVICES RENDERED BY HOSPITAL-BASED PHYSICIANS

After March 31, 1968, hospitals with the approval of the intermediary may combine the billing for certain hospital and physician (professional) services to patients. Hospitals may utilize this combined billing method for the inpatient services rendered by hospital-based radiologists and pathologists, and for the outpatient services rendered by all hospital-based physicians except for those providing psychiatric services. In the case of radiology and/or pathology, all of the physicians in these departments must agree to combine billing for both inpatient services before this method may be used. In the case of all other physicians providing outpatients services, all physicians in a particular medical specialty department must agree tot he use of combined billing for outpatient services in that department. Physicians in other medial specialty departments in the hospital do not have to approve it.

When the combined billing method is used, the total remuneration applicable to the physician (professional) services rendered to patients must

be apportionment to the program on the basis of the ratio of charges applicable to individuals covered under the program to total charges of all patients applied to total remuneration for professional services.

Total remuneration includes direct compensation paid to the hospital-based physician plus the cost of all applicable fringe benefits, perquisites and maintenance (see § 2108), and must agree with the reduction for professional services made to total expenses. (See § 2328E.)

The following example illustrates how apportionment based on the ratio of beneficiary charges to total charges applied to professional remuneration on a departmental basis would be determined for cost reporting periods starting after march 31, 1968.

		(1) Charges	(2) Ratio to Total Charges	(3) Cost Col. 2 x Line 1 Col. 3
1.	Remuneration to hospital-based pathologist	----	----	$35,344
2.	Charges to beneficiaries-in-patient	$ 81,167	26.18%	$ 9,253
3.	Charges to all other inpatients	213,366	68.82%	24,320
4.	Charges to beneficiaries-out-patient	930	.30%	110
5.	Charges to all other outpatient	14,572	4.70%	1,661
	Totals for beneficiaries and all other patients	$310,035	100.00%	$35,344

Forms.--The following schedules or exhibits shall be used by providers utilizing the combined billing method to apportion remuneration for professional services.

Type of Provider	Schedule or Exhibit	SSA Form
Hospitals	Exhibit H & H-1	1992
Hospital, Hospital-based Skilled Nursing Facility	Exhibit VI & VI-A	9554

Instructions for the completion of these exhibits are include with the forms.

2214. OPTIONAL CALCULATION OF PERCENTAGE OF BAD DEBTS FOR OUTPATIENT SERVICES APPLICABLE TO PROFESSIONAL COMPONENT OF HOSPITAL-BASED PHYSICIANS - COMBINED BILLING

Bad debts for deductible and coinsurance amounts attributable to the professional component services of hospital-based physicians are not an allowable cost under the health insurance program. Therefore, where providers do not maintain separate bad debt records for physicians' professional services and for provider service, providers may compute the percentage relationship of Medicare outpatient professional component charges to total Medicare outpatient combined charges for professional component and for provider services as follows:

1.	Bad debts for deductibles and coinsurance-physician and provider	$ 224
2.	Total combined outpatient charges applicable to Medicare. (Includes provider services and professional component services of hospital-based physicians.	17,549
3.	Outpatient professional component charges of hospital-based physicians applicable to Medicare	304
4.	Percentage of Medicare outpatient professional component charges to total Medicare outpatient combined charges (Line 3 ÷ Line 2)	1.73%
5.	Bad debts applicable to professional component and unallowable under Medicare program (Line 4 x Line 1)	$ 4

Forms.--The following exhibits shall be used by providers to calculate bad 0debts under this method.

Type of Provider	Exhibit - SSA Form
Hospitals	Exhibit E-1 1992
Hospital, Hospital-based Skilled Nursing Facility	Exhibit IV 9554

Instructions for the completion of these exhibits are included with the forms.

2215. COST APPORTIONMENT OF AMBULANCE SERVICES RENDERED BY PROVIDERS

Ambulance services rendered to Medicare beneficiaries enrolled under Part B-supplemental medical insurance plan - are reimbursable on a reasonable cost basis.

Providers should set up a cost center for ambulance service and all appropriate overhead costs applicable to this center, should be

allocated through the cost-finding process. The total cost for ambulance service should be apportioned to the program based on the ratio of beneficiary charges to total charges as follows:

1.	Total gross charges for ambulance service-all patients	$1,339
2.	Gross charges applicable to Medicare patients	$176
3.	Ratio of program charges to total charges (Line 2 ÷ Line 1)	13.14%
4.	Total ambulance service costs applicable to all patients	$1,370
5.	Costs applicable to Medicare program (Line 3 x Line 4)	$180

Forms.--The following exhibits shall be used by providers to allocate ambulance service costs to the program.

Type of Provider	Exhibit	SSA Form
Hospitals	Exhibit I	1992
Hospital, Hospital-based Skilled Nursing Facility and/or Hospital-based Home Health Agency	Exhibit VIII	9554

Instructions for the completion of these exhibits are included with the forms.

2216. CALCULATION OF REIMBURSEMENT FOR THE SERVICES OF INTERNS AND RESIDENTS NOT UNDER APPROVED TEACHING PROGRAM

Services performed for inpatients and outpatients by interns and residents who are not under approved teaching programs are reimbursable to the provider on a reasonable cost basis under the supplementary medical insurance plan - Part B. The Part B deductible will not be applicable when using billing Form SSA-1453 (Inpatient Hospital and Skilled Nursing Facility Admission and Billing) but will be applicable when using billing Form SSA-1482 (Provider Billing for Medical and Other Health Services). Interim reimbursement for the costs of these services rendered to both inpatients and outpatients is made by the Part A intermediary.

Providers should set up a cost center with the direct costs for these intern and resident services and allocate through the cost-finding processes all appropriate overhead costs applicable to such services. Then, the total cost for these interns and residents not under an approved teaching program should be allocated between inpatient services and outpatient services on the basis of time spent by interns and residents in each of these areas.

The cost of inpatient services rendered by these interns and residents for program beneficiaries is determined on the basis of an average cost per diem. The cost of outpatient services for beneficiaries is apportioned to the program based on the ratio of the sum of program Part A and Part B outpatient charges to total outpatient charges for all patients applied to the cost of the intern and resident services. The costs of all outpatient services furnished beneficiaries after March 31, 1968, are reimbursed under Part B. (See also §2120, Reimbursement for Costs of Interns and Residents.)

Forms.--The following schedules or exhibits shall be used by providers with interns and residents not under an approved teaching program.

Type of Provider	Exhibit	SSA Form
Hospitals	Exhibit J	1992
Hospital, Hospital-based Skilled Nursing Facility and/or Hospital-based Home Health Agency	Exhibit IX AND IX-A	9554

Instructions for the completion of these exhibits are included with the forms.

Special Care Units Providing General Care

2217. REIMBURSEMENT FOR HOSPITAL SPECIAL CARE UNITS (INTENSIVE CARE UNIT [ICU], CORONARY CARE UNIT [CCU], ETC.) THAT PROVIDE GENERAL ROUTINE CARE

One of the requirements for recognition of a hospital special routine care unit is that it must be physically identifiable as separate from general routine care areas and render only special routine care. Medicare will reimburse for special care services at the special routine care rate when appropriate.

Where a hospital places general care patients temporarily in special care units because all beds available for general care patients are occupied, the Medicare program will still consider such special care units ass meeting the program requirement of being physically separate.

For purposes of Medicare reimbursement, the days for the general care patients placed in the special care units will be counted as special care days and not as general care days in determining the average per diem for the special care unit(s). Medicare will reimburse for special care services at that rate. However, where Medicare patients requiring

only general care are placed in the special care units, the program will reimburse only at the level of cost associated with general inpatient routine care. The excess resulting from the difference between the higher level of cost for special care and the level of cost for general inpatient routine care would represent nonreimbursable standby costs. Program charges for these patients should reflect the general level of routine care.

The hospital must be able to furnish sufficient documentation to satisfy the intermediary that only overflow general care patients are being placed in the special care units.

Physicians' Services in Teaching Hospitals

2218. AGGREGATE PER DIEM METHODS OF APPORTIONMENT FOR PHYSICIANS' DIRECT MEDICAL AND SURGICAL SERVICES RENDERED IN A TEACHING HOSPITAAL IN THE CARE OF INDIVIDUAL PATIENTS (INCLUDING SUPERVISION OF INTERNS AND RESIDENTS RENDERING SUCH SERVICES)

A. Aggregate Per Diem Method of Apportionment for the Costs of Physicians' Direct Medical and Surgical Services in the Care of Individual Patients (Including Supervision of Interns and Residents Rendering Such Services).--The cost of physicians' direct medical and surgical services rendered in a teaching hospital to Medicare patients is determined on the basis of an average cost per diem as defined in subparagraph C1 of this section for physicians' direct medical and surgical services to all patients in each of the following categories of physicians:

1. Physicians on the hospital staff

2. Physicians on the medical school faculty

B. Aggregate Per Diem Method of Apportionment for the Imputed Value of Physicians" Volunteer Direct Medical and Surgical Services in the Care of Individual Patients (Including Supervision of Interns and Residents Rendering Such Care).--The imputed value of physicians' direct medical and surgical services, including supervision of interns and residents in the care of individual patients, rendered in a teaching hospital to Medicare patients is determined on the basis of an average per diem as defined in subparagraph C1 of this section for physicians' direct medical and surgical services to all patients except that the average per diem will be derived from the imputed value of physicians' volunteer direct medical and surgical services rendered to all patients.

C. Definitions.--

1. Average Cost Per Diem For Physicians' Direct Medical and Surgical Services Rendered in a Teaching Hospital in the Care of

Individual Patients (Including Supervision of Interns and Residents Rendering Such Services).--Average cost per diem for physicians' direct medical and surgical services, including supervision of interns and residents in the care of individual patients, rendered in a teaching hospital to patients in each category of physicians' services as described in subparagraphs A1 and A2 of this section means the amount computed by dividing total reasonable costs of such services in each category by the sum of:

a. Inpatient days (as defined in item 2 which follows), and

b. Outpatient visit days (as defined in item 3 which follows).

2. Inpatient Days.--Inpatient days will be determined by counting the day of admission as 3.5 days and each day subsequent to a patient's day of admission, omitting the day of discharge, as 1 day.

3. Outpatient Visit Days.--Outpatient visit days will be determined by counting one visit day for each calendar day that a patient visits the outpatient department. Where the hospital does not accumulated the data necessary to make such a determination, the following alternative methods may be used to establish outpatient visit days:

a. Divide the hospital's total inpatient charges by the total inpatient days to develop an average inpatient charge per day; then divide this average inpatient charge per day into the total outpatient charges to derive the number of equivalent patient days attributable to outpatient visits.

FACTS:

Total inpatient charges	$800,000
Total inpatient days	8,000
Total outpatient charges	$200,000

COMPUTATION:

$800,000 ÷ 8,000 = $100 average inpatient charge per day

$200,000 ÷ $100 = 2,000 outpatient visit days

b. From the hospital's outpatient records for each completed cost reporting period, a proper sample size covering a representative period of time should be determined. For each day within the sample period, divide the hospital's total outpatient occasions of service by the total number of outpatients (counting each outpatient only once)

to develop an average occasions of service per day per patient. Add up the average occasions of service per day per patient for all days within the sample period and divide this total by the number of days in the sample period; then divide the resultant average occasions of service per day per patient for the sample period into the total outpatient occasions of service for the cost reporting (obtained from the cost report) to derive the total number of estimated outpatient visit days to be added to inpatient days in the determination of the average cost per diem. To derive the Medicare outpatient visit days used in calculating Medicare reimbursable costs, divide the Medicare outpatient occasions of service (obtained from the cost report) by the average occasions of service per day for all patients.

FACT:

Sample Period 1/	Total Outpatient Occasions of Service	Total Number of Outpatients
First Day	2,100	700
Second Day	1,500	300
Third Day	1,600	400
Total outpatient occasions of service for cost reporting period		20,000
Medicare outpatient occasions of service for cost reporting period		6,000

1/ Abbreviated sample size for illustrative purposes only.

COMPUTATION:

2,100 ÷ 700 = 3 average occasions of service per day per patient

1,500 ÷ 300 = 5 average occasions of service per day per patient

1,600 ÷ 400 = 4 average occasions of service per day per patient
12 Total

12 ÷ 3 days = 4 average occasions of service per day per patient for the sample period

20,000 ÷ 4 = 5,000 total outpatient visit days

6,000 ÷ 4 = 1,500 Medicare outpatient visit days

D. Application.--

1. Illustrative Example of the Aggregate Per Diem Method for the Costs of Physicians' Direct Medical and Surgical Services Rendered to Patients in a Teaching Hospital.--

TEACHING HOSPITAL Y

Statistical and Financial Data:

Total inpatient days as defined in §2218C3 and Outpatient visit days as defined in §2218C3	75,000
Total inpatient Part A days applicable to Medicare patients	20,000
Total inpatient Part B days applicable to Medicare patients where Part A coverage is not available	1,000
Total outpatient Part B visit days applicable to Medicare patients	5,000
Total cost of direct medical and surgical services rendered to all patients by physicians on the hospital staff as determined in accordance with § 2148.4	$1,500,000
Total cost of direct medical and surgical services rendered to all patients by physicians on the medical school faculty as determined in accordance with § 2148.4	$1,650,000

Computation of Cost Applicable to Program for Physicians on the Hospital Staff:

Average cost per diem for direct medical and surgical services to patients by physicians on the hospital staff: $1,500,000 ÷ 75,000 = $20 per diem

Cost of physicians' direct medical and surgical services rendered to Medicare inpatients covered under Part A: $20 per diem x 20,000 ..... $400,000

Cost of physicians' direct medical and surgical services rendered to Medicare inpatients covered under Part B: $20 per diem x 1,000 ..... $ 20,000

Cost of physicians' direct medical and surgical services rendered to Medicare outpatients covered under Part B: $20 per diem x 5,000 ..... $100,000

Computation of Cost Applicable to Program for Physicians on the Medical School Faculty:

Average cost per diem for direct medical and surgical services to patients by physicians on the medical school faculty: $1,650,000 ÷ 75,000 = $22 per diem

Cost of physicians' direct medical and surgical services rendered to Medicare inpatients covered under Part A: $22 per diem x 20,000 ..... $440,000

Cost of physicians' direct medical and surgical services rendered to Medicare inpatients covered under Part B: $22 per diem x 1,000 ..... $ 22,000

Cost of physicians' direct medical and surgical services rendered to Medicare outpatients covered under Part B: $22 per diem x 5,000 ..... $110,000

2. Illustrative Example of the Aggregate Per Diem Method for the Imputed Value of Physicians' Volunteer Direct Medical and Surgical Services Rendered to Medicare Patients in a Teaching Hospital.--The physicians on the medical staff of Teaching Hospital Y donated a total of 5,000 hours in rendering direct medical and surgical services to patients of the hospital during a cost reporting period; and did not receive any compensation from either the hospital or the medical school. Also, the imputed value for any physician's volunteer services did not exceed the rate of $30,000 per year per physician. The total salaries paid to the full-time salaried physicians of the hospital (excluding interns and residents) for services rendered in the hospital during that period were $800,000. The hospital employed a total of 20 physicians who were paid for an average of 40 hours per week or 2,080 (52 weeks x 40 hours per week) hours per year.

Computation of Total Imputed Value of Physicians' Volunteer Services Applicable to all Patients:

Total salaries paid $800,000

Average hourly rate equivalent: $800,000 ÷ 41,600 (2,080 hours x 20 physicians) $19.23

Total imputed value of physicians' volunteer services applicable to all patients: Donated hours x average hourly rate equivalent - 5,000 x $19.23 ..... $96,l50

Statistical and Financial Data:

Total inpatient days (as defined in §2218C2) and outpatient visit days (as defined in §2218C3)	75,000
Total inpatient Part A days applicable to Medicare patients	20,000
Total inpatient Part B days applicable to Medicare patients where Part A coverage is not available	1,000
Total outpatient Part B visit days applicable to Medicare patients	5,000

Computation of Imputed Value of Physicians' Volunteer Direct Medical and Surgical Services Applicable to Medicare Patients:

Average per diem for physicians' direct medical and surgical services to patients: $96,160 ÷ 75,000 = $1.28 per diem

Imputed value of physicians' direct medical and surgical services rendered to Medicare patients covered under Part A: $1.28 per diem x 20,000 ..... $25,600

Imputed value of physicians' direct medical and surgical services rendered to Medicare inpatients covered under Part B: $1.28 per diem x 1,000 ..... $ 1,280

Imputed value of physicians' direct medical and surgical services rendered to Medicare outpatients covered under Part B: $1.28 per diem x 5,000 ..... $ 6,400

Total $33,280

Provider Physical Therapy Department

2220. PART A SERVICES FURNISHED BY THE PHYSICAL THERAPY DEPARTMENT OF A HOSPITAL OR SKILLED NURSING FACILITY TO ITS INPATIENTS

Direct identifiable services furnished to program beneficiaries by the physical therapy department of a hospital or skilled nursing facility which do not require the skills of a qualified physical therapist,

although considered routine restorative nursing services, can be billed as ancillary services in order to establish an equitable basis for apportioning costs of the physical therapy cost center if the following conditions are met:

1. The services are medically necessary;

2. The treatment furnished is prescribed by a physician;

3. All services are provided by salaried employees (whether full-time or part-time) of the physical therapy department of the provider (if, on the other hand, the services are furnished under arrangements, the services would not be covered since under the law, routine restorative nursing services must be furnished by the provider directly, and cannot be covered if furnished under arrangements);

4. The cost incurred is reasonable in amount (i.e., the employees' salaries are reasonably related to the level of skill and experience required to perform the services in question); and

5. Charges are equally imposed on all patients.

A provider will be considered as having a physical therapy cost center if the services it furnishes meet the above conditions even when the provider has a qualified physical therapist who works only a few hours per week or when the provider has no qualified physical therapist, e.g., that period of time between the periods of employment of qualified physical therapists. In other words, it is not necessary for a provider to have a qualified physical therapist or an actual physical therapy department to establish a physical therapy cost center. Charging practices will be evaluated to insure that an equitable basis for apportioning costs results.

Services requiring the skills of a qualified physical therapist are covered and reimbursable only if performed by or under the direct supervision of such a therapist, i.e., a qualified physical therapist must be on the premises when the services are rendered and the services must meet all the conditions listed in §210.8 of the Hospital Manual and §212.3 of the Skilled Nursing Facility Manual. It is not necessary that, in order to be covered and reimbursable, the physical therapist who provides of supervises the services be an employee of the provider or that he furnish services on a full-time basis.

2220.1 Part B Outpatient Physical Therapy Provision.--The services furnished program beneficiaries must meet the definition of physical therapy where the entitlement to benefits is at issue. Since the outpatient physical therapy benefit under Part B provides coverage only of physical

therapy services, payment can be made only for those services which constitute physical therapy. Services which do not require the skills of a qualified physical therapist are neither covered nor reimbursable under the Part B outpatient physical therapy provision. Accordingly, services furnished by hospitals or skilled nursing facilities to their own inpatients under the Part B outpatient physical therapy provision as described in §242.4 of the Hospital Manual and §271.4 of the Skilled Nursing Facility Manual are covered and reimbursable only if they require the skills of a qualified physical therapist and are performed by or under the direct supervision of such a therapist.

HHA Medical Supply Costs

2221. APPORTIONMENT OF HOME HEALTH AGENCY MEDICAL SUPPLY COSTS

Where a home health agency incurs the cost of medical supplies for certain categories of patients, the cost is apportioned only to those patients. For example, certain State title XIX programs and private patients pay the supplier directly. In such situations, the cost incurred for medical supplies not applicable to these patients are not allocated to them, but only to those patients for which they are incurred.

Some types of medical supplies such as thermometers, nursing bags, etc., are purchased by the provider for all patients. The costs of these supplies must be apportioned to all patients.

Swing-Bed Reimbursement

2230. SWING-BED REIMBURSEMENT FOR QUALIFYING SMALL, RURAL HOSPITALS

A swing-bed hospital is a small, rural hospital that has been approved by the Health Care Financing Administration to use its beds interchangeably to furnish either acute care services or skilled nursing facility (SNF)-type services to Medicare beneficiaries. To be eligible for a swing-bed approval, the hospital must have fewer than 100 beds (excluding intensive care type beds and newborn bassinets) and must be located in an area not designated as "urbanized" in the most recent census. Those hospitals that wish to enter into a swing-bed agreement and have more than 49 beds (but fewer than 100) are subject to additional conditions. (See §2230.10.)

Prior to October 1, 1990, a swing-bed hospital could also furnish intermediate care facility (ICF) type services to non-Medicare patients. Effective with services furnished on or after October 1, 1990, the distinction between SNFs and ICFs for certifying a facility for the Medicaid program has been eliminated. Thus, for purposes of the Medicaid program, facilities may no longer be certified as ICFs but instead may be certified only as nursing facilities (NFs) and can provide services as defined in §1919(a)(1) of the Act. The NF level of care encompasses services that were formerly known as ICF and SNF-type services. Effective October 1, 1990, such services furnished by swing-bed hospitals to Medicaid and to other non-Medicare patients are referred to as NF-type services.

2230.1 Availability of Swing-Bed Reimbursement Method.--The swing-bed reimbursement method is effective for small, rural hospitals on the date a hospital receives swing-bed approval from CMS and effective for small, rural hospital-SNF complexes that elect the optional reimbursement method (see §2230.9) beginning on the first day of the provider's cost reporting period following the date the election is made.

2230.2 Patient Days for Purposes of Swing-Bed Reimbursement.--Under the swing-bed reimbursement method, a patient may be admitted to a swing-bed hospital as an inpatient requiring a hospital level of care and subsequently require a reduced level of care at the SNF or NF level (or before October 1, 1990, care at the SNF or ICF level). When a patient's level of care is reduced, the situation is treated as a discharge from the hospital and an admission to a SNF, ICF (or NF) bed, even though the change in level of care may not involve a physical move of the patient. The day on which a patient begins to receive a lower level of care is considered to be the day of discharge from the hospital and the day of admission to a SNF or ICF (or NF) bed. Medicare SNF days are covered if the 3-day prior hospitalization and other coverage criteria are met. (See Skilled Nursing Facility Manual, §212.)

Also subject to meeting the 3-day prior hospitalization requirement and other coverage criteria, a patient may be admitted to a swing-bed hospital directly as a SNF patient without first receiving hospital level services in the swing-bed hospital, i.e., the patient may receive the 3 days of hospital services in another hospital. In which case, all days are counted as SNF days and no hospital inpatient days are incurred by the swing-bed hospital.

2230.3 Definitions.--

A. Skilled Nursing Facility (SNF)-Type Services.--SNF-type services are services furnished by a swing-bed hospital that would constitute extended care services if furnished by a SNF. SNF-type services include SNF services furnished in the distinct part SNF of a hospital-SNF complex that elects to be reimbursed under the optional reimbursement method. On or after October 1, 1990, only Medicare covered services are included in the definition of SNF-type services.

B. Intermediate Care Facility (ICF)-Type Services.--ICF-type services are services furnished by a swing-bed hospital prior to October 1, 1990, that would constitute ICF services, as defined by Medicaid, if furnished by an ICF. ICF-type services are not covered under Medicare.

C. Nursing Facility (NF)-Type Services.--NF-type services are services furnished by swing-bed hospitals to Medicaid and other non-Medicare patients. Formerly, ICF-type services could be furnished by swing-bed hospitals to non-Medicare patients. However, effective October 1, 1990, the distinction between SNFs and ICFs for certifying a provider for the Medicaid program is eliminated. For purposes of the Medicaid program, facilities may no longer be certified as ICFs but instead may be certified as NFs and can provide services as defined in §1919(a)(1) of the Act. The NF level of care encompasses services that were formerly known as ICF and SNF-type services.

D. General Routine Hospital Services.--General routine hospital services are services furnished by a swing-bed hospital in the general routine service area that constitute a hospital level of care. Services furnished in intensive care type units and newborn bassinets as well as SNF-type, ICF-type and NF-type services are excluded from the definition of general routine hospital services.

2230.4 Payment To Swing-Bed Hospitals Prior To October 1, 1990.--

A. Payment for Medicare SNF-Type Services.--

1. Payment for Routine SNF-Type Services.--Payment for the reasonable cost of routine SNF-type services furnished in a swing-bed hospital is based on the average statewide Medicaid rate paid for routine services furnished by SNFs in the State during the previous calendar year.

NOTE: More than one SNF State Medicaid rate applies to cost reporting periods that are not on a calendar year basis.

2. Payment for Ancillary Services Furnished to SNF-Level Patients.-Payment for ancillary services furnished in a swing-bed hospital is based on the reasonable cost of services using the departmental method of cost apportionment.

B. Payment for General Routine Hospital Services - The Carve-Out Method.-Average cost per diem for general routine hospital services in swing-bed hospitals is computed, under the carve-out method, by subtracting the costs attributable to routine SNF-type and ICF-type services, for all classes of patients, from the total allowable inpatient cost for general routine services and dividing the remaining amount by the total number of inpatient general routine hospital days (excluding SNF days and ICF days).

The routine cost of SNF services furnished to all SNF patients is determined using the average cost per diem described in §2230.4A1. ICF-type services furnished in swing-bed hospitals are not covered under Medicare. However, the routine costs associated with furnishing ICF-type services must be determined for purposes of calculating the cost of inpatient general routine hospital services under the carve-out method. Average cost per diem for routine ICF-type services is the average statewide rate paid for routine services in ICFs (other than ICFs for the mentally retarded) during the previous calendar year under the State Medicaid plan. If the hospital is located in a State that does not have a Medicaid plan, or that does not provide for ICF services under Medicaid, the cost per diem for routine ICF-type services is based on the average ratio of ICF rate to the SNF rate for those States that provide for both SNF and ICF services under Medicaid. The ratio is multiplied by the SNF cost per diem to determine the average ICF cost per diem. The average cost per diem for ICF-type services may be obtained from your intermediary.

The following illustrates the apportionment of routine costs under the carve-out method for swing-bed hospitals and qualifying hospital-SNF complexes that elect the optional reimbursement method:

Statistical and Financial Data:	HOSPITAL K		
	General Routine Hospital	SNF-Type	ICF-Type
Total days of care	2,000	400	100
Medicare days of care	600	300	N/A
Average statewide Medicaid rate for the previous calendar year	N/A	$35	$20

Total inpatient general routine service costs: $250,000

Calculation of Cost of Routine SNF-type Services Applicable to Medicare:

$ 35 X 300 days =			$ 10,500
Calculation of Average Cost Per Diem for General Routine Hospital Services:			
Total inpatient general routine service costs		$250,000	
Less:			
Total SNF-type inpatient days multiplied by appropriate State Medicaid rate (400 X $35)	($14,000)		
Total ICF-type inpatient days multiplied by appropriate State Medicaid rate (100 days X $20)	(2,000)		
Total routine service costs applicable to SNF-type and ICF-type care		($ 16,000)	
General routine inpatient service costs applicable to hospital care		$234,000	
Average cost per diem for general routine inpatient service costs applicable to hospital care ($234,000 divided by 2,000 days)		$ 117.00	
Medicare general routine hospital cost: $117 X 600 days =			$ 70,200
Total Medicare Reasonable Cost for General Routine Services:			$ 80,700

NOTE: This example assumes a calendar year cost reporting period. Hospitals that do not report costs on a calendar year basis must separately identify the number of SNF-type and ICF-type days of service in each calendar year. Since State Medicaid SNF and ICF rates are based on a calendar year, different rates apply to SNF-type and ICF-type services occurring in each of the different calendar years the cost reporting period overlaps.

2230.5 Payment To Swing-Bed Hospitals On And After October 1, 1990.--

A. Payment For Medicare SNF-Type Services.--

1. Payment for Routine SNF-Type Services.--On or after October 1, 1990, payment is based on the average rate per patient day paid by Medicare for routine services provided in freestanding SNFs in the region where the swing-bed hospital is located. The rates are calculated using the regions as defined in §1886(d)(2)(D) of the Act. See §2231 for a list of the regional Medicare swing-bed SNF rates and how these rates are calculated.

Payment for routine SNF-type services furnished on or after October 1, 1990, is subject to a hold harmless provision. Under this provision, if the payment rate in effect for the current calendar year is less than the payment rate for the prior calendar year, payment is based on the prior calendar year rate.

For example, if the Medicaid routine SNF rate used to pay for routine SNF-type services furnished during calendar year 1989 is $85 and the regional Medicare SNF rate applicable to SNF-type services furnished from October 1 through December 31, 1990, is $70, payment for routine SNF services furnished from October through December 1990 is based on $85. If the regional Medicare swing-bed SNF for calendar year 1991 increases to $80, payment is compared to the amount paid under the hold harmless provision in 1990, and payment continues to be based on the higher amount, i.e., $85. If the regional Medicare SNF rate for 1992 is $90, it exceeds the amount paid under the hold harmless provision during 1991 and payment is based on $90.

2. Payment for Ancillary Services Furnished to SNF-Level Patients.-Payment is based on the reasonable cost of the services using the departmental method of cost apportionment.

B. Payment for General Routine Hospital Services - Carve-Out Method.--The reasonable cost of general routine hospital services furnished by a swing-bed hospital is calculated under the carve-out method.

Under this method, the reasonable cost of hospital routine services is determined by subtracting the reasonable costs attributable to routine SNF-type and NF-type services from total inpatient routine service costs for SNF and NF services furnished on or after October 1, 1990. For swing-bed SNF days covered by Medicare, the amount subtracted, or carved-out, is based on the regional Medicare swing-bed SNF rate. For all non-Medicare swing-bed days, the amount subtracted is based on the average statewide rate paid for routine services in NFs under the State Medicaid plan during the prior calendar year, trended forward to approximate the average NF rate for the current calendar year. (The NF rate is used for non-Medicare covered swing-bed days because such services may encompass services that were formerly known as ICF and SNF-type services. The NF rate accounts for this range of services.) The average statewide routine NF rate may be obtained from your intermediary.

If, under the hold harmless provision discussed in §2230.5.A.1, a swing-bed hospital is paid based on the swing-bed SNF rate which was in effect during the prior calendar year, that higher rate must also be used for purposes of calculating the reasonable cost of routine Medicare SNF days, to be subtracted from total routine costs under the carve-out method.

2230.6 Application of Lower of Cost or Charges Principle to Services Furnished in Swing-Bed Hospital.--The lower of cost or charges principle does not apply to routine SNF-type services furnished in a swing-bed hospital. This principle also does not apply to routine SNF services furnished to inpatients of a distinct part SNF, which is part of a qualified small, rural hospital complex that has elected the optional reimbursement method.

2230.7 Application of Ceiling on Rate of Hospital Cost Increases.--Under most circumstances when a hospital is reimbursed on the basis of reasonable costs, the hospital's inpatient cost per discharge decreases under the swing-bed provision. However, a swing-bed hospital that exceeds the rate of increase ceilings solely due to the reimbursement mechanism of this provision may

request a CMS review of its circumstances. File the request with the fiscal intermediary who reviews the request and forwards it to CMS for a determination. If appropriate, relief may be granted under 42 CFR 413.40(g).

2230.8 Swing-Bed Reimbursement Under Prospective Payment System.--A swing-bed hospital that is subject to the prospective payment system (PPS) is reimbursed for SNF-type services in the same manner as any other swing-bed hospital. That is, routine SNF-type services are reimbursed at the Medicare swing-bed SNF rate (or the average statewide Medicaid rate prior to October 1, 1990), and ancillary services furnished to SNF-level patients are reimbursed based on reasonable cost using the departmental method. The prospective payment rates (based on diagnosis related groups (DRGs)) for inpatient hospital services under PPS are unaffected by the carve-out method. Use the carve-out method to determine proper payment of pass through costs of PPS hospitals.

2230.9 Swing-Bed Reimbursement for Small, Rural Hospitals with Distinct Part SNF.--A small, rural hospital that is part of a hospital-SNF complex may obtain approval to participate as a swing-bed hospital. The hospital and SNF components are then treated as separate entities and the hospital beds only are used interchangeably to furnish hospital or SNF-type services. If the complex includes a Medicare certified distinct part SNF and the combined bed count is fewer than 50, the optional reimbursement method may be elected. The optional reimbursement method combines the hospital and SNF components into a single cost center for purposes of applying the swing-bed reimbursement method. A description of the methods follows.

A. Swing-Bed Reimbursement.--If the hospital component of a rural hospital-SNF complex obtains swing-bed approval, it is treated in the same manner as any other hospital for purposes of swing-bed reimbursement. Only the general routine service beds in the hospital component are counted to determine that the hospital has fewer than 50 or 100 beds, respectively, depending on how the hospital qualifies for swing-bed approval. (Prior to April 1, 1988, approval could be granted only to hospitals with fewer than 50 beds.) Beds in the hospital component are used interchangeably to furnish either hospital or SNF-type services and only patient days and costs attributable to the hospital component are used in computing routine service costs under the swing-bed reimbursement method. SNF services furnished in the distinct part are reimbursed separately.

B. Optional Reimbursement Method.--The optional reimbursement method is available to small, rural hospitals with Medicare participating distinct part SNFs. To qualify for the optional reimbursement method, a hospital-SNF complex must be located in a rural area (defined as any area not designated as urbanized in the most recent census), and the hospital and SNF must have a combined bed count of fewer than 50 beds on the first day of the cost reporting period.

NOTE: Hospitals with distinct part SNFs with a combined bed count of more than 49 beds but fewer than 100 beds are not eligible to use the optional reimbursement method.

The bed count includes beds in the Medicare participating SNF and beds in the general routine service area of the hospital (excluding newborn bassinets and beds in intensive care type units). The hospital may continue to use the optional reimbursement method as long as it continues to meet the bed size

requirement. The optional reimbursement method does not authorize a facility to use hospital beds to furnish SNF-type services. Under this method, the general routine service costs of the hospital component and SNF component are combined into a single cost center for purposes of computing the average cost per diem for hospital and SNF services under the swing-bed reimbursement method. The two components remain as separate providers for certification and coverage purposes.

The hospital must make its election to use the optional reimbursement method in writing to the intermediary before the beginning of the hospital's affected cost reporting year. The hospital must also make any request to revoke the election in writing before the beginning of the affected cost reporting period. Requests to terminate use of the optional reimbursement method must be approved by the intermediary. The optional reimbursement method may be elected only one time. If a hospital-SNF complex reverts to separate cost finding for the distinct part SNF after electing the optional reimbursement method, it cannot again elect the optional reimbursement method.

C. Combined Swing-Bed and Optional Reimbursement.--A small, rural hospital-SNF complex that has a swing-bed approval for the hospital component may also elect the optional reimbursement method if the requirements in subsection B are met. In this case, the SNF component remains as a distinct part for certification and coverage purposes, but its costs are combined with those of the hospital for reimbursement purposes. The distinct part SNF furnishes SNF services and the hospital component furnishes both acute care and SNF-type services.

2230.10 Additional Conditions Relating to Swing-Bed Reimbursement for Rural Hospitals With More Than 49 Beds.--Under §§1883(d)(2) and (3) of the Act, effective for swing-bed agreements entered into after March 31, 1988, payment for extended care services furnished by hospitals with more than 49 beds (but fewer than 100 beds) is subject to the following additional conditions:

o If there is an available SNF bed in the geographic area, the extended care patient must be transferred within a 5-day period beginning on an availability date for a SNF (excluding weekends and holidays) unless the patient's physician certifies within that 5-day period that transfer is not medically appropriate. An "availability date" means, with respect to an extended care patient at a hospital, any date on which a bed is available for the patient in a SNF located within the geographic region in which the hospital is located.

o The number of Medicare covered days of extended care services in a cost reporting period must not exceed 15 percent of the product of the number of days in the period and the average number of licensed beds at the hospital, except that Medicare payment continues in the period for those patients who are already receiving extended care services at the time the hospital reaches the payment limit. In those States that do not license beds, hospitals must use the total number of hospital beds reported on their most recent Certificate of Need (CON) (excluding bassinets). If, during the cost reporting period, there is an increase or decrease in the number of licensed beds, the number of licensed beds for each part of the period is multiplied by the number of days for which that number of licensed beds was available. After totaling the results, compute 15 percent of the total available licensed bed days to determine the payment limitation.

According to §1883(d) of the Act, a hospital is not to receive payment for those SNF days that exceed the 15 percent cap. Therefore, a hospital, in conducting its daily census-taking, is to separately account for patients receiving Medicare covered extended care services. It is necessary to monitor the number of these Medicare extended care days in order to prevent the hospital's exceeding the 15 percent payment limitation.

NOTE: Use licensed beds in the calculation of the 15 percent limitation requirement. The method used to count beds for eligibility to participate in the swing bed program remains unchanged.

2231. REGIONAL MEDICARE SWING-BED SNF RATES

Prior to the establishment of the SNF prospective payment system (PPS) in the Balanced Budget Act of 1997 (Public Law 105-33), Medicare payment to swing-bed hospitals for routine SNF-type services *was* based on the average rate per patient day paid by Medicare during the calendar year for routine services provided in freestanding skilled nursing facilities in the region where the hospital is located. *While those regional rates no longer serve to determine the actual payment amount for these services, they are still used in carving out the cost of such services on the hospital cost report.* The *regional* rates are calculated based on the most recent year for which cost reporting data are available trended forward *to the current calendar year*.

The rates are calculated using the regions as defined in §1886 (d)(2)(D) of the Act (that is, one of the nine census divisions established by the Bureau of the Census). The census bureau divisions are referenced in 61 FR 51613; however, the numbering of the regions below differed from the numbering of the divisions by the Bureau of the Census. In order to clarify the regions and divisions, the table below identifies both, with the numbering of the regions being used consistently throughout the tables for Medicare swing-bed SNF rates for each calendar year. The states that are included in each region are:

Regions	Divisions (Census Bureau)	Divisions (Census Bureau)	States in each Region/Division
1	1	New England	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
2	2	Middle Atlantic	New Jersey, New York, Pennsylvania
3	5	South Atlantic	Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
4	3	East North Central	Indiana, Illinois, Michigan, Ohio, Wisconsin
5	6	East South Central	Alabama, Kentucky, Mississippi, Tennessee
6	4	West North Central	Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
7	7	West South Central	Arkansas, Louisiana, Oklahoma, Texas
8	8	Mountain	Arizona, Colorado, Idaho, New Mexico, Montana, Utah, Nevada, Wyoming
9	9	Pacific	Alaska, California, Hawaii, Oregon, Washington

The following tables list the regional Medicare swing-bed SNF rates for each calendar year.

TABLE 1

Medicare Swing-Bed SNF Rates - For Services Rendered on or After October 1, 1990 through December 31, 1990

Region	Routine Payment	Return on Equity *
1	86.51	1.42
2	86.39	1.27
3	75.28	1.48
4	75.03	1.18
5	65.79	1.21
6	74.09	1.34
7	67.85	1.87
8	81.32	1.47
9	86.73	1.07

TABLE 2

Medicare Swing-Bed SNF Rates - For Services Rendered During Calendar Year 1991

Region	Routine Payment	Return on Equity *
1	90.92	1.42
2	90.73	1.27
3	79.03	1.28
4	78.78	1.18
5	69.14	1.21
6	77.83	1.34
7	71.22	1.87
8	85.34	1.47
9	91.10	1.07

* The return on equity capital component must be added to the routine payment rate to determine the rate payable to proprietary hospitals.

TABLE 3

Medicare Swing-Bed SNF Rates - For Services Rendered During Calendar Year 1992

Region	Routine Payment	Return on Equity *
1	95.10	1.42
2	94.91	1.27
3	82.67	1.48
4	82.40	1.18
5	72.32	1.21
6	81.41	1.34
7	74.50	1.87
8	89.27	1.47
9	95.29	1.07

TABLE 4

Medicare Swing-Bed SNF Rates - For Services Rendered During Calendar Year 1993

Region	Routine Payment	Return on Equity *
1	100.05	1.42
2	99.84	1.27
3	86.97	1.28
4	86.69	1.18
5	76.08	1.21
6	85.64	1.34
7	78.37	1.87
8	93.91	1.47
9	100.24	1.07

*The return on equity capital component must be added to the routine payment rate to determine the rate payable to proprietary hospitals.

TABLE 5

Medicare Swing-Bed SNF Rates - For Services Furnished During Calendar Year 1994

Region	Routine Payment
1	108.48
2	104.33
3	89.47
4	88.76
5	79.44
6	83.84
7	84.97
8	100.11
9	104.58

TABLE 6

Medicare Swing-Bed SNF Rates - For Services Furnished During Calendar Year 1995

Region	Routine Payment
1	121.71
2	117.28
3	105.22
4	105.73
5	94.61
6	99.75
7	99.63
8	117.21
9	125.80

TABLE 7

Medicare Swing-Bed SNF Rates – For Services Furnished During Calendar Year 1996

Region	Routine Payment
1	126.65
2	121.74
3	109.04
4	109.51
5	99.51
6	103.38
7	102.89
8	121.31
9	130.62

TABLE 8

Medicare Swing-Bed SNF Rates - For Services Furnished During CALENDAR Year 1997

Region	Routine Payment
1	133.22
2	124.24
3	112.56
4	112.67
5	102.39
6	105.81
7	103.12
8	121.78
9	133.53

TABLE 9

Medicare Swing-Bed SNF Rates - For Services Furnished During CALENDAR Year 1998

Region	Routine Payment
1	138.10
2	129.18
3	118.26
4	116.08
5	108.49
6	109.13
7	106.69
8	126.06
9	134.44

TABLE 10

Medicare Swing-Bed SNF Rates - For services Furnished During CALENDAR Year 1999

Region	Routine Payment
1	144.92
2	136.94
3	126.75
4	123.05
5	111.04
6	114.45
7	107.96
8	132.67
9	141.87

TABLE 11

Medicare Swing-Bed SNF Rates - For Services Furnished During CALENDAR Year 2000

Region	Routine Payment
1	155.91
2	146.41
3	138.03
4	132.30
5	116.31
6	123.62
7	121.82
8	137.60
9	151.08

TABLE 12

Medicare Swing-Bed SNF Rates - For Services Furnished During CALENDAR Year 2001

Region	Routine Payment
1	165.81
2	153.93
3	142.61
4	140.19
5	124.34
6	132.40
7	121.62
8	145.20
9	157.51

TABLE 13

Medicare Swing-Bed SNF Rates - For Services Furnished During CALENDAR Year 2002

Region	Routine Payment
1	171.57
2	159.28
3	147.57
4	145.06
5	128.66
6	137.00
7	125.85
8	150.25
9	162.98

TABLE 14

Medicare Swing-Bed Rates – For Services Furnished During CALENDAR Year 2003

Region	Routine Payment
1	177.05
2	164.37
3	152.28
4	149.69
5	132.77
6	141.38
7	129.87
8	155.05
9	168.19

TABLE 15

Medicare Swing-Bed Rates – For Services Furnished During CALENDAR Year 2004

Region	Routine Payment
1	182.11
2	169.07
3	156.63
4	153.97
5	136.57
6	145.42
7	133.58
8	159.48
9	173.00

TABLE 16

Medicare Swing-Bed SNF Rates - For Services Furnished During CALENDAR Year 2005

Region	Routine Payment
1	187.51
2	174.09
3	161.28
4	158.54
5	140.62
6	149.74
7	137.55
8	164.21
9	178.14

TABLE 17

Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2006

Region	Routine Payment
1	193.79
2	179.92
3	166.68
4	163.85
5	145.33
6	154.75
7	142.16
8	169.71
9	184.10

TABLE 18

Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2007

Region	Routine Payment
1	200.42
2	186.08
3	172.39
4	169.46
5	150.30
6	160.05
7	147.03
8	175.52
9	190.40

TABLE 19

Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2008

Region	Routine Payment
1	206.90
2	192.09
3	177.96
4	174.94
5	155.16
6	165.22
7	151.78
8	181.19
9	196.55

TABLE 20

Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2009

Region	Routine Payment
1	213.49
2	198.21
3	183.63
4	180.51
5	160.10
6	170.48
7	156.61
8	186.96
9	202.81

TABLE 21

Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2010

Region	Routine Payment
1	217.79
2	202.21
3	187.33
4	184.15
5	163.33
6	173.92
7	159.77
8	190.73
9	206.90

TABLE 22

Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2011

Region	Routine Payment
1	222.67
2	206.74
3	191.52
4	188.27
5	166.99
6	177.81
7	163.35
8	195.00
9	211.53

TABLE 23

Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2012

Region	Routine Payment
1	228.15
2	211.83
3	196.23
4	192.90
5	171.10
6	182.19
7	167.37
8	199.80
9	216.74

TABLE 24
Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2013

Region	Routine Payment
1	234.06
2	217.31
3	201.32
4	197.90
5	175.53
6	186.91
7	171.70
8	204.98
9	222.35

TABLE 25
Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2014

Region	Routine Payment
1	239.51
2	222.37
3	206.01
4	202.51
5	179.62
6	191.26
7	175.70
8	209.75
9	227.53

TABLE 26

Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2015

Region	Routine Payment
1	245.25
2	227.71
3	210.95
4	207.37
5	183.92
6	195.85
7	179.92
8	214.78
9	232.99

TABLE 27

Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2016

Region	Routine Payment
1	251.38
2	233.41
3	216.23
4	212.56
5	188.52
6	200.75
7	184.42
8	220.15
9	238.82

TABLE 28
Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2017

Region	Routine Payment
1	258.82
2	240.31
3	222.63
4	218.85
5	194.10
6	206.69
7	189.88
8	226.66
9	245.88

TABLE 29
Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2018

Region	*Routine Payment*
1	*265.47*
2	*246.48*
3	*228.35*
4	*224.47*
5	*199.09*
6	*212.00*
7	*194.76*
8	*232.48*
9	*252.20*

TABLE 30
Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2019

Region	Routine Payment
1	273.59
2	254.02
3	235.33
4	231.33
5	205.18
6	218.48
7	200.72
8	239.59
9	259.91

TABLE 31
Medicare Swing-Bed SNF Rates – For Services Furnished During CALENDAR Year 2020

Region	*Routine Payment*
1	*281.46*
2	*261.33*
3	*242.10*
4	*237.99*
5	*211.08*
6	*224.77*
7	*206.49*
8	*246.48*
9	*267.39*