Revised 5/18/2017

# Medicare interim rate request form -- hospital

Provider name:

Provider number:

FYE from: to:

Rate review period if different from FYE:

**Medicare bad debts** - For the period to:

*Report total amount written off in this period, net of recoveries, not reduced for BBA. Attach the bad debt list or support for your estimate.*

1. Medicare Part A allowable bad debts
2. Medicare Part B allowable bad debts

**Medicare disproportionate share adjustment -** *Attach supporting summary schedules from your records.*

1. In-state Medicaid days (include healthy newborn)
2. + Out-of-state Medicaid days
3. + Medicaid eligible days
4. + Medicaid HMO days
5. + Non-concurrent nursery Medicaid days
6. +/ - Medicaid observation days (refer to cost report instructions for W/S S-3 line 26)
7. - Medicaid labor & delivery days (if included in any lines above)
8. - Dually eligible days (if included in any lines above)
9. - Distinct part unit (excluded unit) days (if included in any lines above)
10. = Total hospital Medicaid days

11. Total hospital days (include healthy newborn)

12. - Distinct part unit (excluded unit) days (if in line 11)

13. +/- Observation days (refer to cost report instructions for W/S S-3 line 26)

14. - Labor & delivery days (if in line 11)

15. + Employee inpatient days not included above

16. = Total days

17. Available beds (excluding nursery and subunits)

(For available bed days, refer to August 11, 2004, *Federal Register*, pages 49092-49098)

**Indirect medical education cost** *If new program, attach documentation of its approval by appropriate agency.*

1. Full-time equivalent (FTE) interns and/or residents in an approved teaching program

+ allopathic & osteopathic

+ dental & podiatric

= Total FTEs

2. Total *available* beds (excluding nursery and subunits)

(For available bed days, refer to August 11, 2004, *Federal Register*, pages 49092-49098)
Explain and support unavailable licensed beds.

**Direct graduate medical education cost information** *If new program, attach documentation of its approval by appropriate agency.*

1. Intern & resident FTEs for the current year from your records

Unweighted FTEs for allopathic & osteopathic programs

Weighted FTEs for primary care physicians in an allo/osteopathic program

Weighted FTEs for all other physicians in an allo/osteopathic program

Weighted FTEs for dental and podiatric residents

2. Medicare Part A inpatient days (hospital and subunits)

3. Total inpatient days (excluding nursery and including subunits)

4. Medicare utilization (line 2/line 3)

5. Medicare Part A reasonable cost

6. Medicare Part B reasonable cost

| | |
|---|---|
| 7. Total Medicare cost (line 5 + line 6) | |
| 8. Ratio of Part A to total (line 5/line 7) | |
| 9. Ratio of Part B to total (line 6/line 7) | |

**Non-physician nurse anesthetists cost (CRNA)** *(Note: Cost report pass-through reimbursement for CRNA is only allowed for hospitals that have received specific approval from Provider Audit & Reimbursement Department)*

| | |
|---|---|
| 1. Total CRNA cost | |
| 2. Medicare I/P anesthetist charges | |
| 3. Total anesthetist charges | |
| 4. Medicare utilization (line1/line 3) | |
| 5. Medicare CRNA reimbursement (line 1x 4) | |

**Organ acquisition reimbursement** *These amounts should be from your current records and relate to the cost report W/S D-6; attach support for number of organs.*

**Hearts**

| | |
|---|---|
| 1. Direct organ acquisition cost | |
| 2. Routine & ancillary cost | |
| 3. Total cost for hearts (line 1 + line 2) | |
| 4. Revenue for hearts sold (not third-party payments for non-Medicare patients) | |
| 5. Medicare usable hearts | |
| 6. Total usable hearts | |

**Kidneys**

| | |
|---|---|
| 1. Direct organ acquisition cost | |
| 2. Routine & ancillary cost | |
| 3. Total cost for kidneys (line 1 + line 2) | |
| 4. Revenue for kidneys sold (not third-party payments for non-Medicare patients) | |
| 5. Medicare usable kidneys | |
| 6. Total usable kidneys | |

**Livers**

| | |
|---|---|
| 1. Direct organ acquisition cost | |
| 2. Routine & ancillary cost | |
| 3. Total cost for livers (line 1 + line 2) | |
| 4. Revenue for livers sold (not third-party payments for non-Medicare patients) | |
| 5. Medicare usable livers | |
| 6. Total usable livers | |

**Lungs**

| | |
|---|---|
| 1. Direct organ acquisition cost | |
| 2. Routine & ancillary cost | |
| 3. Total cost for lungs (line 1 + line 2) | |
| 4. Revenue for lungs sold (not third-party payments for non-Medicare patients) | |
| 5. Medicare usable lungs | |
| 6. Total usable lungs | |

**Others** *(describe)*

| | |
|---|---|
| 1. Direct organ acquisition cost | |
| 2. Routine & ancillary cost | |
| 3. Total cost for other organs (line 1 + line 2) | |
| 4. Revenue for other organs sold (not third-party payments for non-Medicare patients) | |
| 5. Medicare usable other organs | |
| 6. Total usable other organs | |

**Other significant factors**

During the current period, were there any costs or other factors that may significantly affect current Medicare reimbursement? This may include availability of beds, type of service, change in ownership etc. Please document changes that have occurred and identify other factors that may affect reimbursement.

Other significant factors (255 character limit)

Contact person for interim rate:

Telephone number:

Fax number:

Email address:

Person certifying that the information provided is accurate to the best of your knowledge:

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## Send this information:

By email to InterimReimbReviews@fcso.com - please include the provider number in the subject line

By fax: (904) 791-8441

By mail:

JN PARD Reimbursement
First Coast Service Options Inc.
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050-9419

(Do not mail a copy if you have faxed or emailed the information)

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