Revised 5/18/2017

Critical access hospital (interim rate analysis)

Provider name: _____

Provider number: _____

Covered period: From: _____ To: _____

The purpose of reviewing your interim rate is to ensure the rate you are paid reflects, as accurately as possible, the expected cost report reimbursement. We appreciate your efforts in providing this required data as accurately and timely as possible

The following information should be obtained from your current records.

1. Direct cost (see note) _____ relates to W/S A col. 3 line 25
2. Estimated overhead cost (see note) _____
3. Total hospital's general I/P routine service cost (line 1 + line 2) _____ relates to W/S D-1 line 21
4. Total I/P routine days (incl. PR, swing bed-days, excl. newborn) _____ relates to W/S D-1 line 1

Total Swing -bed SNF/NF days (if applicable) SNF-like: _____ NF-like: _____

5. During the current period, were there significant events or cost incurred which may affect the Medicare reimbursement?

_____

Note: There are several factors that must be taken into consideration when providing information. Examples are changes in expenditures resulting from delicensing of beds (costs for the "idle space" are non-reimbursable under Medicare), changes in capital expenditures, changes in overhead allocation, changing Medicare utilization, changing charges, etc.). Please indicate the anticipated effect.

6. Estimation of inpatient Medicare ancillary cost

Cost center	Cost to charge ratio (1)	Current period Medicare charges (2)	Estimated current Medicare cost (2 X 1)
Ancillary service cost center			
Radiology-diagnostic			
Radiology-therapeutic			
Laboratory			
Intravenous therapy			
Respiratory therapy			
Physical therapy			
Occupational therapy			
Speech pathology Electrocardiology			
Electroencephalography			
Medical supplies			
Drugs charged to patients			
Outpatient service cost center			
Emergency			
Observation beds (non-distinct part)			
			(A)
Total			

Total I/P Medicare ancillary cost		**(A)**
Total I/ P Medicare days		
Total I/P Medicare ancillary Cost per diem		

7. Estimation of outpatient Medicare cost

Standard method ☐ Optional method ☐

Standard method - cost-based facility, with billing of carrier for professional services.

Optional method - cost-based facility plus fee schedule for professional services.

Note: Optional method should be made in writing by the CAH, which notifies the FI 30 days in advance of the beginning of the affected cost reporting period. (Pls. Refer to section 3610.23 of Medicare Intermediary Manual or Transmittal 1843 CR 1888, dated 10/10/2001).

Cost center	Cost to charge ratio (1)	Current period Medicare charges (2)	Estimated current Medicare cost (2 X 1)
Ancillary service cost center			
Radiology-diagnostic			
Radiology-therapeutic			
Laboratory			
Intravenous therapy			
Respiratory therapy			
Physical therapy			
Occupational therapy			
Speech pathology			
Electrocardiology			
Electroencephalography			
Medical supplies			
Drugs charged to patients			
Outpatient service cost center			
Emergency			
Observation beds			
		(B)	**(A)**
Total			

Total outpatient cost		**(A)**
Total outpatient charges		**(B)**
Ratio of cost to charge		**(A/B)**

8. Medicare bad debts (Report total write-off amount, not reduced for BBA)

For the period: To:

Medicare Part A allowable bad debts

Medicare Part B allowable bad debts

(Please submit a bad debts list to support the above amounts)

I hereby certify that to the best of my knowledge and belief that this is a true, and complete statement prepared from the books and records of the provider in accordance with applicable instruction, except as noted.

Prepared by: Title:

(printed/signed)

Phone #: Date prepared:

Send this information:

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

By fax: (904) 791-8441, Attn: Melody Smith

By mail: Melody Smith
First Coast Service Options, Inc.
JN Provider Audit & Reimbursement
532 Riverside Avenue
Jacksonville, FL 32202-4918

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

Print form Save form Submit by email Reset form

Attachment for critical access/PIP providers

1.Provider number:

2.FYE: From: To:

3.Quarterly review (1) (2) (3) (4)

Statistical data

A. Medicare days:

	Month	Prior year* Actual	Current year* Projected	Current year* Actual
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
	Total			

Swing bed unit (interim rate analysis)

Provider name:

Provider number:

Covered period: From: To:

The purpose of reviewing your interim rate is to ensure the rate you are paid reflects, as accurately as possible, the expected cost report reimbursement. We appreciate your efforts in providing this required data as accurately and timely as possible

The following information should be obtained from your current records.

A. Estimation of inpatient Medicare ancillary cost

Cost center	Cost to charge ratio (1)	Current period Medicare charges (2)	Estimated current Medicare cost (2 X 1)
Ancillary service cost center			
Radiology-diagnostic			
Radiology-therapeutic			
Laboratory			
Intravenous therapy			
Respiratory therapy			
Physical therapy			
Occupational therapy			
Speech pathology			
Electrocardiology			
Electroencephalography			
Medical supplies			
Drugs charged to patients			
Outpatient service cost center			
Emergency			
Observation beds (non-distinct part)			

			(A)
Total			

Total I/P Medicare ancillary cost		(A)
Total I/ P Medicare days		
Total I/P Medicare ancillary Cost per diem		

B. Medicare bad debts (Report total write-off amount, not reduced for BBA)

For the period: To:

Medicare Part A allowable bad debts

Medicare Part B allowable bad debts

(Please submit a bad debts list to support the above amounts)

I hereby certify that to the best of my knowledge and belief that this is a true, and complete statement prepared from the books and records of the provider in accordance with applicable instruction, except as noted.

Prepared by: Title:

(printed/signed)

Phone #: Date prepared:

Email:

Send this information:

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

By fax: (904) 791-8441, Attn: Melody Smith

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First Coast Service Options, Inc.
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532 Riverside Avenue
Jacksonville, FL 32202-4918

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