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# WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

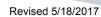
Critical access hospital (interim rate analysis) Provider name: Provider number: Covered period: From: To: The purpose of reviewing your interim rate is to ensure the rate you are paid reflects, as accurately as possible, the expected cost report reimbursement. We appreciate your efforts in providing 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) relates to W/S D-1 line 21 3. Total hospital's general I/P routine service cost (line 1 + line 2) 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) NF-like: SNF-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.



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# 6. Estimation of inpatient Medicare ancillary cost

	Cost to	Current period	Estimated
	charge	Medicare	current Medicare
Cost center	ratio	charges	cost
	(1)	(2)	(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)

# Total

(A)

Total I/P Medicare ancillary cost

Total I/ P Medicare days

Total I/P Medicare ancillary Cost per diem



(A)

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# 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 to	Current period	Estimated
	charge	Medicare	current Medicare
Cost center	ratio	charges	cost
	(1)	charges (2)	(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)



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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:

(printed/signed)

Phone #:

# 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)



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Title:

Date prepared:

# Attachment for critical access/PIP providers

1. Provider number:

2.FYE:	From:	То:	
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				
Tota	I			



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# Swing bed unit (interim rate analysis)

Provider name:

Provider number:

Covered period:	From:	То:
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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 to charge	Current period Medicare	Estimated current Medicare
Cost center	ratio	charges	cost
	(1)	(2)	(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)



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**(A)** 

Total I/P Medicare ancillary cost

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:

(printed/signed)

Phone #:

Email:

# Send this information:

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

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Title:

Date prepared: