

**3513. WORKSHEET S-6 - SKILLED NURSING FACILITY-BASED OUTPATIENT REHABILITATION STATISTICAL DATA**

NOTE: If this component is paid 100% under established fee schedules, you are not required to complete lines 1 through 19, or the related J series worksheets for cost reporting periods beginning on or after 04/01/2001.

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics required to be reported on this worksheet pertain to a skilled nursing facility-based outpatient rehabilitation provider. Complete a separate schedule for each box checked at the top of this form. The data needed to be maintained, depending on the services provided by the outpatient rehabilitation facility, include number of program treatments, total number of treatments, number of program patients, and total number of patients. In addition, FTE data is required by employee staff, contracted staff, and total.

Lines 1 through 19.--These lines provide statistical data related to the human resources of the outpatient rehabilitation provider checked. The human resources statistics are required for each of the job categories specified on lines 1 through 17. Enter any additional categories needed on lines 18 and 19.

Enter the number of hours in your normal work week in the space provided.

Report in column 1 the FTE employees on the outpatient rehabilitation provider's payroll. These are staff for which an IRS Form W-2 is issued.

Report in column 2 the FTE contracted and consultant staff of the outpatient rehabilitation provider.

Staff FTEs are computed for column 1 as follows: sum of all hours for which employees were paid divided by 2080 hours, rounded to two decimal places, e.g., round .4452 to .45. Contract FTEs are computed for column 2 as follows: sum of all hours for which contracted and consultant staff worked divided by 2080 hours, rounded to two decimal places.

If employees are paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the numerator in the calculations.

## 3514. WORKSHEET S-7 - NHCMQ DEMONSTRATION AND PPS STATISTICAL DATA

**NOTE:** Public Law 105-33 (Balanced Budget Act of 1997) requires that all SNFs be reimbursed under PPS for cost reporting periods beginning on and after July 1, 1998. Therefore, SNFs will not be reimbursed under demonstration procedures for cost reporting periods beginning on and after that date. An expansion to Worksheet S-7 was needed to accommodate cost reporting periods which begin on and after July 1, 1998. This expansion is designated as Part II. Part I will continue as the original form as published in June 1996, and updated with Transmittal # 3, and will be in effect for providers with cost reporting periods which begin PRIOR to July 1, 1998. Part II will be used for ALL SNFs with cost reporting periods beginning on and after July 1, 1998.

3514.1 Part I - NHCMQ Demonstration Statistical Data.-- Complete this part for cost reporting periods beginning prior to July 1, 1998.

The statistics reported on this worksheet pertain to SNF facilities participating in the NHCMQ demonstration. 42 CFR 413.30 provides waivers to enable the use of the Resource Utilization Group (RUG-III) case mix adjusted prospective payment rate setting methodology for routine costs and Part A ancillary rehabilitation services in place of the routine systems of cost finding/payment determination and/or prospective payment option for low utilization providers.

Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration. The data to be maintained for title XVIII demonstration days include, by group, the M3PI revenue code, the rate, the number of inpatient days, and the dollar amount for Medicare residents during this cost reporting period.

Column Descriptions

Column 1.--The case mix group designations are already entered in this column.

Column 2.--The M3PI revenue code designations are already entered in this column.

**NOTE:** Worksheet S-7 was designed to accommodate one RUG group rate applicable for the entire year. However, since this rate could change each calendar year, this worksheet needs to be modified to accommodate TWO rates. This form has been revised to reflect heading changes published in Transmittal #3. Column headings are as follows:

Services Prior To January 1st		Services On Or After January 1st	
Rate	Days	Rate	Days
3	3.01	4	4.01

Columns 3 and 4.--Enter the rate assigned to the provider for each applicable group. This rate is effective as of January 1 and may be changed each January 1. Providers with fiscal years other than the calendar year could have two rates to report. The second rate is entered in column 4. If your fiscal year begins January 1 and ends December 31, enter your rate in column 4, and do not use column 3.

Column 3.01.--Enter the number of demonstration inpatient days applicable to each group, associated with the rate in place at the beginning of your fiscal year. This column is not used for calendar year providers. Enter the total on line 46.

Column 4.01.--Enter the number of demonstration inpatient days applicable to each group associated with the rate in effect January 1 through the end of your fiscal year. Enter the total on line 46.

Add the amounts on line 46, columns 3.01 and 4.01, and enter the result on Worksheet E, Part V, line 2.

Column 5.--Calculate the total for each revenue group by multiplying the rate by the days covered by that rate. Where you must report two rates and two sets of days for each group, multiply the rate in column 3 by the days in column 3.01. Multiply the second rate in column 4 by the days in column 4.01. For each line (group), add the product of column 3 multiplied by the 3.01 plus the product of columns 4 multiplied by 4.01, and enter the result in column 5 on the same line. Add lines 1 through 45, column 5, and enter the total on line 46. Transfer column 5, line 46, to Worksheet E, Part V, line 6.

3514.2 Part II - PPS Statistical Data. --Complete this part for cost reporting periods beginning on and after July 1, 1998. Use this part to report the Medicare days of the provider by RUG. The total on line 46 must agree with the amount on Worksheet S-3, column 4, line . This part has been revised with the issuance of Transmittal # 5. As of the issuance of Transmittal # 5, Part II has been replaced with Part III, and should not be completed.

3514.3 Part III - PPS Statistical Data.-- **Complete Part III for cost reporting periods beginning on or after July 1, 1998.** Use this part to report the Medicare days of the provider by RUG. **Do not use Part III for cost reporting periods ending on and after February 28, 2001.**

Transition Period.--Indicate the applicable transition period. Your fiscal intermediary will provide you with this status. Example: If your cost report year begins on July 1, 1998, check the box for year number 1. For the next fiscal year beginning on July 1, 1999, check the box for year number 2. For the following fiscal year beginning on July 1, 2000, check the box for year number 3. For the last fiscal year in the transition period beginning on July 1, 2001, check the box for year number 4.

EXCEPTION: THE TRANSITION PERIOD PAYMENT METHOD WILL NOT APPLY TO A SNF THAT (1) ELECTED FOR IMMEDIATE TRANSITION TO FEDERAL RATE UNDER SECTION 102 OF THE BALANCED BUDGET REFINEMENT ACT OF 1999, OR (2) **FIRST** RECEIVED MEDICARE PAYMENTS (INTERIM OR OTHERWISE) ON OR AFTER OCTOBER 1, 1995 UNDER PRESENT OR PREVIOUS OWNERSHIP. THESE FACILITIES WILL BE PAID BASED ON ONE HUNDRED PERCENT (100%) OF THE FEDERAL RATE. Enter this rate in column 5.

For the first year of the provider's transition period, the PPS rate will be twenty-five percent (25%) of the Federal Case Mix Rate and seventy-five percent (75%) of the Facility Specific Rate. In the second year of the Provider's transition period, the PPS rate will be fifty percent (50%) of the Federal Case Mix Rate and fifty percent (50%) of the Facility Specific Rate. For the third year of the Provider's transition period, the PPS rate will be seventy-five percent (75%) of the Federal Case Mix Rate and twenty-five percent (25%) of the Facility Specific Rate. For the fourth and final year of the Provider's transition period, the PPS rate will be one hundred percent (100%) of the Federal Case Mix Rate. See columns 9 and 10 below.

Column 2.--Enter the Federal Specific Rate on each applicable RUG line.

Column 3.--Enter the Federal Case Mix rate applicable to each RUG for services from the beginning of the fiscal year through September 30.

Column 4.--Enter the number of days applicable to each RUG for services from the beginning of the fiscal year through September 30.

Columns 5 and 5.01.--Enter in column 5 the Federal Case Mix (adjusted for the labor portion by the update factor specific to the provider's MSA) rate times 104 percent, applicable to each NON-High-Cost RUG for services from October 1, through the end of the fiscal year. Enter in column 5.01 the Federal Case Mix rate times 124 percent applicable to each High-Cost RUGs for services from October 1, through the end of the fiscal year.

Columns 6 and 6.01.--Enter in column 6 the number of days applicable to ALL RUGs for services from October 1 through the end of the fiscal year. Enter in column 6.01 the number of days applicable to each High-Cost RUG for services from October 1 through the end of the fiscal year (This should be the same amount that is reported in column 5 for that RUG.)

The total on line 75, columns 4 and 6 must agree with the amount on Worksheet S-3, Part I, column 4, line 1.

Do not use columns 3 and 4 for a cost report period that begins on October 1. Report the applicable Federal Case Mix rates in column 5 for each NON-High-Cost RUG. Report Medicare days for ALL RUG's in column 6. Report the applicable High-Cost Rates in column 5.01, and the High-Cost Days in column 6.01. (This should be the same amount that is reported in column 5 for that RUG.)

Column 7.--Multiply the rates in column 3 times the days in column 4. Round to zero places. Multiply the rates in column 3.01 times the days in column 4.01. Round to zero places. Multiply the rates in column 5 times the days in column 6. Round to zero places. Multiply the rates in column 5.01 times the days in column 6.01. Round to zero places. Add the results from column 4, 4.01, 6, and 6.01. Enter the combined total on each line. Round each line in column 7 to zero decimal places.

Column 8.--Multiply the facility specific rate times the total program annual days (sum of columns 4, 4.01, and 6) for each RUG, and enter the product in column 8.

Columns 9.--Multiply the Federal amount in column 7 times your transition period percentage. i.e. year # 1 is 25 percent year # 2 is 50 percent year # 3 is 75 percent, an year # 4 and forward is 100 percent. Enter the results on the appropriate line for each RUG. Enter the sum of lines 1 through 45 on line 75.

Column 10.--Multiply the facility specific amount times the reciprocal percentage applied to the Federal rate, i.e. 75 percent, 50 percent, 25 percent, or 0 percent. Enter the result on the appropriate line for each RUG. Enter the sum of lines 1 through 45 on line 75. Add the amount in column 9, line 75, plus the amount in column 10, line 75, together, and transfer this total to Worksheet E, Part III, line 7.

**SPECIAL INSTRUCTIONS TO CALCULATE THE INCREASE FOR CERTAIN HIGH COST PATIENTS, EFFECTIVE FOR SERVICES FURNISHED ON AND AFTER APRIL 1, 2000.**

Section 101 of the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) provides for a temporary, 20 percent increase in payment for 15 specified RUGs (listed below). The BBRA provides that this 20 percent increase becomes effective for services furnished beginning on April 1, 2000, and remains in effect until the date that CMS implements a refined case-mix classification system. The following is a list of the affected RUGs along with the corresponding line on Worksheet S-7, Part III.

**HIGH - COST RUGS**

<u>RUG</u>	<u>Line #</u>	<u>RUG</u>	<u>Line #</u>	<u>RUG</u>	<u>Line #</u>
RHC	7	RMC	10	RMB	11
SE3	15	SE2	16	SE1	17
SSC	18	SSB	19	SSA	20

CC2 21  
CB1 24  
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CC1 22  
CA2 25

CB2 23  
CA1 26

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Subscript columns 3 and 4 of this worksheet to columns 3.01 and 4.01 respectively. Identify column 3.01 as “Federal Rate – High Cost Add-On”, (for services between April 1, 2000 and September 30, 2000). Identify column 4.01 as “Add-On Days” (for services between April 1, 2000 and September 30, 2000). Enter in column 3.01 for each of the 15 lines identified above, 20 percent of the amount on the corresponding line in column 3. Enter in column 4.01 the days applicable to services, for the 15 lines listed above, from April 1, 2000 through September 30, 2000 or the end of the fiscal year. Where the fiscal year ends between April 2, 2000 and September 30, 2000 the provider should report in column 6.01 only the days applicable for April 1 through the end of the fiscal year. The days from the beginning of the next fiscal year through September 30, 2000 will be reported in column 4.01 of the subsequent cost report.

Section 101 of the BBRA also provides for an additional 4 percent increase in payment for ALL services furnished during fiscal years (FYs) 2001 and 2002. Therefore, for services furnished after September 30, 2000, and before October 1, 2002, columns 5 and 6 of this worksheet should be subscripted to columns 5.01 and 6.01, respectively. Identify column 5.01 as “Federal Rate – High Cost Add-On” (for services after September 30), and identify column 6.01 as “Add-On Days” (for services after September 30). Enter in column 5.01 for each line identified above, 20 percent of the Federal Case Mix Rate. Enter in column 6.01 the days applicable to services associated with the high cost RUGs (as listed above), from October 1, 2000 to the end of the provider’s fiscal year.

All of the RUG rates will be increased by 4 percent. Enter in column 5, the Federal Case Mix Rate times 104 percent.

3514.4 Part IV - PPS Statistical Data for Electronic Filing.--Use Part IV for cost reporting periods ending on and after February 28, 2001. Use this part to report the Medicare days of the provider by RUG.

*NOTE: Effective for services on and after January 1, 2006, nine new RUGs are introduced into the reimbursement calculation on this worksheet. These new RUGs are: “RUX”, “RUL”, “RVX”, “RVL”, “RHX”, “RHL”, “RMX”, “RML”, and “RLX”.*

*Subscript the lines on Worksheet S-7, Part IV to accommodate the following. Line 3.01 for “RUX”, Line 3.02 for “RUL”, Line 6.01 for “RVX”, Line 6.02 for “RVL”, Line 9.01 for “RHX”, Line 9.02 for “RHL”, Line 12.01 for “RMX”, Line 12.02 for “RML”, and Line 14.01 for “RLX”. All payment data is reported as a total amount paid under the RUG PPS payment system on Worksheet E, Part III, line 7, and is generated from the PS&R or your records. The total on line 46 must agree with the amount on Worksheet S-3, column 4, line 1. DO NOT COMPLETE columns 3, 4, 4.01, 4.05 or 5.*

*Instructions from this point to the end of the section are not applicable after January 1, 2006.*

All SNF’s which have elected the 100 percent Federal rate, or those that are on the 100 percent rate via the fourth transition year (or forward), should enter all days in column 3.01 with no calculations indicated. The amount previously indicated on line 46, column 5 is now to be entered on Worksheet E, Part III, line 7 as an input. However, this may not apply to SNF’s in MSA’s # 1123, 3810, and 7520, for cost reporting periods that overlap 12/01/01. Complete column 3.01.

For cost reporting periods beginning on and after July 1, 2001, the only data required to be reported are the days associated with each RUG. These days can be reported in column 3.01, and do not have to be split between “before and after” October 1. The calculation of the total payment for each RUG is no longer required. All payment data is reported as a total amount paid under the RUG PPS payment system on Worksheet E, Part III, line 7, and is generated from the PS&R or your records. The total *days* on line 46 must agree with the amount on Worksheet S-3, column 4, line 1. DO NOT COMPLETE columns 3, 4, 4.01, 4.05 or 5.

Column Descriptions

Column 1--The case mix group designations are already entered in this column.

Column 2--The M3PI revenue code designations are already entered in this column.

Columns 3 and 4--Enter the rate assigned to the provider for each applicable RUG, and period. This rate is updated annually effective October 1. Providers with fiscal years other than October 1 to September 30 may have two rates to report. Enter the rate prior to October 1 in column 3 and the rate on or after October 1 in column 4. Providers with a fiscal year October 1st to September 30th use column 4 only. This Federal rate is adjusted for the labor portion by the update factor specific to the provider's MSA. This update factor is reported on Worksheet S-2, line 3.2 columns 1 and 2.

Columns 3.01 and 4.01--Enter in column 3.01 the days, for each RUG, of the period before October 1 and in column 4.01 for the days on and after October 1. Enter the total on line 46.

Column 4.05--For cost reporting periods that end prior to April 1, 2000, do not complete this column. For services rendered on and after April 1, 2000, through September 30, 2000, enter the days associated with the high cost RUGs at an increase of 20 percent.

Column 5--Multiply columns 3 and 4 times columns 3.01 and 4.01 (column 4 times column 4.01 for cost reporting periods beginning October 1) respectively, rounded to zero and add the two results. This becomes the Federal amount. Multiply the Federal amount by the appropriate transition period percentage, i.e. 25 percent, 50 percent, 75 percent, or 100 percent identified on Worksheet S-2 line 3.1, column 2. Add to the Federal amount the result of the calculation of (total days from columns 3.01 and 4.01 multiplied by the facility specific rate (that result rounded to zero) identified on worksheet S-2, line 3.1, column 1) times the reciprocal percentage applied to the Federal rate, i.e., 75 percent, 50 percent, 25 percent, or 0 percent. Enter the result on the appropriate line for each RUG. Enter the sum of lines 1 through 45 on line 46, and transfer this total to Worksheet E, Part III, line 7.

3515. WORKSHEET S-8 - HOSPICE IDENTIFICATION DATA

In accordance with 42 CFR 418.310, hospice providers of service participating in the Medicare program are required to submit information for health care services rendered to Medicare beneficiaries. 42 CFR 413.20 requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a SNF-based hospice. Complete a separate Worksheet S-8 for each SNF-based hospice.

3515.1 Part I - Enrollment Days Based on Level of Care.

Lines 1--4--Enter on line 1 through 4 the enrollment days applicable to each type of care. Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four types of care. Where a patient moves from one type of care to another, count only one day of care for that patient for the last type of care rendered. For line 5, an inpatient care day may be reported only where the hospice provides or arranges to provide the inpatient care.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Line 1--**Continuous Home Care Day** - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a

maximum of 24 hours of predominantly nursing care. Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.

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Line 2.--Routine Home Care Day - A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

Line 3.--Inpatient Respite Care Day - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

Line 4.--General Inpatient Care Day - A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

Column 1.--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Column 2.--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 5 the total unduplicated Medicaid days.

Column 3.--Enter only the unduplicated days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 5 the total unduplicated days.

Column 4.--Enter only the unduplicated days applicable to the four types of care for all Medicaid hospice patients residing in a nursing facility. Enter on line 5 the total unduplicated days.

Column 5.--Enter in column 5 only the days applicable to the four types of care for all other non Medicare or non Medicaid hospice patients. Enter on line 5 the total unduplicated days.

Column 6.--Enter the total days for each type of care, (i.e., sum of columns 1, 2, and 5). The amount entered in column 6 line 5 represents the total days provided by the hospice.

**NOTE:** Convert continuous home care hours into days so that column 6 line 5 reflects the actual total number of days provided by the hospice.

#### 3515.2 Part II --Census Data

Line 6.--Enter on line 6 the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source.

The total under this line equals the actual number of patients served during the cost reporting period for each program. Thus, if a patient's total stay overlapped two reporting periods, the stay is counted once in each reporting period. The patient who initially elects the hospice benefit, is discharged or revokes the benefit, and then elects the benefit again within a reporting period is considered to be a new admission with a new election and is counted twice.

A patient transferring from another hospice is considered to be a new admission and is included in the count. If a patient entered a hospice under a payer source other than Medicare and then subsequently elects Medicare hospice benefit, count the patient once for each pay source.

The difference between line 6 and line 9 is that line 6 equals the actual number of patients served during the reporting period for each program, whereas under line 9, patients are counted once, even if their stay overlaps more than one reporting period.

Line 7.--Enter the total Title XVIII unduplicated continuous care hours billable to Medicare. When computing the unduplicated continuous care hours, count only one hour regardless of the number of services or therapies provided simultaneously within that hour.



Line 8.--Enter the average length of stay for the reporting period. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payer source other than Medicare and Medicaid is not limited to the number of days under a hospice election.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then reelects the Medicare hospice benefits for an additional 45 days, under a new benefit period and dies (patient B). Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D was admitted with private insurance for 27 days, then their private insurance ended and Medicaid covered an additional 92 days. Patient E, with private insurance, received hospice care for 87 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the cost reporting period) is computed as follows:

Medicare Days (90 & 45 & 29) Patient (A, B & C)	164 days
Medicare Patients	/3
Average LOS Medicare	54.67 Days
Medicaid Days Patient D (92) Medicaid Patient	92 Days 1
Average LOS Medicaid	92 Days
Other Payments (D & E) Average LOS (Other)	2 54 Days
All Patients (90+45+29+92+87+27) Total number of patients	370 Days 6
Average LOS for all patients	61.67 Days

Enter the hospice's average length of stay, without regard to payer source, in column 6, line 8.

Line 9.--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (see CMS Pub. 21 §204). However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and is counted twice.

The total under this line equals the unduplicated number of patients served during the reporting period for each program. Thus, you do not include a patient if their stay was counted in a previous cost reporting period. If a patient enters a hospice source other than Medicare and subsequently becomes eligible for Medicare and elects the Medicare hospice benefit, then count that patient only once in the Medicare column, even though he/she may have had a period in another payer source prior to the Medicare election. A patient transferring from another hospice is considered to be a new admission and is included in the count.

3516. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, C, and D, the line numbers are consistent, and the total line is set at number 75). All of the cost centers listed do not apply to all providers using these forms. An "X" on the cost center line identifies ONLY those cost centers which may be used for the Simplified Method cost report.

Do not include on this worksheet items not claimed in the cost report because they conflict with the regulations, manuals, or instructions but which you wish nevertheless to claim and contest. Enter amounts on the appropriate settlement worksheet (Worksheet E, Part I, line 37; Worksheet E, Part II, line 29; Worksheet E, Part III, Part A, line 18, Part B, line 38; Worksheet H-6, Part II, line 23; Worksheet J-3, line 25; or Worksheet I-3, line 27).

If the cost elements of a cost center are separately maintained on your books, you must maintain a reconciliation of the costs per the accounting books and records to those on this worksheet. The reconciliation is subject to review by the intermediary.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If you need to use additional or different cost center descriptions, you may do so by adding additional lines to the cost report. When an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line description. Identify the added line as a numeric (only) subscript of the immediately preceding line. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02. If additional lines are added for general service cost centers, add corresponding columns for cost finding on Worksheets B, B-1, J-1, and K-5.

If you checked yes on Worksheet S-2, line 52, indicating that you wish to file this cost report under 42 CFR 413.321 (the simplified cost report method), certain cost centers on Worksheet A will not be used. Section 3504.2, step # 6 identifies the cost centers that will be allowed under this method. Worksheet A, Column C also identifies the cost centers that may be used under the simplified cost reporting method. **Column C is not applicable to the "full" SNF cost report, and as such, is not required to be printed (via the PI file) on the "full" SNF cost report. This column may be printed (via the PI file) on the "simplified" SNF cost report, but is not required.** Overhead cost centers, nursing administration, central supply, pharmacy, medical records & library, and social service are combined into one category, and is reported on line 9.



Submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and used as a basic summary for financial statements.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. Form CMS 2540-96 provides for preprinted cost center descriptions on Worksheet A. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. Nonstandard cost center descriptions have been identified through analysis of frequently used labels.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. You are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center table # 5, in §3595.

Columns 1, 2, and 3.--The expenses listed in these columns must be in accordance with your accounting books and records. List on the appropriate lines in columns 1, 2, and 3 the total expenses incurred during the cost reporting period. Detail the expense between salaries (column 1) and other than salaries (column 2). The sum of columns 1 and 2 must equal column 3. Record any needed reclassification and/or adjustments in columns 4 and 6, as appropriate.

Column 4.--Enter any reclassification among the cost center expenses in column 3 which are needed to effect proper cost allocation.

Worksheet A-6 reflects the reclassification affecting the cost center expenses. This worksheet need not be completed by all providers but must be completed only to the extent that the reclassification are needed and appropriate in the particular provider's circumstances. Show reductions to expenses in parentheses ().

The net total of the entries in column 4 must equal zero on line 75.

Column 5.--Adjust the amounts entered in column 3 by the amounts in column 4 (increase or decrease) and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 75.

Column 6.--Enter on the appropriate lines in column 6 of Worksheet A the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The total on Worksheet A, column 6, line 75 must equal Worksheet A-8, column 2, line 32.

Column 7.--Adjust the amounts in column 5 by the amounts in column 6 (increases or decreases) and extend the net balances to column 7. Transfer the amounts in column 7 to the appropriate lines on Worksheet B, Part I, column 0, or Worksheet B, Part III, column 0.

#### Line Descriptions

The trial balance of expenses is broken down into general service, inpatient routine service, ancillary service, outpatient service, other reimbursable, special purpose, and nonreimbursable cost center categories to facilitate the transfer of costs to the various worksheets. For example, the categories "Ancillary Cost Centers" and "Outpatient Cost Centers" appear on Worksheet D using the same line numbers as on Worksheet A.

**NOTE:** The category titles do not have line numbers. Only cost centers, data items, and totals have line numbers.

Lines 1 and 2.--These cost centers include depreciation, leases, and rentals for the use of facilities and/or equipment, interest incurred in acquiring land or depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care. Do not include in these cost centers costs incurred for the repair or maintenance of equipment or facilities, amounts included in rentals or lease payments for repair and/or maintenance agreements, interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care, general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets, or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Many providers incur costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control. 42 CFR 413.17 and CMS Pub. 15-I, chapter 10, require that the reimbursable cost of the provider include the costs for these items at the cost to the supplying organization (unless the exception provided in 42 CFR 413.17(d) and CMS Pub. 15-I, §1010 is applicable). However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to you may not exceed the market price.

The rationale behind this policy is that when you are dealing with a related organization, you are essentially dealing with yourself. Therefore, your costs are considered equal to the cost to the related organization.

If you include on the cost report costs incurred by a related organization, the nature of the costs (i.e., capital-related or operating costs) do not change. Treat capital-related costs incurred by a related organization as your capital-related costs.

However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplying related organization, your allowable cost may not exceed the market price. Unless the services, facilities, or supplies are otherwise considered capital-related cost, no part of the market price is considered capital-related cost. Also, if the exception in 42 CFR 413.17(d) and CMS Pub.15-I, §1010 applies, no part of the cost to you of the services, facilities, or supplies is considered capital-related cost unless the services, facilities, or supplies are otherwise considered capital-related.

If the supplying organization is not related to you within the meaning of 42 CFR 413.17, no part of the charge to you may be considered a capital-related cost (unless the services, facilities, or supplies are capital-related in nature) unless:

- o The capital-related equipment is leased or rented by you;
- o The capital-related equipment is located on your premises or is located offsite and is on real estate owned, leased, or rented by you; and
- o The capital-related portion of the charge is separately specified in the charge to you.

Under certain circumstances, costs associated with minor equipment may be considered capital-related costs. CMS Pub. 15-I, §106 discusses methods for writing off the cost of minor equipment. Three methods are presented in that section. Amounts treated as expenses under method (a) are not capital-related costs because they are treated as operating expenses. Amounts included in expense

under method (b) are capital-related costs because such amounts represent the amortization of the cost of tangible assets over a projected useful life. Amounts determined under method (c) are capital-related costs because method (c) is a method of depreciation.

Line 9.--This cost center normally includes only the cost of nursing administration. The salary cost of direct nursing services (including the salary cost of nurses who render direct service in more than one patient care area) are directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks.

However, if your accounting system fails to specifically identify all direct nursing services to the applicable patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 12.--This cost center includes the direct cost of the medical records cost center including the medical records library. The general library and the medical library must not be included in this cost center. Report them in the administrative and general cost center.

Line 14.--Use this line to record the cost of intern and residents if the SNF maintains an intern and residents program.

Lines 16 through 20.--These lines are for the inpatient routine service cost centers.

Line 19.--This cost center accumulates the direct costs incurred in maintaining long term care services not specifically required to be included in other cost centers. A long term care unit refers to a unit where the average length of stay for all patients is 25 days or more. The beds in this unit are not certified for titles V, XVIII, or XIX.

| Line 20.--No data should be entered on this line for cost reports ending on and after November 30, 1999.

Lines 21 through 33.--These lines are for the ancillary cost centers.

Line 32.--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 beds.

**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.

Lines 34, 35, and 36.--These lines are for outpatient cost centers.

Lines 37 through 51.--These lines are for other reimbursable cost centers.

Lines 37 through 47.--These lines are provided to accumulate costs which are specific to HHA services.

Line 37.--This cost center accumulates the direct costs attributable to HHA administrative and general costs.

Provider-based HHAs are operated and managed in a variety of ways within the context of the health care complexes of which they are components. In some instances, there are discrete management and administrative functions pertaining to the HHA, the cost of which is readily identifiable from the books and records.

In other instances, the administration and management of the provider-based HHA is integrated with the administration and management of the health care complex to such an extent that the cost of administration and management of the home health agency can be neither identified nor derived from the books and records of the health care complex. In other instances, the cost of administration and management of the HHA is integrated with the administration and management of the health care complex, but the cost of the HHA administration and management can be derived through cost finding. However, in most cases, even where the cost of HHA administration and management can be either identified or derived, the extent to which the costs are applicable to the services furnished by the provider-based HHA is not readily identifiable.

Even when the costs of administration and management of a provider-based HHA can be identified or derived, such costs do not generally include all of the general service costs (i.e., overhead costs) applicable to the HHA. Therefore, allocation of general service costs through cost finding is necessary for the determination of the full costs of the provider-based HHA.

If the provider-based HHA can identify discrete management and administrative costs from its books and records, include these costs on line 37.

Similar situations occur for services furnished by the provider-based HHA. For example, in some instances, physical therapy services are furnished by a discrete HHA physical therapy department. In other instances, physical therapy services are furnished to the patients of the provider-based HHA by an integrated physical therapy department of an SNF health care complex in such a manner that the direct costs of furnishing the physical therapy services to the patients of the provider-based HHA cannot be readily identified or derived.

In still other instances, physical therapy services are furnished to patients of the provider-based HHA in an integrated physical therapy department of an SNF health care complex in such a manner that the costs of physical therapy services furnished to patients of the provider-based HHA can be readily identified or derived.

If you maintain a separate therapy department for the HHA apart from the SNF therapy department furnishing services to other patients of the health care complex or are able to reclassify costs from an integrated therapy department to an HHA therapy cost center, then make a reclassification entry on Worksheet A-6 to the appropriate HHA therapy cost center. Make a similar reclassification to the appropriate line for other ancillaries when the HHA costs are readily identifiable.

**NOTE:** This cost report provides separate HHA cost centers for all therapy services. If services are provided to HHA patients from a shared SNF ancillary cost center, make the cost allocation on Worksheet B.

Line 38.--This cost center includes the direct patient care costs incurred for skilled nursing care to patients who are normally at their place of residence.

Lines 39 through 41.--These lines provide for Physical Therapy - HHA, Occupational Therapy - HHA, and Speech Pathology - HHA cost centers when only HHA patients are serviced from them.

Line 42.--This cost center includes the direct patient care cost incurred for counseling and assessment activities which contribute meaningfully to the treatment of a patient's condition within the context of home health care.

Line 43.--This cost center includes the direct patient care costs incurred for services performed by specially trained personnel who assist individuals in carrying out physicians' instructions under an established plan of care.

Line 44.--Enter the cost of durable medical equipment (DME) rented to home health patients. (See CMS Pub. 11, §206.)

Line 45.--Enter the cost of DME sold to home health patients.

Line 46.--Enter the cost of a home delivered meals program. This service is not reimbursable under title XVIII. However, it may be reimbursable by a State program, and, as such, identify the cost for that purpose.

Line 47.--This cost center includes the direct costs of noncovered home health services for Medicare cost reporting purposes. Noncovered services include homemaker services, home dialysis aide services, private duty nursing, health promotion activities, and day care programs. Report "telemedicine" services rendered on and after October 1, 2000, on a subscript line of line 47. Transfer this amount to Worksheet H, line 23.50.

Line 48.--Enter on this line the ambulance cost where the ambulance is owned and operated by the facility.

Line 49.--Use this line if your SNF operates an intern and resident program not approved by Medicare.

Line 50.--This cost center accumulates the direct costs attributable to an outpatient rehabilitation facility. This line should be subscripted to accommodate the following: comprehensive outpatient rehabilitation facility (CORF) should use line 50.00, community mental health center (CMHC) should use line 50.10, outpatient physical therapy (OPT) should use line 50.20, outpatient occupational therapy (OOT) should use line 50.30, and outpatient speech therapy (OSP) should use line 50.40. Direct costs normally include such cost categories as are listed on the applicable Worksheet J-1, lines 1 through 21.

Lines 52 through 56.--These lines are for special purpose cost centers.

Line 52.--This cost center includes the costs of malpractice insurance premiums and self insurance fund contributions. Also, include the cost if you pay uninsured malpractice losses incurred either through deductible or coinsurance provisions, as a result of an award in excess of reasonable coverage limits, or as a governmental provider. After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.

Line 53.--After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.



Line 54.--Only include utilization review costs of the SNF. Either reclassify or adjust all costs depending on the scope of the review. If the scope of the review covers all patients, reclassify all allowable costs in column 4 to administrative and general expenses (line 4). If the scope of the review covers only Medicare patients or Medicare, title V, and title XIX patients, then (1) in column 4, reclassify to administrative and general expenses all allowable costs other than physician compensation and (2) deduct, in column 6, the compensation paid to the physicians for their personal services on the utilization review committee. After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.

Line 55.--This cost center accumulates the direct costs attributable to a hospice.

Lines 58 through 63.--Use these lines to record the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers than those shown, add a subscript consisting of a numeric subscript code to one or more of these lines. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, if the expense (direct and all applicable overhead) attributable to any nonallowable cost area is so insignificant as not to warrant establishment of a nonreimbursable cost center and the sum total of all such expenses is so insignificant as not to warrant the establishment of a composite nonreimbursable cost center, adjust these expenses on Worksheet A-8. (See CMS Pub. 15-I, §2328.)

Line 60.--Establish a nonreimbursable cost center to accumulate the cost incurred by the provider for services related to the physicians' private practice. Examples of such costs include depreciation costs for the space occupied, movable equipment used by the physicians' offices, administrative services, medical records, housekeeping, maintenance and repairs, operation of plant, drugs, medical supplies, and nursing services.

This nonreimbursable cost center does not include costs applicable to services which benefit the general population or for direct patient services rendered by SNF-based physicians.

### 3517. WORKSHEET A-6 - RECLASSIFICATIONS

This worksheet provides for the reclassification of certain costs to effect proper cost allocation under cost finding. Submit, with the cost report, copies of any workpapers used to compute reclassification affected on this worksheet.

COMPLETE WORKSHEET A-6 ONLY TO THE EXTENT THAT EXPENSES HAVE BEEN INCLUDED IN COST CENTERS THAT DIFFER FROM THE RESULT THAT IS OBTAINED USING THE INSTRUCTIONS FOR THIS SECTION.

Examples of reclassification that may be needed are:

1. Capital-related costs that are not included in one of the capital-related cost centers on Worksheet A, column 3. Examples include insurance on buildings and fixtures and movable equipment, rent on buildings and fixtures and movable equipment, interest on funds borrowed to purchase buildings and fixtures and movable equipment, personal property taxes, and real property taxes. Interest on funds borrowed for operating expenses is not included in capital related costs. It must be allocated with administrative and general expenses.

2. Employee benefits expenses (e.g., personnel department, employee health service, hospitalization insurance, workmen's compensation, employee group insurance, social security taxes, unemployment taxes, annuity premiums, past service benefits and pensions) included in the administrative and general cost center.

3. Insurance expense included in the administrative and general cost center and applicable to buildings and fixtures and/or movable equipment.

4. Interest expense included on Worksheet A, column 3, line 53 and applicable to funds borrowed for administrative and general purposes (e.g., operating expenses) or for the purchase of buildings and fixtures or movable equipment.

5. Rent expenses included in the administrative and general cost center and applicable to the rental of buildings and fixtures and to movable equipment from other than related organizations. (See the instructions for Worksheet A-8-1 for treatment of rental expenses for related organizations.)

6. Any taxes (real property taxes and/or personal property taxes) included in the administrative and general cost center and applicable to buildings and fixtures and/or movable equipment.

7. Utilization review costs. Administrative costs related to utilization review and the costs of professional personnel other than physicians are allowable costs and are apportioned among all users of the SNF, irrespective of whether utilization review covers the entire patient population. Reclassify these costs from Worksheet A, column 3, line 54 to administration and general costs.

This reclassification includes the costs of physician services in utilization review only if a valid allocation between Medicare and the other programs is not supported by documentation. Otherwise, the costs of physician services in utilization review are in accordance with the instructions for Worksheet A-8 relating to utilization review.

Make the appropriate adjustment for physician compensation on Worksheet A-8. For further explanations concerning utilization review in SNFs, see CMS Pub. 15-I, §2126.2.

8. Any dietary cost included in the dietary cost center and applicable to any other cost centers, e.g., gift, flower, coffee shop, and canteen.

9. Any direct expense included in the central service and supply cost center and directly applicable to other cost centers, e.g., intravenous therapy, oxygen (inhalation) therapy.

10. Any direct expenses included in the laboratory cost center and directly applicable to other cost centers, e.g., electrocardiology.

11. Any direct expenses included in the radiology cost center and directly applicable to other cost centers, e.g., electrocardiology.

12. When you purchase services (e.g., physical therapy) under arrangements for Medicare patients but do not purchase such services under arrangements for non-Medicare patients, your books reflect only the cost of the Medicare services. However, if you do not use the grossing up technique for purposes of allocating your overhead and if you incur related direct costs applicable to all patients, Medicare and non-Medicare (e.g., paramedics or aides who assist a physical therapist in performing physical therapy services), such related costs are reclassified on Worksheet A-6 from the ancillary service cost center and ARE allocated as part of administrative and general expense.

However, when you purchase therapy services that include performing administrative functions such as completion of medical records, training etc. as discussed in CMS Pub 15-I, §1412.5, the bundled charge for therapies provided under arrangements includes the provision of these services. Therefore for cost reporting purposes, these related services are NOT reclassified to A&G.

13. Rental expense on movable equipment which was charged directly to the appropriate cost center or cost centers must be reclassified on this worksheet to the capital-related movable equipment cost center unless the provider has identified and charged all depreciation on movable equipment to the appropriate cost centers.

14. Malpractice insurance cost to administrative and general for cost reports beginning on or after May 1, 1986.

3518. WORKSHEET A-7 - ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES

This part enables the Medicare program to analyze the changes that occurred in your capital asset balances during the current reporting period. This worksheet is completed only once for the entire SNF complex.

The analysis of changes in capital asset balances during the cost reporting period must be completed by all SNFs and SNF health care complexes. Do not reduce the amount entered by any accumulated depreciation reserves.

Columns 1 and 6.--Enter the balance recorded in your books of accounts at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6).

Columns 2 through 4.--Enter the cost of capital assets acquired by purchase (including assets transferred from another provider, noncertified health care unit, or nonhealth care unit) in column 2 and the fair market value at date acquired of donated assets in column 3. Enter the sum of columns 2 and 3 in column 4.

Column 5.--Enter the cost or other approved basis of all capital assets sold, traded, or transferred to another provider, a noncertified health care unit, or nonhealth care unit or retired or disposed of in any other manner during your cost reporting period.

The sum of columns 1 and 4 minus column 5 equals column 6.



**3519. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES**

In accordance with 42 CFR 413.9(c)(3), if your operating costs include amounts not related to patient care (specifically not reimbursable under the program) or amounts flowing from the provision of luxury items or services (i.e., those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts are not allowable.

This worksheet provides for the adjustment in support of those listed on Worksheet A, column 6. These adjustments, which are required under the Medicare principles of reimbursement, are made on the basis of cost or amount received (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the cost. Submit with the cost report a copy of any workpapers used to compute a cost adjustment. Once an adjustment to an expense is made on the basis of cost, you may not determine the required adjustment to the expense on the basis of revenue in future cost reporting periods. Enter the following symbols in column 1 to indicate the basis for adjustment: "A" for cost, and "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or which result in costs incurred for reasons other than patient care and, thus, require adjustments.

The types of adjustments entered on this worksheet are (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, grants, gifts; (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process.

If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on Worksheet A-8.

Line 5.--For patient telephones, either make an adjustment on this line or establish a nonreimbursable cost center. When line 5 is used, base the adjustment on cost. Revenue cannot be used. (See CMS Pub. 15-I, §2328.)

Line 8.--Enter the adjustment amount from Worksheet A-8-2, column 18. Amounts paid to SNF-based physicians for general SNF services rendered are not included in these adjustments. (See CMS Pub. 15-I, §§2108 - 2108.11.)

Line 9.--Enter allowable home office costs which have been allocated to the SNF and which are not already included in your cost report. Use additional lines to the extent that various SNF cost centers are affected. (See CMS Pub. 15-I, §§2150 - 2153.)

Line 11.--Obtain the amount from your records.

Line 12.--Obtain the amount from Part B, column 6 of Worksheet A-8-1. Note that Worksheet A-8-1 represents the detail of the various cost centers on Worksheet A, which must be adjusted.

Line 13.--An adjustment is required for nonallowable patient personal laundry.

Line 14.--Enter the amount received from the sale of meals to employees. This income offsets the dietary expense.

Line 15.--Enter the cost of meals provided for non-employees. This amount offsets the allowable dietary costs.

Line 20.--Enter the cash received from imposition of interest, finance, or penalty charges on overdue receivables. This income must offset the allowable administrative and general costs. (See CMS Pub. 15-I,§2110.2.)

Line 21.--Enter the interest expense imposed by the intermediary on Medicare overpayments to you. Also, enter the interest expense on borrowing made to repay Medicare overpayments to you. (See CMS Pub 15-I, chapter 2.)

For therapy services provided on or after April 10, 1998, complete lines 22-25, as follows:

Line 22.--Enter the adjustment for speech therapy services in excess of the limitation for the SNF from Worksheet A-8-5, Part VII, line 77. Subscript this line to report the adjustment for speech therapy for each subprovider as follows:

Line 22.10. --Enter the adjustment for speech therapy in excess of the limitation for all SNF-based CORF services from Worksheet A-8-5, Part VII, sum of lines 78-78.90, if line 78 is subscripted; otherwise, enter the amount from line 78.

Line 22.20.--Enter the adjustment for speech therapy in excess of the limitation for all SNF-based CMHC services from Worksheet A-8-5, Part VII, sum of lines 79-79.90, if line 79 is subscripted; otherwise, enter the amount from line 79.

Line 22.30.--Enter the adjustment for speech therapy in excess of the limitation for all SNF-based OPT services from Worksheet A-8-5, Part VII, sum of lines 80-80.90, if line 80 is subscripted; otherwise, enter the amount from line 80.

Line 22.50.---Enter the adjustment for speech therapy in excess of the limitation for all SNF-based HHA services from Worksheet A-8-5, Part VII, sum of lines 81-81.90, if line 81 is subscripted; otherwise, enter the amount from line 81.

Line 23.--For services provided on or after April 10, 1998, add the adjustment for occupational therapy in excess of the limitation for the SNF from Worksheet A-8-5, Part VII, line 77. Subscript this line to report the adjustment for occupational therapy for each subprovider as follows:

Line 23.10. --Enter the adjustment for occupational therapy in excess of the limitation for all SNF-based CORF services from Worksheet A-8-5, Part VII, sum of lines 78-78.90, if line 78 is subscripted; otherwise, enter the amount from line 78.

Line 23.20.--Enter the adjustment for occupational therapy in excess of the limitation for all SNF-based CMHC services from Worksheet A-8-5, Part VII, sum of lines 79-79.90, if line 79 is subscripted; otherwise, enter the amount from line 79.

Line 23.30.--Enter the adjustment for occupational therapy in excess of the limitation for all SNF-based OPT services from Worksheet A-8-5, Part VII, sum of lines 80-80.90, if line 80 is subscripted; otherwise, enter the amount from line 80.

**Line 23.50.**--Enter the adjustment for occupational therapy in excess of the limitation for all SNF-based HHA services from Worksheet A-8-5, Part VII, sum of lines 81-81.90, if line 81 is subscripted; otherwise, enter the amount from line 81. For HHA services provided prior to April 10, 1998, also add the amount from Worksheet A-8-3, Part VII, line 63 and enter on this line.

**Line 24.**--Enter the amount for an adjustment for respiratory therapy in excess of limitation for the SNF. Obtain the amount from Worksheet A-8-4, Part V, line 46, for services provided before April 10, 1998. Obtain the amount from Worksheet A-8-5, Part VII, line 77, for services provided on or after April 10, 1998. For providers with cost reporting periods which straddle the April 10, 1998 implementation date, line 24 should be a combination of the amounts from Worksheet A-8-4, Part V, line 46 and Worksheet A-8-5, Part VII, line 77. Subscript this line to report the adjustment for respiratory therapy services for each subprovider, as follows:

**Line 24.10.** --Enter the adjustment for respiratory therapy in excess of the limitation for all SNF-based CORF services from Worksheet A-8-5, Part VII, sum of lines 78-78.90, if line 78 is subscripted; otherwise, enter the amount from line 78.

**Line 24.20.**--Enter the adjustment for respiratory therapy in excess of the limitation for all SNF-based CMHC services from Worksheet A-8-5, Part VII, sum of lines 79-79.90, if line 79 is subscripted; otherwise, enter the amount from line 79.

**Line 24.30.**--Enter the adjustment for respiratory therapy in excess of the limitation for all SNF-based OPT services from Worksheet A-8-5, Part VII, sum of lines 80-80.90, if line 80 is subscripted; otherwise, enter the amount from line 80.

**Line 25.**--Enter the adjustment for physical therapy in excess of the limitation for all SNF services. Obtain the amount from Worksheet A-8-3, Part VI, line 57 for services provided prior to April 10, 1998. For services provided on or after April 10, 1998, also enter the amount of physical therapy in excess of the limitation for SNF services from Worksheet A-8-5, Part VII, line 77. The adjustment will be the sum of these amounts. Subscript this line to report the adjustment for respiratory therapy services for each subprovider, as follows:

**Line 25.10.** --Enter the adjustment for physical therapy in excess of the limitation for all SNF-based CORF services from Worksheet A-8-5, Part VII, sum of lines 78-78.90, if line 78 is subscripted; otherwise, enter the amount from line 78.

**Line 25.20.**--Enter the adjustment for physical therapy in excess of the limitation for all SNF-based CMHC services from Worksheet A-8-5, Part VII, sum of lines 79-79.90, if line 79 is subscripted; otherwise, enter the amount from line 79.

**Line 25.30.**--Enter the adjustment for physical therapy in excess of the limitation for all SNF-based OPT services from Worksheet A-8-5, Part VII, sum of lines 80-80.90, if line 80 is subscripted; otherwise, enter the amount from line 80.

**Line 25.50.**--Enter the adjustment for physical therapy in excess of the limitation for all SNF-based HHA services from Worksheet A-8-5, Part VII, sum of lines 81-81.90, if line 81 is subscripted; otherwise, enter the amount from line 81. For HHA services provided prior to April 10, 1998, also add the amount from Worksheet A-8-3, Part VII, line 63 and enter on this line. The adjustment will be the sum of these amounts.

Line 26.--Obtain the amount from Worksheet A-8-3, Part VI, line 57 or Part VII, line 64, as appropriate.

**NOTE:** When an amount is entered on Worksheet A-8-3, Part VI, line 57, Part VII is not completed. Transfer the amount to Worksheet A-8, line 25, when applicable to the skilled nursing facility or to line 26 when applicable to the HHA. However, when one or more suppliers provide physical therapy services to you and to the HHA, allocate the excess cost between you and the HHA on Worksheet A-8-3, Part VII.

Line 28.--If the utilization review covers only Medicare patients, the costs of the physician services are removed from the utilization review costs and are shown as a direct reimbursement item of Worksheet E, Part I, line 5 or line 11 of Worksheet E, Part III for SNFs under PPS.

If the utilization review extends to beneficiaries under titles V or XIX, then providing that there is a sufficient documentation of physician activities, the costs of physician review services for the utilization review are a direct reimbursement item for each title under which reimbursement is claimed.

If the utilization review extends to more than the Medicare patients, but the records of the physician activities are not satisfactory for allocation purposes, then apportion the utilization review physician services cost among all the patients using the SNF. Accomplish this apportionment by including the cost of the physician services in the administrative and general costs.

| The reference on this form in column 4 has been changed to line 54.

Line 29.--When depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on line 29 and/or line 30. (See CMS Pub. 15-I, chapter 1.)

| Line 31.--Enter any additional adjustments which are required under the Medicare principles of reimbursement. Appropriately label the lines to indicate the nature of the required adjustments.

**NOTE:** An example of an adjustment entered on these lines is the grossing up of costs in accordance with provisions of CMS Pub. 15-I, §2314, and is explained below.

If you furnish ancillary services to health care program patients under arrangements with others but simply arrange for such services for non-health care program patients and do not pay the non-health care program portion of such services, your books reflect only the costs of the health care program portion. Therefore, allocation of indirect costs to a cost center which includes only the cost of the health care program portion results in excessive assignment of indirect costs to the health care programs. Since services were also arranged for the non-health care program patients, allocate part of the overhead costs to those groups.

In the foregoing situation, no indirect costs may be allocated to the cost center unless the intermediary determines that you are able to gross up both the costs and the charges for services to non-health care program patients so that both costs and charges for services to non-health care program patients are recorded as if you had provided such services directly.



The instructions for Worksheet A-6, line 12 explain the correct handling for any direct provider costs for services purchased under arrangement. The instructions for Worksheet B, Part I explain the circumstances when indirect costs are allocated to the cost of services purchased under arrangements. The instructions to Worksheet C explain the grossing up of charges for services purchased under arrangement.

Line 32.--Enter the amount on line 27 plus the sum of lines 28 through 31. TRANSFER THE AMOUNTS IN COLUMN 2 TO WORKSHEET A, COLUMN 6.

**3520. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS**

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includible in the allowable cost of the provider at the cost to the related organization (except for the exceptions outlined in 42 CFR 413.17(d).) This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the SNF by organizations related to the provider. In addition, certain information concerning the related organizations with which the provider has transacted business must be shown. (See CMS Pub. 15-I, chapter 10.)

Part A.--If there are any costs included on Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10, then complete Worksheet A-8-1. If there are no costs included on Worksheet A which resulted from transactions with related organizations, DO NOT complete Worksheet A-8-1.

Part B.--Cost applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includible in the allowable cost of the provider at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost conscious buyer would pay for comparable services, facilities, or supplies that could be purchased elsewhere.

Part C.--Use this part to show the interrelationship of the provider to organizations furnishing services, facilities, or supplies to the provider. The requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to the provider, a common ownership of the provider, or control over the provider as defined in CMS Pub. 15-I, chapter 10, must be shown in columns 1 through 6, as appropriate.

Complete only those columns which are pertinent to the type of relationship which exists.

Column 1.--Enter the appropriate symbol which describes the interrelationship of the provider to the related organization.

Column 2.--If the symbols A, D, E, F, or G are entered in column 1, enter the name of the related individual in column 2.

Column 3.--If the individual indicated in column 2 or the organization indicated in column 4 has a financial interest in the provider, enter the percent of ownership in the provider.

Column 4.--Enter the name of the related corporation, partnership, or other organization.

Column 5.--If the individual indicated in column 2 or the provider has a financial interest in the related organizations, enter the percent of ownership in such organization.

Column 6.--Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry, and linen service).

**3521. WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS**

In accordance with 42 CFR 413.9, 42 CFR 405.480, 42 CFR 405.481, 42 CFR 405.482, and 42 CFR 405.550(e), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population. (See 42 CFR 405.465 and 42 CFR 405.466 for an exception for teaching physicians under certain circumstances.) 42 CFR 405.482 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost incurred by you. 42 CFR 405.481 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services such as research. Only provider services are reimbursable to you through the cost report. This worksheet also provides for computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 405.482. The methodology used in this worksheet applies the RCE limit to the total physician compensation attributable to provider services that are reimbursable on a reasonable cost basis.

**NOTE:** Where several physicians work in the same department, see CMS Pub. 15-I, §2182.6C for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

Column Descriptions

Columns 1 and 10.--Enter the line numbers from Worksheet A for each cost center that contained compensation for physicians who are subject to RCE limits. Enter the line numbers in the same order as displayed on Worksheet A.

Columns 2 and 11.--Enter the description of the cost center used on Worksheet A.

When RCE limits are applied on an individual basis to each physician in a department, list each physician on successive lines below the cost center. List each physician using an individual identifier which is not necessarily either the name or social security number of the individual (e.g., Dr. A, Dr. B). However, the identity of the physician must be made available to your fiscal intermediary upon audit.

Columns 3 through 9 and 12 through 18.--When the aggregate method is used, enter the data for each of these columns on the aggregate line for each cost center. When the individual method is used, enter the data for each column on the individual physician identifier lines for each cost center.

Column 3.--Enter the total physician compensation paid by you for each cost center. Physician compensation means monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services) that you or other organizations furnish to a physician in return for the physician's services. (See 42 CFR 405.481(a).) Include the compensation in column 3 of Worksheet A or, if necessary, through appropriate reclassification on Worksheet A-6 or as a cost paid by a related organization through Worksheet A-8-1.

Column 4.--Enter the amount of total remuneration included in column 3 which is applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B carrier in accordance with 42 CFR 405.550(b). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 405.481(f).)

Column 5.--Enter the amount of the total remuneration included in column 3, for each cost center, which is applicable to general services to you (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 405.481(f).)

**NOTE:** 42 CFR 405.481(b) requires that physician compensation be allocated between physician services to patients, to the provider, and nonallowable services such as research. Physicians' nonallowable services must not be included in columns 4 or 5. The instructions for column 18 ensure that the compensation for nonallowable services which is included in column 3 is correctly eliminated on Worksheet A-8.

Column 6.--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the Federal Register before any allowable adjustments.

The final notice on the annual update to RCE limits published in the Federal Register, Vol. 50, No. 34, February 20, 1985, on page 7126 contains Table 1, Estimates of FTE Annual Average Net Compensation Levels for 1984. Obtain the RCE applicable to the specialty from this table. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable (non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million).

Column 7.--Enter for each line of data the physician's hours which are allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040.

The hours entered are the actual hours for which the physician is compensated by you for furnishing services of a general benefit to your patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered. Time records or other documentation that supports this allocation must be available for verification by your intermediary upon request. (See CMS Pub. 15-I, §2182.3E.)

Column 8.--Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 6 and the ratio of the physician's provider component hours entered in column 7 to 2080 hours.

Column 9.--Enter for each line of data five percent of the amounts entered in column 8.

Column 12.--The computed RCE limit in column 8 may be adjusted upward (up to five percent of the computed limit (column 9)) to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by you.

Enter for each line of data the actual amounts of these expenses paid by you.

Column 13.--Enter for each line of data the result of multiplying the amount in column 5 by the amount in column 12 and dividing that amount by the amount in column 3.

Column 14.--The computed RCE limit in column 8 may also be adjusted upward to reflect the actual malpractice expense incurred by you for the physician's (or a group of physicians) services to your patients.

Enter for each line of data the actual amounts of these malpractice expenses paid by you.

Column 15.--Enter for each line of data the result of multiplying the amount in column 5 by the amount in column 14 and dividing the result by the amount in column 3.

Column 16.--Enter for each line of data the sum of the amounts in columns 8 and 15 plus the lesser of the amounts in columns 9 or 13.

Column 17.--Compute the RCE disallowance for each cost center by subtracting the RCE limit in column 16 from your component remuneration in column 5. If the result is a negative amount, enter zero.

Column 18.--The adjustment for each cost center entered represents the provider-based physician elimination from costs entered on Worksheet A-8, column 2, line 8 and on Worksheet A, column 6 to each cost center affected. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 16 (adjusted RCE limit) from the total remuneration recorded in column 3.

Line Descriptions

Total Line.--Total the amounts in columns 3 through 5, 7 through 9, and 12 through 18.

**3522. WORKSHEET A-8-3 - REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS**

This worksheet provides for the computation of any needed adjustments to costs applicable to physical therapy services furnished by outside suppliers. The information required on this worksheet must provide for, in the aggregate, all data for physical therapy services furnished by all outside suppliers in determining the reasonableness of the physical therapy for services provided prior to April 10, 1998. (See CMS Pub. 15-I, chapter 14.) Prorate based on total charges, any statistics and costs for purposes of calculating standards, allowances, or the actual reasonable cost determination if your cost report overlaps April 10, 1998, i.e., overtime hours. This form is not applicable for services on or after April 10, 1998.

If a provider contracts with an outside supplier for **physical therapy services**, the potential for limitation and the amount of payment a provider can receive depends on several factors:

- o An initial test to determine whether these services are categorized as intermittent part time or full time services;
- o The location where the services are rendered, i.e, provider site or HHA home visit;
- o For HHA services, whether detailed time and mileage records are maintained by the contractor and HHA;
- o Add-ons for supervisory functions, aides, overtime, equipment, and supplies; and
- o Intermediary determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

**3522.1 Part I - General Information.**--This part provides for furnishing certain information concerning **physical therapy** services furnished by outside suppliers.

Line 1.--Enter the number of weeks that services were performed at the provider site. Count only those weeks during which a supervisor, therapist, or an assistant was on site. For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patient's of the HHA. Weeks when services were performed both at the provider's site and at the patient's home are only counted once. (See CMS Pub. 15-I, chapter 14.)

Line 2.--Multiply the amount on line 1 by 15 hours per week. Use this calculation to determine whether services are full time or intermittent part time.

Line 3.--Enter the number of days during which the supervisor or therapist was at the provider's site. Only count one day when both the supervisor and therapist were at the site during the same day.

Line 4.--Enter the number of days during which the therapy assistant was at the provider's site. Do not include in the count days when either the supervisor or therapist was also at the site during the same day.

**NOTE:** An unduplicated day is counted for each day that the contractor has at least one employee on site. For example, if the contractor furnishes a supervisor, therapist, and assistant on one day, count one therapist day. If the contractor provides two assistants on one day (and no supervisors or therapists), count one assistant day.

Line 5.--Enter the number of unduplicated HHA visits made by the supervisor or therapist. Only count one visit when both the supervisor and therapist were present during the same visit.

Line 6.--Enter the number of unduplicated HHA visits made by the therapy assistant. Do not include in the count the visits when either the supervisor or therapist were present during the same visit.

Line 7.--Enter the standard travel expense rate applicable as published in CMS Pub. 15-I, chapter 14.

Line 8.--Enter the optional travel expense rate applicable as published in CMS Pub. 15-I, chapter 14. Use this rate only for home health patient services for which time records are available.

Line 9.--Enter in the appropriate columns the total number of hours worked for supervisors, therapists, therapy assistants, and aides furnished by outside suppliers.

Line 10.--Enter in each column on this line the appropriate adjusted hourly salary equivalency amount (AHSEA). These amounts are the prevailing hourly salary rate plus the fringe benefit and expense factor described in CMS Pub. 15-I, chapter 14. These amounts are determined on a periodic basis for appropriate geographical areas and are published as exhibits at the end of CMS Pub. 15-I, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisors' AHSEA, adjusted for administrative and supervisory responsibilities, which is determined in accordance with the provisions of CMS Pub. 15-I, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants, and aides, respectively) the AHSEA from the appropriate exhibit found in CMS Pub. 15-I, chapter 14 or in the latest publication of rates. When the going hourly rate for assistants in the area is unobtainable, no more than 75 percent of the therapist's adjusted hourly salary equivalency amount (AHSEA) may be used. Evaluate the cost of services of a therapy aide or trainee at the hourly rate not to exceed the hourly rate paid to the provider's employees of comparable classification and/or qualification, e.g., nurses aides). (See CMS Pub. 15-I, §1412.2.)

Line 11.--Enter the standard travel allowance equal to one half of the AHSEA as follows. Enter in columns 1 and 2 one half of the amount in column 2, line 10; and enter in column 3, one half of the amount in column 3, line 10. (See CMS Pub. 15-I, §1402.4.)

Lines 12 and 13.--Enter on these lines (for HHA services only) the number of travel hours and number of miles driven, respectively, when time records of visits are kept. (See CMS Pub. 15-I, §§1402.5 and 1403.1.)

**NOTE:** There is no travel allowance for aides employed by outside suppliers.

3522.2 Part II - Salary Equivalency Computation.--This part provides for the computation of the full time or intermittent part time salary equivalency.

When you furnish **physical therapy services** by outside suppliers for health care program patients but simply arrange for such services for non-health care program patients and do not pay the non-health care program portion of such services, your books reflect only the cost of the health care program portion. If you can gross up your costs and charges in accordance with provisions of CMS Pub. 15-I, §2314, complete Part II, lines 14 through 19 and 22 in all cases and lines 20 and 21 when appropriate. See the instructions in §3519, Worksheet A-8, for grossing up of your costs and charges. However, if you cannot gross up your costs and charges, complete lines 14 through 19 and 22.

Lines 14 through 19.--Complete these lines for computing the total salary equivalency allowance amounts by multiplying the total hours worked (line 9) by the AHSEA for supervisors, therapists, assistants, and aides.

Lines 20 and 21.--Complete these lines if the sum of hours in columns 1 through 3, line 9, is less than or equal to the product found on line 2. (See the exception above where you cannot gross up your costs and charges, and services are provided to program patients only.)

Line 22.--Where there are no entries on lines 20 and 21, enter the amount on line 19. Otherwise enter the sum of the amounts on line 18 plus line 21.

3522.3 Part III - Standard Travel Allowance and Standard Travel Expense Computation - Provider Site.--This part provides for the computation of the standard travel allowance and standard travel expense for services rendered at the provider site.

Lines 23 through 27.--These lines provide for the computation of the standard travel allowance and standard travel expense for **physical therapy services** performed at the provider site. One standard travel allowance is recognized for each day an outside supplier performs **physical therapy services** at the provider site. For example, if a contracting organization sends three therapists to a provider each day, recognize only one travel allowance per day. (See CMS Pub. 15-I, §1403.1 for a discussion of standard travel allowance and §1412.6 for standard travel expense.)

Line 23.--Enter the standard travel allowance for supervisors and therapists. This standard travel allowance for supervisors appropriately does not take into account the additional allowance for administrative and supervisory responsibilities. (See CMS Pub. 15-I, §1402.4.)

3522.4 Part IV - Standard Travel Allowance and Standard Travel Expense Computation - HHA Services Outside Provider Site.--This part provides for the computation of both the standard travel allowance and standard travel expense as well as the optional travel allowance and the optional travel expense. (See CMS Pub. 15-I, §§1402.4, 1402.5, 1403.1, and 1412.6.)

Lines 28 through 31.--These lines provide for the computation of the standard travel allowance and standard travel expense for **physical therapy services** performed in conjunction with HHA visits. Use these lines only if you do not use the optional method of computing travel. Recognize a standard travel allowance for each visit to a patient's residence. If services are furnished to more than one patient at the same location, only one standard travel allowance is permitted, regardless of the number of patients treated.



Lines 32 through 35.--These lines provide for the optional travel allowance and optional travel expense computations for **physical therapy services** in conjunction with home health services only. Compute the optional travel allowance on lines 32 through 34. Compute the optional travel expense on line 35.

Lines 36 through 38.--Only one of the options on lines 36 through 38 may be chosen and completed. However, lines 37 or 38 may only be used if you maintain time records of visits. (See CMS Pub. 15-I, §1402.5.)

3522.5 Part V - Overtime Computation.--This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for you in excess of your standard work week. No overtime allowance may be given to a therapist who receives an additional allowance for supervisory or administrative duties. (See CMS Pub. 15-I, §1412.4.)

Line 39.--Enter in the appropriate columns the total overtime hours worked. If the total hours in column 4 are either zero or equal to or greater than 2080, the overtime computation is not applicable and do not make any further entries on lines 40 through 47. Enter zero in each column of line 48. Enter the sum of the hours recorded in columns 1 through 3 in column 4.

Line 40.--Enter in the appropriate column the overtime rate (the AHSEA from line 10, column as appropriate, multiplied by 1.5).

Line 42.--Enter the percentage of overtime hours, by class of employee, by dividing each column on line 39 by the total overtime hours in column 4, line 39.

Line 43.--This line is for the allocation of your standard work year for one full time employee. Enter the numbers of hours in the standard work year for one full time employee in column 4 of this line. Multiply the standard work year in column 4 by the percentage on line 42, and enter the result in the corresponding columns of this line.

Line 44.--Enter in columns 1 through 3 the AHSEA from Part I, line 10, columns 2 through 4, as appropriate.

3522.6 Part VI - Computation of Therapy Limitation and Excess Cost Adjustment.--This part provides for calculating the adjustment to **physical therapy service** costs in determining the reasonableness of **physical therapy cost**.

Lines 53 and 54.--If the outside supplier provides the equipment and supplies used in furnishing direct services to your patients, the actual cost of the equipment and supplies incurred by the outside supplier, as specified in CMS Pub. 15-I, §1412.1, may be considered as an additional allowance in computing the limitation.

Line 56.--Enter the amounts paid and/or payable to the outside suppliers for physical therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime or any other expenses related to supplying **physical therapy services for you**.

Line 57.--Enter the excess cost over the limitation, i.e., line 56 minus line 55. If negative, enter zero.

**NOTE:** When the amount entered on line 57 only applies to one component, do not complete Part VII. Transfer the amount to Worksheet A-8, line 25, when applicable to the skilled nursing facility or to line 26 when applicable to the HHA. But when one or more suppliers provide physical therapy services to you and to the HHA, allocate the excess cost between you and the HHA in Part VII.

3522.7 Part VII - Allocation of Therapy Excess Cost Over Limitation for Non-Shared Therapy Department Services.--This part provides for computing the excess cost of both SNF services and HHA services over the limitation for outside suppliers. Compute this part only when the physical therapy services provided are not shared by the SNF and the HHA components, i.e., only when both supplier's service costs are recorded on Worksheet A on lines 25 and 39.

Lines 58 and 59.--Enter the total cost of services supplied by the outside suppliers for provider services and HHA services, respectively, from your records.

Line 63.--This line identifies the excess of the supplier's physical therapy costs for services at the provider site over the limitation. Transfer the amount to Worksheet A-8, line 25.

Line 64.--This line identifies the excess of the HHA physical therapy costs over the limitation. Transfer this amount to Worksheet A-8, line 26.



3523. WORKSHEET A-8-4 - REASONABLE COST DETERMINATION FOR RESPIRATORY THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

This worksheet provides for the computation of any needed adjustments to costs applicable to respiratory therapy services furnished by outside suppliers. The information required on this worksheet provides, in the aggregate, all data for respiratory therapy services furnished by all outside suppliers in determining the reasonableness of respiratory therapy costs. (See CMS Pub. 15-I, chapter 14.) **DO NOT complete this worksheet for cost reporting periods beginning on and after 1/1/1999. Services rendered after 12/31/1998 are reimbursed on a fee schedule. No data should be entered on this worksheet for services after that date.**

**NOTE:** The use of an operating room and the provision of inhalation therapy services by an inhalation therapist are reimbursable skilled nursing services only when furnished to the SNF by a hospital with which the SNF has a transfer agreement. This service may be performed in either the hospital or the SNF, but the therapist must be an employee of the hospital.

If you contract with an outside supplier for respiratory therapy services, the potential for limitation and the amount of payment you can receive depends on the following factors:

- o An initial test to determine whether these services are categorized as intermittent part time or full time services;
- o Add-ons for supervisory functions, aides, trainees, overtime, equipment, and supplies; and
- o An intermediary determination of reasonableness of rates charged by the supplier compared with the going rates in the area.

3523.1 Part I - General Information.--This part provides for furnishing certain information concerning respiratory therapy services furnished by outside suppliers.

Line 1.--Enter the number of weeks during which respiratory therapy services were performed at your site. Count only those weeks during which a registered therapist supervisor, certified therapist supervisor, nonregistered/certified therapist supervisor, registered therapist, certified therapist, or nonregistered/noncertified therapist was onsite.

Line 2.--Multiply the amount on line 1 by 15 hours per week. Use this calculation to determine whether services are full time or intermittent part time.

Lines 3 through 5.--Enter on the applicable line the number of unduplicated days on which services for that category has the highest AHSEA (adjusted hourly salary equivalency amount) of all supplier respiratory therapy staff on-site that day. The AHSEA is the prevailing hourly salary rate plus the fringe benefits and expense factor described in CMS Pub. 15-I, chapter 14. This amount is determined on a periodic basis for appropriate geographical area and is published as an exhibit at the end of chapter 14 of CMS Pub. 15-I. For example, when a registered therapist has a higher AHSEA than a certified therapist and both are on-site in the same day, one day is recorded for the registered therapist. If two certified therapists are on-site in one day, only one day is counted for a certified therapist.

Line 6.--Enter the standard travel expense rate as published in CMS Pub. 15-I, §1412.6.

Line 7.--Enter in the appropriate columns the total number of hours worked at your site for each category.

Line 8.--Enter in the appropriate columns the AHSEA for each category.

This amount is the prevailing hourly salary rate plus the fringe benefit and expense factor described in CMS Pub. 15-I, chapter 14. This amount is determined on a periodic basis for appropriate geographical areas and is published as an exhibit at the end of chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in columns 1 through 3 the appropriate AHSEA adjusted for administrative and supervisory responsibility determined in accordance with CMS Pub. 15-I, §1412.5. Enter in columns 4 through 6 the AHSEA for those categories from the exhibit in chapter 14 or from the latest publication of rates. The cost of services of a respiratory therapy aide or trainee is evaluated at the hourly rate not to exceed the hourly rate paid to your employees of comparable classification and/or qualification, e.g., nurses aides). Adjust the base hourly rate by the appropriate fringe benefit and expense factor. (See CMS Pub. 15-I, §1412.2.) An aide or trainee is never considered a nonregistered/noncertified therapist. (See CMS Pub. 15-I, §1403.)

Line 9.--Enter the standard travel allowance equal to one half of the AHSEA. (See CMS Pub. 15-I, §1402.4) Enter in columns 1 through 3 one half of the amounts in columns 4 through 6 respectively, line 8 (the supervisory allowance does not enter into the travel allowance). Enter in columns 4 through 6 one half of the amounts in columns 4 through 6, respectively, line 8.

3523.2 Part II - Salary Equivalency Computation.--This part provides for the computation of the full time or intermittent part time salary.

When you furnish respiratory therapy services by outside suppliers for health care program patients but simply arrange for such services for non-health care program patients and do not pay for the non-health care program portion of such services, your books reflect only the cost of the health care program portion. If you gross up costs and charges in accordance with the provisions of CMS Pub. 15-I, §2314, complete Part II, lines 10 through 19 and 22 in all cases and lines 20 and 21, when applicable. See the instructions for Worksheet A-8, §3519 with respect to grossing up costs and charges. However, if you cannot gross up costs and charges, complete lines 10 through 19 and 22 only. (See CMS Pub. 15-I, §1404.)

Lines 10 through 19.--Compute the total salary equivalency allowance amounts by multiplying the total hours worked for each category (line 7) by the AHSEA for supervisory registered therapist, supervisory certified therapist, supervisory nonregistered/noncertified therapist, registered therapist, certified therapist, nonregistered/noncertified therapist, aides, and trainees.

Lines 20 and 21.--Complete if the sum of the hours in columns 1 through 6, line 7 is less than or equal to the hours on line 2. (See exception above where you cannot gross up costs and charges, and services are provided to program patients only.)

Line 22.--If there are no entries on lines 20 and 21, enter the amount on line 19. Otherwise, enter the sum of the amounts on lines 17, 18, and 21.

**3523.3 Part III - Travel Allowance and Travel Expense Computation.**--This part provides for computing the standard travel allowance and standard travel expense.

Lines 23 through 26.--These lines compute the standard travel allowance for registered therapists, certified therapists, and nonregistered/noncertified therapists and the total standard travel allowance for services performed at your site. The travel allowance for supervisors does not take into account the additional allowance for administrative and supervisory responsibilities. Therefore, supervisory therapists are combined with the appropriate category of therapists (e.g., supervisory registered therapist is included with registered therapists).

Recognize one standard travel allowance for each day an outside supplier performed skilled respiratory therapy services at your site. Base the allowance on the rate for the supplier's staff with the highest AHSEA on-site that day. (See instructions for lines 3 through 5 and CMS Pub. 15-I, §1403.1, for a discussion of travel allowance.)

Line 27.--Include the standard travel expense for services rendered at your site. Compute this amount as the sum of the days on lines 3 through 5 multiplied by the amount on line 6.

**3523.4 Part IV - Overtime Computation.**--This part is for the computation of an overtime allowance when employees of the outside supplier perform services for you in excess of your standard work week. No overtime allowance is given to a therapist who receives an additional allowance for supervisory or administrative duties.

Line 29.--Enter in the appropriate columns the total overtime hours worked. If the total hours in column 6 are either zero or equal to or greater than 2080 hours, the overtime computation is not applicable. Make no further entries on lines 30 through 37. Enter zero in each column of line 38. Enter the sum of the hours recorded in columns 1 through 5 in column 6.

Line 30.--Enter in the appropriate column the overtime rate (the AHSEA from Part I, line 8, column as appropriate, times 1.5).

Line 32.--Calculate the percentage of overtime hours by class of employee by dividing each column on line 29 by the total overtime hours in column 6, line 29, in the appropriate column.

Line 33.--This line allocates your standard work year for one full time employee. Enter the number of hours in your standard work year for one full time employee in column 6. Multiply the number of hours in column 6 by the percentage on line 32 and enter the results in the corresponding columns.

Line 34.--Enter in columns 1 through 5 the AHSEA from Part I, line 8, columns 4 through 8, as appropriate.

3523.5 Part V - Computation of Respiratory Therapy Limitation and Excess Cost Adjustment.--This part provides for calculating the adjustment to respiratory therapy service costs in determining the reasonableness of respiratory therapy cost.

Lines 42 and 43.--When the outside supplier provides the equipment and supplies used in furnishing direct services to your patients, the actual costs of the equipment and supplies incurred by the outside supplier, as specified in CMS Pub. 15-I, §1412.1, is considered as an additional allowance in computing the limitation.

Line 45.--Enter the amounts paid and/or payable to the outside supplier for respiratory therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime, or any other expense related to supplying respiratory therapy services for you.

Line 46.--Enter the excess of respiratory therapy cost over the limitation (line 45 minus line 44) and transfer this excess cost to Worksheet A-8, line 24. If negative, enter zero.

3524. WORKSHEET B, PART I - COST ALLOCATION - GENERAL SERVICE COSTS AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

In accordance with 42 CFR 413.24(a), cost data must be based on an approved method of cost finding and on the accrual basis of accounting except where governmental institutions operate on a cash basis of accounting. Cost data based on such basis of accounting are acceptable subject to appropriate treatment of capital expenditures. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs. The various cost finding methods recognized are outlined in 42 CFR 413.24(d). Worksheets B, Part I and B-1 have been designed to accommodate the stepdown method of cost finding. These worksheets may have to be modified to accommodate other methods of cost finding which have been approved for use by the SNF.

Worksheet B, Part I provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, ancillary service cost centers, inpatient routine service cost centers, outpatient service cost centers, special purpose and other reimbursable cost centers, and non-reimbursable cost centers. The total direct expenses are obtained from Worksheet A, column 7.

Worksheet B-1 provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B, Part I.

To facilitate the allocation process, the general format of Worksheets B, Part I and B-1 are identical. Each general service cost center has the same line number as its respective column number across the top. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers of each ancillary, routine, other reimbursable, and non-reimbursable cost centers are identical on the two worksheets. The cost centers and line numbers are consistent with Worksheet A. Note that lines 52 through 54 from Worksheet A are not needed on Worksheets B and B-1. Therefore, line number 55 immediately follows line number 51.

The statistical basis shown at the top of each column on Worksheet B-1 is the recommended basis of allocation of the cost center indicated.

**Change column 3A on Worksheet B-1 to 4A. This aligns the reconciliation column in the SNF cost report with the hospital cost report.**

A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year if received by the intermediary, in writing, within 90 days prior to the end of the fiscal year. The intermediary has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, should be changed due to simplification of maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until an approval is made. If both sets of statistics are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used.



Most cost centers are allocated on different statistical bases. However, for those cost centers for which the basis is the same (e.g., square feet), the total statistical base over which the costs are allocated differs because of the prior elimination of cost centers that have been closed.

When closing the general service cost centers, first close the cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheets. However, your circumstances may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

If the amount of any cost center on Worksheet A, column 7, has a credit balance, this must be shown as a credit balance on Worksheet B, Part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to such cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is to be allocated, such general service cost center must not be allocated. Rather, enter the credit balance in parentheses on line 65 as well as on the first line of the column and on line 75. This enables column 18, line 75, to crossfoot to columns 0 and 4A, line 75. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, Part I, column 18, do not carry forward such credit balance to Worksheet C.

On Worksheet B-1, enter on the first line in the column of the cost center being allocated the total statistical base (including accumulated cost for allocating administrative and general expenses) over which the expenses are to be allocated (e.g., for column 1, Capital Related - Buildings and Fixtures, enter on line 1 the total square feet of the building on which depreciation was taken).

Such statistical base including accumulated cost for allocating administrative and general expenses does not include any statistics related to services furnished under arrangements except where:

- o Both Medicare and non-Medicare costs of arranged for services are recorded in your records; or
- o The intermediary determines that you are able to and do gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if you had furnished such services directly to all patients. (See CMS Pub. 15-1, §2314.)

For all cost centers (below the first line) to which the capital related cost is allocated, enter that portion of the total statistical base applicable to each. The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total base entered on the first line.

Enter on line 66 of Worksheet B-1 the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B, Part I, from the same column and line number used to enter the statistical base on Worksheet B-1 (in the case of Capital Related - Buildings and Fixtures, this amount is on Worksheet B, Part I, column 1, line 1).

Divide the amount entered on line 66 by the total statistics entered in the same column on the first line. Enter the resulting unit cost multiplier on line 67. The unit cost multiplier must be rounded to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B, Part I, in the corresponding column and line. (See §3500.1 for rounding standards.)

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 75) of all of the cost centers receiving the allocation on Worksheet B, Part I, must equal the amount entered on the first line. The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Worksheets B, Part I, and B-1 before proceeding to the next cost center.

If a general service cost center has a credit balance at the point it is allocated on Worksheet B, Part I, such general service cost center must not be allocated. However, the statistic must be displayed departmentally. No unit cost multiplier is calculated for lines 67 and 69 on Worksheet B-1.

Use lines 68 and 69 of Worksheet B-1 in conjunction with the allocation of capital-related cost on Worksheet B, Part II. Complete line 68 for all columns after Worksheets B, Part I, and B-1 have been completed and the amount of direct and indirect capital-related cost has been determined on Worksheet B, Part II. Line 69 for all columns is the unit cost multiplier used in allocating the direct and indirect capital-related cost on Worksheet B, Part II. Compute the unit cost multiplier after the amounts to be entered on line 68 have been determined by dividing the capital-related cost recorded on line 68 by the total statistics entered in the same column on the first line. Round the unit cost multiplier to six decimal places. (See instructions for Worksheet B, Part II, for the complete methodology and exceptions.)

After the costs of the general service cost center have been allocated on Worksheet B, Part I, enter in column 16 the sum of the costs in columns 4A through 15 for lines 16 through 63.

When an adjustment is required to expenses after cost allocation, show the amount applicable to each cost center in column 17 of Worksheet B, Part I. A corresponding adjustment to Worksheet B, Part II, may be applicable for capital-related cost adjustments. You must submit a supporting worksheet showing the computation of the adjustment in addition to completing Worksheet B-2.

Some examples of adjustments which may be required to expenses after cost allocation are (1) the allocation of available costs between the certified portion and the noncertified portion of a distinct part provider and (2) costs attributable to unoccupied beds of an SNF with restrictive admission policy. (See CMS Pub. 15-I, §§2342 - 2344.3.)

**Line 20 is not used on Worksheets B and B-1.**

After the adjustments have been made on Worksheet B, Part I, column 17, adjust the amounts in column 16 by the amounts in column 17 and extend the new balances to column 18 for each line. The total costs entered in columns 18, line 66, must equal the total costs entered in column 0, line 66.

Transfer the totals in column 18, lines 21 through 33 (ancillary service cost centers) and lines 34, 35, and 36 (outpatient service cost centers) to Worksheet C, column 1, lines 21 through 36.

Transfer the totals in column 18:

From Worksheet B, Part I, Column 18

To Worksheet D-1, Line 5

Line 16, SNF

For SNF

Line 18, NF  
answer Sum of lines 16 and 18  
line 43).

For Titles V or XIX. For NF (when you  
"yes" to question on Wkst. S-2,

Line 18.1, ICF/MR  
answer  
2, line 49).

For Title XIX. For ICF/MR (when you  
yes to question on Wkst. S-

Transfer the direct SNF-based HHA costs in column 18, lines 37 through 47, to Worksheet H-4, Part I, column 1, lines as indicated. **Transfer the HHA-Telemedicine cost in column 18, line 47.1 to Worksheet H-4, line 13.1.**

Transfer the total SNF-based outpatient rehabilitation provider costs in column 18, line 50, to the applicable Worksheet J-1, Part I, column 0, line 18.

The non-reimbursable cost center totals, lines 58 through 63, are not transferred.

#### Column Descriptions

Column 1.--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation.

Column 2.--Providers that do not directly assign the depreciation on movable equipment and expenses pertaining to movable equipment such as insurance, interest, and rent as part of their normal accounting systems must accumulate the expenses in this cost center.

Column 4.--Allocate the administrative and general expenses on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-1, column 4, line 4, is the difference between the amount on Worksheet B, Part I, column 4A and the amount entered on Worksheet B-1, column 4A.

A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

3524.1 Worksheet B, Part III - Cost Allocation - General Service Costs with Less Than 1500 Program Days, and Worksheet B-1, Part II - Cost Allocation - Statistical Basis with Less Than 1500 Program Days.--

Complete this worksheet **only** if you answered yes on Worksheet S-2 question # 52. Worksheet B, Part III provides the allocation of the expenses of each general service cost center with **less than 1500 Medicare days** to those cost centers which receive the services. The total direct expenses are obtained from Worksheet A, column 7. The cost centers and line numbers are consistent with Worksheet A. Note that several lines from Worksheet A are not needed on Worksheets B, Part III and B-1, Part II.

The general service cost centers listed on Worksheet A, column 7, lines 1-9, are listed in the order they are combined on Worksheet B, Part III, columns 1, 2, 3, and 4, line 15.1.

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<u>To Worksheet B, Part III</u>	<u>From Worksheet A, Column 7</u>
Column 1	Sum of lines 1, 2, 5, and 7 *
Column 2	Line 3
Column 3	Sum of lines 6, 8, and 9
Column 4	Line 4

\* Due to consolidation of CMS 2540S-97 into CMS 2540-96, Capital - Interest account replaced one of three accounts in CMS 2540-96, which are Capital-Related Costs - Building & Fixture, Administrative and General, and Interest Expense.

Column 0, line 15.1 is the total of columns 1 through 4, line 15.1.

The amounts on Worksheet B, Part III, column 0, lines 16 through 33, 59, and 63 are transferred from Worksheet A, column 7, lines 16 through 33, 59, and 63.

Worksheet B-1, Part II provides for the proration of the statistical data with **less than 1500 Medicare days** needed to equitably allocate the expenses of the general service cost centers on Worksheet B, Part III.

The statistical basis shown at the top of each column on Worksheet B-1, Part II is the basis of allocation of the cost centers indicated. Total statistics indicated on Worksheet B-1, Part II line 71 refers to the sum of the statistics reported on lines 16 through 63 of Worksheet B-1, Part II. For the allocation of administrative and general costs in column 4, lines 16 through 63 are obtained from Worksheet B, Part III, sum of columns 0 through 3, lines 16 through 63.

If the amount of any combined cost center on Worksheet A, column 7 has a credit balance, this amount must be shown as a credit balance on Worksheet B, Part III, column 0. If a revenue producing cost center has a credit balance on Worksheet B, Part III, column 5, do not carry forward such credit balance to Worksheet C.

On Worksheet B-1, Part II, enter on line 71 in the column of the cost center group being allocated, the total statistical base (including accumulated cost for allocating administrative and general expenses) over which the expenses are allocated (e.g., for column 1, capital costs, enter on line 71 the total square feet of the building on which depreciation was taken).

For all cost centers to which the capital cost group are being allocated, enter that portion of the total statistical base applicable to each. The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total base entered on line 71.

Enter on line 70 of Worksheet B-1, Part II, the total expenses of the cost centers to be allocated; they are obtained from Worksheet B, Part III, line 15.1, columns 1 through 4.

Divide the amount entered on line 70 by the total statistics entered on line 71. Enter the resulting unit cost multiplier on line 72. The unit cost multiplier must be rounded to six decimals.

Multiply the unit cost multiplier by the portion of the total statistics applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B, Part III in the corresponding column and line. (See §3500.1 for rounding standards.)

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After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 70) of all the cost centers receiving the allocation on Worksheet B, Part III must equal the amount entered on line 15.1. The preceding procedures must be performed for each general service cost center group. Each cost center group must be completed on both Worksheets B, Part III and B-1, Part II before proceeding to the next cost center group.

If a general service cost group (after combining centers) has a credit balance at the point it is to be allocated on Worksheet B, Part III, such general service costs must not be allocated. The statistic must be displayed departmentally, but not the unit cost multiplier which is calculated for line 72 on Worksheet B-1, Part II.

After the costs of the general service cost group have been allocated on Worksheet B, Part III, enter in column 5, the sum of the costs in columns 0 through 4 for lines 16 through 63. The total cost entered in column 5, line 75 must equal the total costs entered in column 0, line 75.

Transfer the totals on Worksheet B, Part III, column 5, lines 21 through 33 (ancillary service cost centers) to Worksheet C, column 1 lines 21 through 33.

The non-reimbursable cost center totals, lines 59 and 63, are not transferred.