

Column Descriptions for Cost Limitation Computation

Column 4.--Enter the Medicare limitation (see §1861(v)(1)(L) of the Act) for the applicable MSA for each discipline on lines 8 through 13. The intermediary furnishes these limits to the provider.

Columns 5 and 8.--To determine the Medicare limitation cost for Part A cost of services, multiply

the number of covered Part A visits made to beneficiaries prior to October 1, 2000 (column 5) from your records by the Medicare cost limit amount in column 4 for each discipline. Enter the product in column 8.

Columns 6 and 9.--To determine the Medicare limitation cost for Part B cost of services, multiply the number of visits made to Part B beneficiaries not subject to deductibles and coinsurance prior to October 1, 2000 (column 6) from your records by the Medicare cost limit amount in column 4 for each discipline. Enter the product in column 9.

**NOTE:** Column 5, line 7 may not equal column 5, line 14; Column 6, line 7 may not equal Column 6, line 14. Columns 5 and 6, respectively, lines 1-6 (excluding subscripts) must equal columns 5 and 6, lines 8-13.

Columns 7 and 10.--**DO NOT USE THESE COLUMNS.** See §3215.5.

Column 11.--Enter the total Medicare limitation cost for each discipline (sum of columns 8 and 9). Add the amounts on lines 8 through 13. Enter this total on line 14.

3215.3 Part III - Supplies and Drugs Cost Computation.--Certain items covered by Medicare and furnished by an HHA are not included in the visit for apportionment purposes. Since an average cost per visit and the cost limit per visit do not apply to these items, the ratio of total cost to total charges is developed and applied to Medicare charges to arrive at the Medicare cost for these items. Enteral/parenteral nutrition therapy (EPNT) items which are considered prosthetic devices furnished by an HHA on or after March 14, 1986, are reimbursed on a reasonable charge basis through billings submitted to the Part B specialty carrier. (As a prosthetic device, such items are reimbursable under Part B only.) Charges for these items must be included in the total charges, but excluded from Title XVIII charge statistics in the apportionment of medical supply costs on Worksheet C, Part III, line 15. Lines 15 and 16 are subscripted to isolate pre 10/1/2000 costs to facilitate the flow of these costs to Worksheet D in order to apply LCC.

**NOTE:** For services furnished on or after January 1, 1989, the HHA Part A reimbursement for DME, prosthetics, and orthotics was changed from cost reimbursement to a fee schedule reimbursement.

Additionally, certain items furnished by an HHA on or after January 1, 1990, are not considered as DME. This includes medical supplies such as catheters, catheter supplies, ostomy bags, and supplies relating to ostomy care.

Lines 15 and 16.--Enter in column 2 the total applicable costs for the entire cost reporting period for each line item from Worksheet B, column 6, lines 12 and 13, respectively (the costs entered on lines 15 and 15.01 must be equal; the costs entered on lines 16 and 16.01 must be equal). Enter in column 3 the total charges for the entire cost reporting period for each line (the charges entered on lines 15 and 15.01 must be equal; the charges entered on lines 16 and 16.01 must be equal). Enter in column 4 the ratio of costs (column 2) to charges (column 3) for each line.

Line 15.--Enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule for services rendered prior to October 1, 2000. **For cost reporting periods beginning on**

or after October 1, 2000, continue to capture medical supply charges in columns 5, 6, and 7 for statistical

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purposes (has no reimbursement impact) as all medical supplies are covered under the PPS benefit for this period.

Line 15.01.--For reporting periods which overlap October 1, 2000, enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule for services rendered from October 1, 2000 through the fiscal year end. For reporting periods that begin on or after October 1, 2000, eliminate line 15.01 and record all charge and resulting cost data on line 15.

Line 16.--Enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration for services rendered prior to **April 1, 2001**. Enter in column 7 the charge for covered osteoporosis drugs for services rendered prior to October 1, 2000.

For **services rendered** on or after **April 1, 2001 through December 31, 2002**, do not enter any amounts in column 6 as pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration are **reimbursed under OPSS**, but continue to enter in column 7 the charge for covered osteoporosis drugs as they remain cost reimbursed. (See §1833(m)(5) of the Act.)

**Effective for services rendered on or after January 1, 2003, pneumococcal vaccines and its administration and influenza vaccine and its administration are cost reimbursed not subject to deductibles and coinsurance. For services rendered on and after January 1, 2003, enter in column 6 program charges for hepatitis vaccines and its administration (OPSS reimbursed). Enter in column 6.01 program charges for pneumococcal vaccines and its administration and influenza vaccine and its administration. Continue to enter in column 7 the program charges for covered injectable osteoporosis drugs as they remain cost reimbursed.**

Line 16.01.--For reporting periods which overlap **April 1, 2001**, enter in column 6 the charges for pneumococcal vaccine and its administration **and** influenza vaccine and its administration. **For** hepatitis B vaccine and its administration rendered on or after **April 1, 2001** through the fiscal year end. Enter in column 7 the charges for covered osteoporosis drugs rendered on or after **April 1, 2001** through the fiscal year end. (See §1833(m)(5) of the Act.) For reporting periods that begin on or after **April 1, 2001**, eliminate line 16.01 and record all charge and resulting cost data on line 16. Osteoporosis drugs will continue to be reimbursed on a cost basis for services rendered on and after **April 1, 2001**.

Column 8.--To determine the Medicare Part A cost, multiply the Medicare charges (column 5) by the ratio (column 4) for each line item. Enter the product in column 8.

Column 9-9.01.--To determine the Medicare Part B cost, multiply the Medicare charges (column 6) by the ratio (column 4) for each line item. Enter the product in column 9. **If applicable, multiply the Medicare charges (column 6.01) by the ratio (column 4) for each line item.**

Column 10.--To determine the Medicare Part B cost (subject to deductibles and coinsurance), multiply the Medicare charges (column 7) by the ratio (column 4). Enter the product in column 10.

3215.4 Part IV - Comparison of the Lesser of the Aggregate Medicare Cost, the Aggregate of the Medicare Per Visit Limitation and the Aggregate Per Beneficiary Cost Limitation.--This part provides for the comparison of the reasonable cost limitation applied to each home health agency's total allowable cost attributable to Medicare patient care visits. This comparison is required by 42 CFR 413.30 and 42 CFR 413.53. For cost reporting periods beginning on or after October 1, 1997, §1861(v)(1)(L) of the Social Security Act is amended by §4601 of BBA 1997, requiring home health agency net cost of covered services to be based on the lesser of the aggregate Medicare cost, the aggregate of the Medicare cost per visit limitation or the aggregate per beneficiary cost limitation. The per beneficiary cost limitation is derived by totaling the application of each

MSA/non-MSA's unduplicated census count (two decimal places) (see §3205) to the per-beneficiary cost limitation for

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the corresponding MSA/non-MSA. To accomplish this, the sum of all Worksheets C, Part II amounts in column 11, line 7, plus the applicable cost of medical supplies is compared with the sum

of all Worksheets C, Part II amounts in column 11, line 14 plus the applicable cost of medical supplies and with the amount in column 6, line 24.

Line 17.--Enter in columns 3, 4, and 6, respectively, the sum of the amounts from each Worksheet C, Part II, columns 8, 9, and 11 (exclusive of subscripts), respectively, lines 1-6 (exclusive of subscripts).

Line 18.--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 19.--Enter the sum of lines 17 and 18 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Effective for cost reporting periods beginning on or after October 1, 2000, do not complete lines 20 through 24 as all HHAs are reimbursed under PPS and no longer subject to cost per visit limitations or annual beneficiary limitations.

Line 20.--Enter in columns 3, 4 and 6, respectively, the sum the amounts from each Worksheet C, Part II, columns 8, 9 and 11, respectively, line 14.

Line 21.--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 22.--Enter the sum of lines 20 and 21 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Line 23 and applicable subscripts.--For each MSA/non-MSA enter the following:

Column 0.--Enter the MSA/non-MSA code from Worksheet S-3, Part III, line 29, the corresponding subscripts thereof.

Column 1.--Enter the corresponding Medicare program (Title XVIII) unduplicated census count (two decimal places) from your records associated with services rendered prior to October 1, 2000. (See §3205.)

Column 2.--Enter the applicable per beneficiary annual limitation. Obtain this amount from your intermediary.

Column 6.--For each MSA/non-MSA determine the beneficiary cost limitation by multiplying the unduplicated census count (column 1) by the per beneficiary annual cost limitation (column 2). Enter the result in column 6.

Line 24.--In columns 1 (two decimal places) and 6, respectively, enter the sum of lines 23 through 23.24. Enter in column 3 the result of column 3, line 19 divided by column 6, line 19 multiplied by column 6, line 24. Enter in column 4 the result of column 4, line 19 divided by column 6, line 19 multiplied by column 6, line 24. (The sum of columns 3 and 4 must equal column 6.)

**NOTE:** The Medicare (Title XVIII) unduplicated census count (Worksheet S-3, Part I, column 2, line 10.01 (Pre 10/1/2000 Unduplicated Census Count)) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet C, Part IV, column 1, line 24).

3215.5 Part V - Outpatient Therapy Reduction Computation.--This section computes the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology) and outpatient occupational therapy provided under arrangement for beneficiaries who are not homebound and are not covered by a physician's plan of care as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998. For outpatient therapy services rendered on or after January 1, 1999, §4541 of BBA 1997 mandates a fee schedule payment basis for outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology. Therefore, any outpatient therapy services furnished on or after January 1, 1999 **must not be included** in this section due to the application of a fee schedule for these services, but the corresponding visits must be recorded in column 5.01. These outpatient therapy services are reimbursed the lesser of the fee scheduled amount or the statutory limitation which is applied on a beneficiary specific basis through the Medicare claims system. This requires no provider input on the cost report. Columns 7 (visits) and 10 (costs) of Worksheet C, Part II represent data subject to deductible and coinsurance which should never have been subject to per visit cost limitations. This section (Worksheet C, Part V) was introduced in transmittal 6 (November 1998) to separately compile such visit and cost data not subject to deductible and coinsurance. As such, columns 7 and 10 of Worksheet C, Part II should not be used. Instead, such data should be captured in this section.

Column 2.--Enter in column 2 the average cost per visit amount for each discipline from Worksheet C, Part I, column 4, lines as indicated.

Columns 3 and 4.--To determine the Medicare Part B cost of services subject to deductibles and coinsurance, multiply the number of covered Part B visits made before January 1, 1998 by non-homebound program beneficiaries to rehabilitation facilities under arrangement (column 3) from your records by the average cost per visit amount in column 2 for each discipline. Enter the result in column 4.

Columns 5, 5.01, 5.02 and 6.--Enter in column 5 the number of Medicare covered Part B visits from your records made by non-homebound (not covered by a physician's plan of care) program beneficiaries to rehabilitation facilities under arrangement for services furnished January 1, 1998 thru December 31, 1998 only. Enter in column 5.01 the number of Medicare covered Part B visits from your records made by non-homebound program beneficiaries to rehabilitation facilities under arrangement for services furnished from January 1, 1999 through September 30, 2000. Outpatient therapy service visits rendered between January 1, 1999 and September 30, 2000 are reimbursed based on a fee schedule as described above. Determine the Medicare cost of services subject to deductibles and coinsurance by multiplying the amount in column 5 by the average cost per visit amount in column 2 for each discipline. Enter the result in column 6. Enter in column 5.02 the number of Medicare covered Part B visits from your records made by non-homebound program beneficiaries to rehabilitation facilities under arrangement for services furnished on or after October 1, 2000. Outpatient therapy services furnished to non-homebound program beneficiaries not covered by a physician's plan of care on or after October 1, 2000 are reimbursed under outpatient PPS. The non-homebound visits captured in columns 5.01 and 5.02 are for statistical purposes only and do not impact the settlement.

Column 7.--Compute the reasonable cost reduction by multiplying the cost of Medicare services in column 6 by 90 percent (.90). This is the application of the 10 percent reasonable cost reduction. Enter the result in column 7.

Column 8.--Compute the reasonable costs net of the reduction by adding column 7 to column 4. Enter the result in column 8.

Line 28.--For columns 3 through 8, respectively, enter the sum of lines 25 through 27.

**NOTE:** For cost reporting periods beginning on or after October 1, 2000, the following lines and/or columns revert back to the standard lines or columns (eliminate the subscript(s)): lines 1-1.01, 2-2.01, 3-3.01, 4-4.01, 5-5.01, 6-6.01, respectively, revert to lines 1, 2, 3, 4, 5, 6, respectively; column 11-11.01, lines 1-6 reverts to column 11, lines 1-6; line 15-15.01 reverts to line 15; line 16-16.01 reverts to line 16.

3216. WORKSHEET D - CALCULATION OF REIMBURSEMENT SETTLEMENT - PART A AND PART B SERVICES

This worksheet applies to Title XVIII only and provides for the reimbursement calculation of Part A and Part B. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

Worksheet D consists of the following two parts:

- Part I - Computation of the Lesser of Reasonable Cost or Customary Charges. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in 42 CFR 413.13(e) (1).
- Part II - Computation of Reimbursement Settlement.

3216.1 Part I - Computation of the Lesser of Reasonable Cost or Customary Charges.-- Providers are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in the 42 CFR 413.13(e).

**NOTE:** Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider only completes lines 1, 2, 3, and 11 of Part I. Transfer the resulting cost to line 12 of Part II.

Line Descriptions

Line 1-- Reporting periods beginning prior to October 1, 2000, enter the cost of services from Worksheet C, Parts III, IV and V based on the following table. If the amount in column 6, line 19 is less than the amount in column 6, line 22, and the amount in column 6, line 24, transfer (aggregate Medicare cost). For cost reporting periods beginning on or after October 1, 2000, transfer the cost of osteoporosis drugs from Worksheet C, Part III, column 10, line 16 to column 3 of this worksheet. For services rendered on or after January 1, 2003, do not transfer the cost of hepatitis vaccines from Worksheet C, Part III, column 9, line 16, as they remain OPSS reimbursed; however, transfer the cost of pneumococcal and influenza vaccines from Worksheet C, Part III, column 9.01, line 16 to column 2 of this worksheet, and the cost of osteoporosis drugs from Worksheet C, Part III, column 10, line 16 to column 3 of this worksheet.

To Worksheet D, Line 1

From Worksheet C

|                |   |
|----------------|---|
| Col. 1, Part A | Part IV, col. 3, line 19  |
| Col. 2, Part B | Part III, sum of col. 9 line 16 (excluding subscripted lines), and Part IV, col. 4, line 19 |
| Col. 3, Part B | Part III, sum of col. 10, lines 15 (excluding   |

subscripted lines), 16 and 16.01, and Part V, col. 8,  
line 28

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If the amount in column 6, line 22 is less than the amount in column 6, line 19, and the amount in column 6, line 24, transfer (aggregate Medicare limitation):

To Worksheet D, Line 1

From Worksheet C

Col. 1, Part A

Part IV, col. 3, line 22

Col. 2, Part B

Part III, sum of col. 9, line 16 (excluding  
subscripted lines), and Part IV, col. 4, line 22

Col. 3, Part B

Part III, sum of col. 10, lines 15 (excluding  
subscripted lines), 16 and 16.01, and Part V, col. 8,  
line 28

If column 6, line 24 is less than the amount in column 6, line 19, and the amount in column 6,  
line 22, transfer (aggregate agency beneficiary limitation):

To Worksheet D, Line 1

From Worksheet C

Col. 1, Part A

Part IV, col. 3, line 24

Col. 2, Part B

Part III, sum of col. 9, line 16 (excluding subscripted  
lines), and Part IV, col. 4, line 24

Col. 3, Part B

Part III, sum of col. 10, lines 15 (excluding  
subscripted lines), 16 and 16.01, and Part V, col. 8,  
line 28

Line 2.--Enter in column 3 the cost of services from the HHA-based RHC (Worksheet RH-2,  
Part III) plus the cost of services from the HHA-based FQHC (Worksheet FQ-2, Part III). The  
costs transferred to this location are only the costs associated with RHC/FQHC services rendered  
prior to January 1, 1998.

Line 3.--In each column, enter the amount on line 1 plus the amount on line 2.

Line 4.--In columns 1, 2 and 3, enter from your records the charges for the applicable Medicare  
services rendered prior to October 1, 2000. Also, in columns 2 and 3, enter from your records  
the charges for the applicable Medicare covered drugs (see §3215.3) rendered prior to October 1,  
2000. In column 3, also enter the Medicare charges applicable to all RHCs and FQHCs,  
respectively, for services furnished prior to January 1, 1998.

Line 4.01.--In column 2, enter from your records **only** the charges for applicable Medicare  
covered pneumococcal and influenza vaccines (see §3215.3) rendered on or after January 1,  
2003 (from worksheet C, line 16, column 6.01). In column 3, enter from your records **only** the  
charges for applicable Medicare covered osteoporosis drugs (see §3215.3) rendered on or after  
October 1, 2000 (from worksheet C, line 16, column 7) . For all other services rendered on or  
after October 1, 2000, do not enter any charges in columns 1 and 2.

Lines 5 through 8.--These lines provide for the accumulation of charges which relate to the  
reasonable cost on line 3.



Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-I, §2104.3) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Lines 5, 6, 7, and 8.--These lines provide for the reduction of Medicare charges where the provider does not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fails to make reasonable efforts to collect such charges from those patients. Enter on line 8 the product of multiplying the ratio on line 7 by line 4 for each column. For column 3, lines 5 and 6, prorate, based on the ratio derived in line 4, all amounts applicable to RHC/FQHCs. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 5, 6, and 7, but enter on line 8 the amount from line 4 for column 1 (excluding subscripted lines) and enter on line 8, **columns 2 and 3** the sum of the amounts from lines 4 and 4.01. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 8 exceed the actual charges on line 4.

Line 9.--Enter in each applicable column on line 9 the excess of total customary charges (line 8) over the total reasonable cost (line 3). In situations when in any column the total charges on line 8 are less than the total cost on line 3 of the applicable column, enter zero (0) on line 9.

Line 10.--Enter in each applicable column on line 10 the excess of total reasonable cost (line 3) over total customary charges (line 8). In situations when in any column the total cost on line 3 is less than the customary charges on line 8 of the applicable column, enter zero (0) on line 10.

Line 11.--Enter the amounts paid or payable by workers' compensation and other primary payers where program liability is secondary to that of the primary payer. Primary payer amounts relating to services paid under PPS are included on this line, which may result in line 12 being negative. There are several situations under which Medicare payment is secondary to a primary payer. Prorate, based on the ratio derived in line 4 (including subscripts), all amounts applicable to RHC/FQHCs. Some of the most frequent situations in which the

Medicare program in a secondary payer include:

1. Workers' compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are considered to be nonprogram services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. The provider notes this on no-pay bills submitted in these situations.) The patient visits and charges are included in total patient visits and charges, but are not included in program patient visits and charges. In this situation, no primary payer payment is entered on line 11.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it would otherwise pay (without regard to the

primary payer payment or deductible and coinsurance) less the primary payer payment or (b) the amount it would otherwise pay (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance and are not entered on line 11.

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When the primary payment does not satisfy the beneficiary's liability, include the covered visits and charges in program visits and charges, and include the total visits and charges in total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 11 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 11. The primary payer rules are more fully explained in 42 CFR 411.

### 3216.2 Part II - Computation of Reimbursement Settlement.--

**NOTE:** For Part II, where applicable and not specifically instructed to do so, prorate, based on the ratio derived in Part I, line 4, all amounts applicable to RHCs and FQHCs, respectively.

Line 12.--Enter in column 1 the amount on line 3, column 1, minus the amount on line 11, column 1. Enter in column 2 the sum of the amounts on line 3, columns 2 and 3, minus the sum of the amounts on line 11, columns 2 and 3.

Lines 12.01 through 12.14.--Under PPS enter only payment amounts associated with episodes completed in the current cost reporting period. Payments for episodes of care which overlap fiscal years must be recorded in the fiscal year in which the episode was completed. Enter in columns 1 and 2 for lines 12.01 through 12.06, as applicable, the appropriate PPS payment for each episode of care payment category indicated on the worksheet. Enter in columns 1 and 2 for lines 12.07 through 12.10, as applicable, the appropriate PPS outlier payment for each episode of care payment category indicated on the worksheet. Enter in columns 1 and 2, line 12.11 the sum total of other payments. Enter in columns 1 and 2, lines 12.12 through 12.14, the gross payments for DME, oxygen, and prosthetics and orthotics payments, respectively associated with home health PPS services (bill types 32 and 33 only).

For lines 12.12 through 12.14 do not include any amounts associated with services billed on bill type 34. Obtain these amounts from your records or PS&R report.

Line 13.--Enter in column 2 the applicable Part B deductibles billed to Medicare patients. Exclude coinsurance amounts. Include any amounts of deductibles satisfied by primary payer payments. Prorate, based on the ratio derived in line 4, all amounts applicable to RHCs/FQHCs, respectively. Do not enter deductibles for DME, oxygen, and prosthetics and orthotics.

Line 15.--If there is an excess of reasonable cost over customary charges, enter the Part A excess (line 10, column 1) in column 1 and the Part B excess (sum of line 10, columns 2 and 3) in column 2. **If you are a nominal charge provider (response of "Y" to S-2, line 21), enter zero on this line.**

Line 17.--Enter in column 2 all coinsurance billable to Medicare beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act and is entered in column 2. Prorate, based on the ratio derived in line 4, all amounts applicable to RHCs/FQHCs, respectively. Do not enter coinsurance for DME, oxygen, and prosthetics and orthotics.

**NOTE:** If the component qualifies as a nominal charge provider, enter 20 percent of costs

subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 13 and Part B primary payment amounts in column 3, line 11 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 19.--Enter the reimbursable bad debts, net of recoveries, in the appropriate columns.

Line 20.--Column 2 amount is the combined amount from Worksheets RH-2, column 5, line 10 and FQ-2, column 5, line 11.

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Line 25.5.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-1, §2146.4.) For

purposes of reimbursing costs associated with the Outcome and Assessment Information Set (OASIS) as required by Program Memorandum A-00-03 (cost reporting periods beginning in Federal fiscal year 2000 only), report on this line, in column 1, the result of multiplying the Medicare unduplicated census count on Worksheet S-3, column 2, line 10 (excluding subscripts), times \$10, minus the interim OASIS payment made to the provider on April 1, 2000. **Do not include this interim OASIS payment on Worksheet D-1, but rather attach documentation supporting the payment(s).** (For intermediary use only during final settlement.)

Line 26.--Using the methodology explained in §120, enter the sequestration adjustment.

Line 27.--Enter the amount on line 25 plus line 25.5 minus line 26.

Line 28.--Enter the interim payment from Worksheet D-1, line 4. For intermediary final settlement, report on line 28.5 the amount from Worksheet D-1, line 5.99.

Line 29.--Enter the balance due the provider or the program. Indicate overpayments by parentheses ( ). Transfer the amount in column 1 to Worksheet S, Part II, line 1, column 1. Transfer the amount in column 2 to Worksheet S, Part II, line 1, column 2.

Line 30.--Enter the Medicare reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) A schedule showing the supporting details and computations for this line must be attached.

Line 31.--Do not use this line.

3217. WORKSHEET D-1 - ANALYSIS OF PAYMENTS TO HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.)

The column headings designate two categories of payments:

- Category 1 - Part A
- Category 2 - Part B

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your fiscal intermediary.

**NOTE:** DO NOT reduce any interim payments by recoveries as a result of medical review adjustments where the recoveries were based on a sample percent applied to the

universe of claims reviewed and the Provider Statistical and Reimbursement Report (PS&R) was not also adjusted.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the HHA for all covered services rendered prior to October 1, 2000. Additionally, for services rendered on or after October 1, 2000, enter the total Medicare interim payments paid to the HHA for applicable covered osteoporosis drugs. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period and includes amounts withheld from the

HHA's interim payments due to an offset against overpayments to the HHA applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts; nor does it include

interim amounts; nor does it include interim payments payable. If the HHA is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period. Do not include payments received for services reimbursed on a fee schedule basis.

Also enter in columns 2 and 4, as applicable for HHA services furnished on or after October 1, 2000, the total Medicare PPS payments and the total Medicare PPS outlier payments paid to the HHA for all episode payment categories for related episodes completed during the current cost reporting period. The amounts entered reflect the sum of all interim PPS payments paid on individual claims (net of adjustments) for episodes completed in the current cost reporting period. Enter gross payments for total DME, oxygen, and prosthetics and orthotics, associated with home health PPS services only (bill types 32 and 33). Do not include any payment information associated with services recorded on bill type 34.

Line 2.--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period but not paid as of the end of the cost reporting period and does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to the appropriate column on Worksheet D, Part II, line 28.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET D-1. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR FISCAL INTERMEDIARY.**

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, all settlement payments prior to the current reopening settlement are reported on line 5.

Line 6.--Enter the net settlement amount from Worksheet D, Part II, line 29, transferring the Part A amount to column 2 and Part B amount to column 4.

**NOTE:** On lines 3, 5, and 6, when an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7.--Enter the total Medicare program liability. Enter the sum of the amounts on lines 4, 5.99, and 6.01 or 6.02 in columns 2 and 4, as appropriate. Enter amounts due the program in parentheses ( ).

3218. WORKSHEETS F, F-1, AND F-2 - FINANCIAL STATEMENTS

These worksheets are prepared from your accounting books and records. Additional worksheets may be submitted if necessary.

Complete all worksheets in the "F" series. Worksheets F and F-2 are completed by all providers maintaining fund-type accounting records. Providers not maintaining fund-type accounting records should only complete the General Fund columns of these worksheet. Cost reports received with incomplete "F" worksheets are returned to the provider for completion and the provider is considered as having failed to file a cost report.

3219. WORKSHEET A-8-3 - REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

This worksheet provides for the computation of any needed adjustments to costs applicable to physical therapy, occupational therapy, and speech pathology services furnished by outside suppliers. The information required on this worksheet provides, in the aggregate, all data for therapy services furnished by all outside suppliers in determining the reasonableness of therapy costs. (See CMS Pub.15-I, chapter 14.)

Complete this worksheet for cost reporting periods beginning prior to October 1, 2000 for physical therapy, occupational therapy, or speech pathology services rendered prior to October 1, 2000. Do not complete this worksheet for cost reporting periods beginning on or after October 1, 2000.

**NOTE:** If you furnish physical therapy services under arrangement with outside suppliers, complete a separate worksheet A-8-3 for physical therapy services rendered before April 10, 1998 and a separate worksheet A-8-3 for physical therapy services rendered on or after April 10, 1998. In addition to physical therapy services, if you furnish either occupational therapy and/or speech pathology services on or after April 10, 1998, under arrangement with outside suppliers, complete a separate worksheet for each discipline. For physical therapy, occupational therapy, and speech pathology services that overlap April 10, 1998, prorate, based on total charges, any statistics and costs for purposes of calculating standards, allowances, or the actual reasonable cost determination, e.g., overtime hours. (See 42 CFR § 413.106.)

Complete this worksheet once for each type of therapy service furnished by an outside supplier.

If you contract with an outside supplier for therapy services, the potential for limitation and the amount of payment you 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, 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.

3219.1 Part I - General Information.--This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Line 1.--For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the HHA. (See CMS Pub. 15-I, chapter 14.)

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

Line 3.--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 4.--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 5.--Enter the standard travel expense rate applicable. (See CMS Pub. 15-I, chapter 14.)

Line 6.--Enter the optional travel expense rate applicable. (See CMS Pub. 15-I, chapter 14.) Use this rate only for home health patient services for which time records are available.

Line 7.--Enter in the appropriate columns the total number of hours worked for therapy supervisors, therapists, therapy assistants, and aides furnished by outside suppliers.

Line 8.--Enter in each column the appropriate adjusted hourly salary equivalency amount (AHSEA). 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 CMS Pub. 15-I, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisory AHSEA, adjusted for administrative and supervisory responsibilities. Determine this amount 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 either the appropriate exhibit found in CMS Pub. 15-I, chapter 14 or from the latest publication of rates. If the going hourly rate for assistants in the area is unobtainable, use no more than 75 percent of the therapist AHSEA. The cost of services of a 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. (See CMS Pub. 15-I, §1412.2.)

Line 9.--Enter the standard travel allowance equal to one half of the AHSEA. Enter in columns 1 and 2 one half of the amount in column 2, line 8. Enter in column 3 one half of the amount in column 3, line 8. (See CMS Pub. 15-I, §1402.4.)

Lines 10 and 11.--Enter the number of travel hours and number of miles driven, respectively, if time records of visits are kept. (See CMS Pub. 15-I, §§1402.5 and 1412.6.)

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

3219.2 Part II - Salary Equivalency Computation.--This part provides for the computation of the full time or intermittent part time salary equivalency.

When you furnish therapy services from outside suppliers to Medicare patients but simply arrange for such services for non health care program patients and do not pay the other Medicare portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of CMS Pub. 15-I, §2314, complete Part II, lines 12 through 17 and 20 in all cases and lines 18 and 19, where appropriate. However, where you cannot gross up costs and charges, complete lines 12 through 17 and 20.

Lines 12 through 17.--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 7) by the adjusted hourly salary equivalency amount for supervisors, therapists, assistants, and aides.





Lines 18 and 19.--If the sum of hours in columns 1 through 3, line 7, is less than or equal to the product found on line 2, complete these lines. (See the exception above where you cannot gross up costs and charges, and services are provided to program patients only.)

Line 20.--If there are no entries on lines 18 and 19, enter the amount on line 17. Otherwise, enter the sum of the amounts on lines 16 and 19.

**3219.3 Part III - Travel Allowance and Travel Expense Computation - HHA Services.**--This part provides for the computation of the standard travel allowance, the standard travel expense, the optional travel allowance, and the optional travel expense. (See CMS Pub. 15-I, §§1402ff, 1403.1 and 1412.6.)

Lines 21 through 24.--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with HHA visits. Use these lines only if you do not use the optional method of computing travel. A standard travel allowance is recognized 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 25 through 28.--Complete the optional travel allowance and optional travel expense computations for therapy services in conjunction with home health services only. Compute the optional travel allowance on lines 25 through 27. Compute the optional travel expense on line 28.

Lines 29 through 31.--Choose and complete only one of the options on lines 29 through 31. However, use lines 30 and 31 only if you maintain time records of visits. (See CMS Pub. 15-I, §1402.5.)

**3219.4 Part IV - 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 is given to a therapist who receives an additional allowance for supervisory or administrative duties. (See CMS Pub. 15-I, §1412.4.)

Line 32.--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 4 are either zero or equal to or greater than 2080, the overtime computation is not applicable. Make no further entries on lines 33 through 40. Enter zero in each column of line 41. Enter the sum of the hours recorded in columns 1 through 3 in column 4.

Line 33.--Enter in the appropriate column the overtime rate (the AHSEA from line 8, column as appropriate, multiplied by 1.5).

Line 35.--Enter the percentage of overtime hours by class of employee. Determine this amount by dividing each column on line 32 by the total overtime hours in column 4, line 32.

Line 36.--Use this line to allocate your standard work year for one full time employee. Enter the numbers of hours in your standard work year for one full time employee in column 4. Multiply the standard work year in column 4 by the percentage on line 35 and enter the result in the corresponding columns.

Line 37.--Enter in columns 1 through 3 the AHSEA from Part I, line 10, columns 2 through 4, as appropriate.



3219.5 Part V - Computation of Therapy Limitation and Excess Cost Adjustment.--This part provides for the calculation of the adjustment to therapy service costs in determining the reasonableness of therapy cost.

Lines 45 and 46--When 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) is considered an additional allowance in computing the limitation.

Line 48--Enter the amounts paid and/or payable to the outside suppliers for 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 therapy services for you. For physical therapy, occupational therapy, and speech pathology services rendered to non-homebound beneficiaries on or after January 1, 1999, prorate, based on total HHA visits, the amounts paid and/or payable to outside suppliers, e.g., multiply the amount paid and/or payable to outside suppliers by the ratio of visits made by non-homebound beneficiaries to CORFs (and/or OPTs) to total HHA visits. The result is the amount of the reduction.

Line 49--Enter the excess cost over the limitation, i.e., line 48 minus line 47. Transfer this amount to Worksheet A-5, line 10 for physical therapy services, line 10.1 for occupational therapy services and line 10.2 for speech pathology services. If the amount is negative, enter a zero.

#### 3220. WORKSHEET S-6 - HHA-BASED CORF STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a) and 42 CFR 413.24(c), maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to an HHA-based CORF. If you have more than one provider-based CORF, complete a separate worksheet for each facility. The data maintained, depending on the services provided by the CORF, 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. **Do not complete this worksheet if all services are paid under an established fee schedule for CORF providers for cost reporting periods ending on or after June 30, 2001.**

CORF Treatments.--Use lines 1 through 8 to identify the number of service treatments and corresponding number of patients. The patient count in columns 2 and 4 includes each individual who received each type of service. The sum of the patient count in columns 2 and 4 equals the total in column 6 for each line.

Columns 1 and 3--Enter the number of treatments for title XVIII and other, respectively, for each discipline. Enter the total for each column on line 9.

Columns 2 and 4--Enter the number of patients corresponding to the number of treatments in columns 1 and 3 for title XVIII and other, respectively, for each discipline.

Columns 5 and 6--Enter in column 5 the total of columns 1 and 3. Enter in column 6 the total of columns 2 and 4.

#### Line Descriptions

Lines 1 through 7--These lines identify the type of CORF services which are reimbursable by the program. These lines reflect the number of times a person was a patient receiving a particular service.

Line 8--This line identifies other services not listed on lines 1 through 7 which are not reimbursable by the program.

Line 9--Enter in column 1 the total of the amounts on lines 1 through 7. Enter in columns 3 and 5 the total of the amounts on lines 1 through 8.

Lines 10 through 28--These lines provide statistical data related to the human resources of the CORF. The human resources statistics are required for each of the job categories specified on lines 10 through 26. Enter any additional categories needed on lines 27 and 28.

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

Report in column 1 the full time equivalent (FTE) employees on the CORF's payroll. These are staff for which an IRS Form W-2 is used.

Report in column 2 the FTE contracted and consultant staff of the CORF.

Compute FTEs as follows. Add hours for which employees or contractors were paid, divide by 2080 hours, and round to two decimal places.

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

### 3221. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO CORF COST CENTERS

Use this worksheet only if you operate a certified provider-based CORF as part of your complex. If you have more than one provider-based CORF, complete a separate worksheet for each facility.

3221.1 Part I - Allocation of General Service Costs to CORF Cost Centers.--Worksheet J-1, Part I provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 15) from Worksheet A, column 10, line 24. Obtain the cost center allocation (column 0, lines 1 through 14) from your records. The amounts on line 15, columns 0 through 6, must agree with the corresponding amounts on Worksheet B, columns 0 through 6, line 24. Complete the amounts entered on lines 1 through 15, columns 1 through 8, in accordance with the instructions contained in §3221.3. **If all CORF services are paid under established fee schedules, these worksheets no longer need to be completed for cost reporting periods ending on or after June 30, 2001.**

3221.2 Part II - Computation of Unit Cost Multiplier for Allocation of CORF Administrative and General Costs.--Use this part to compute the unit cost multiplier used to allocate CORF administrative and general costs to the revenue producing CORF cost centers.

Line 1--Enter the amount from Part I, column 6, line 15.

Line 2--Enter the amount from Part I, column 6, line 1.

Line 3--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4--Divide line 2 by line 3 and enter the result. Multiply each amount in column 6, lines 2 through 15, by the unit cost multiplier and enter the result on the corresponding line of column 7.



3221.3 Part III - Allocation of General Service Costs to CORF Cost Centers - Statistical Basis.-- Worksheet J-1, Parts II and III provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet J-1, Part I. If there is a difference between the total accumulated costs reported on the Part III statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part III for reporting any adjustments. See §3214 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line must match the reconciliation column number.

To facilitate the allocation process, the general format of Worksheet J-1, Parts I and III, is identical.

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

**NOTE:** If you wish to change your allocation basis for a particular cost center, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub. 15-I, §2313.)

Lines 1 through 14.--On Worksheet J-1, Part III, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 15.--Enter the total of lines 1 through 14 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 24.

Line 16.--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, line 24, from the same column used to enter the statistical base on Worksheet J-1, Part III (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, column 1, line 24).

Line 17.--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 16 by the total statistic entered in the same column on line 15. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet J-1, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 15, Part I) must equal the total cost on line 16, Part III.

Perform the preceding procedures for each general service cost center.

In column 6, Part I, enter the total of columns 4A through 5.

In column 7, Part I, for lines 2 through 14, multiply the amount in column 6 by the unit cost multiplier on line 4, Part II, and enter the result in this column. On line 15, enter the total of the amounts on lines 2 through 14. The total on line 15 equals the amount in column 6, line 1.

In column 8, Part I, enter on lines 2 through 14 the sum of the amounts in columns 6 and 7. The total on line 15 equals the total in column 6, line 15.





## 3222. WORKSHEET J-2 - COMPUTATION OF CORF COSTS

Use this worksheet only if you operate an HHA-based CORF. If you have more than one provider-based CORF, complete a separate worksheet for each facility. For CORF services rendered on or after January 1, 1999, §4541 of BBA 1997 mandates a fee schedule payment basis for **all CORF services. Drugs, biologicals (and the applicable Part B deductible and coinsurance for both) and supplies rendered on or after July 1, 2000, are also reimbursed based on the fee schedule. Vaccines are reimbursed under the outpatient prospective payment system (OPPS).** Medicare (Title XVIII) charges for services based on the fee schedule **or OPPS** must **not** be included in column 4. Contact your intermediary for specific services reimbursed on a fee schedule.

3222.1 Part I - Apportionment of CORF Cost Centers.--

Column 1.--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, column 8, corresponding cost center. To facilitate the apportionment process, the line numbers are the same on both worksheets.

**NOTE:** Do not transfer prosthetic and orthotic devices (line 9) or DME costs (lines 12 and 13) from Worksheet J-1. The DME costs are paid based on a fee schedule and are therefore not reimbursable through the cost report.

Column 2.--Enter the total charges for each cost center. Obtain the charges from your records.

Column 3.--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

Column 4.--For each cost center, enter the charges from your records for Title XVIII CORF patients for CORF services rendered on or before December 31, 1998. For services rendered on or after January 1, 1999, enter only those charges applicable to services reimbursed on a reasonable cost basis. Do not enter charges for services reimbursed based on a fee schedule. Note: For cost reporting periods beginning on or after January 1, 1999, column 4 must equal column 6.

Column 5.--For each cost center, enter the costs obtained by multiplying the charges in column 4 by the ratio in column 3.

Reasonable Cost Reduction for Outpatient Therapy.--Columns 6 through 8 compute the reduction in the reasonable costs of CORF services including services provided under arrangement for beneficiaries who are not homebound as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998.

Column 6--For each cost center, enter the title XVIII CORF charges (from your records) for services rendered January 1, 1998 through December 31, 1998. For services rendered on or after January 1, 1999, enter only those charges applicable to services reimbursed on a reasonable cost basis. Do not enter charges for services reimbursed based on a fee schedule. That is, the amounts entered in this column must be associated with the amounts entered in column 4.

Column 7--Determine the title XVIII CORF cost for services rendered on or after January 1, 1998 by multiplying the charges in column 6 by the ratio in column 3, and enter the result.

Column 8--Determine the reduction amount by multiplying the cost in column 7 by 10 percent (.10), and enter the result.

Column 9--Determine the title XVIII cost net of the applicable cost reduction by subtracting the amount in column 8 from the amount in column 5. Enter the result in column 9.

Line 15--Enter the totals for columns 1, 2, and 4 through 9.

3222.2 Part II - Apportionment of Cost of CORF Services Furnished by Shared HHA Departments.--Use this part only when the provider complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the HHA's CORF.

Column 1--Enter on each line the total cost for the HHA cost center as previously computed on Worksheet B, column 6, for the corresponding cost centers.

Column 2--Enter the total facility charges for each cost center. Obtain the charges from your records.

Column 3--For each of the cost centers listed, enter the ratio of cost to charges (column 1 divided by column 2).

Column 4--For each cost center, enter the charges from your records for title XVIII CORF patients.

Column 5--For each cost center, enter the costs obtained by multiplying the charges in column 4 by the ratio in column 3.

Columns 6-8--Follow the instructions for worksheet J-2, Part I, columns 6 through 8, respectively.

Column 9--Determine the title XVIII cost net of the applicable cost reduction by subtracting the amount in column 8 from the amount in column 5. Enter the result in column 9.

Line 23--Enter in columns 4 through 9 the sum of lines 16 through 21.

3222.3 Part III - Total CORF Costs.--

Columns 4-8--Enter the sum of the total cost from Part I, line 15 and Part II, line 23 for each column 4 through 8, respectively.

Column 9--Enter the total cost from Part I, column 9, line 15 plus Part II, column 9, line 23. Transfer this amount to Worksheet J-3, line 1.



3223. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT - CORF SERVICES

Submit a Worksheet J-3 only if you operate an HHA-based CORF. If you have more than one provider-based CORF, complete a separate worksheet for each facility.

3223.1 Part I - Computation of Customary Charges for CORF Services.--

Computation of the Lesser of Reasonable Costs or Customary Charges for CORF Services Rendered in Calendar Year 1998.--Pursuant to §4541 of BBA 1997, §1834(k) of the Act is appended to require that payment for CORF services be subject to the lesser of the charges imposed for CORF services or the adjusted reasonable costs.

Line 1--Enter the cost of CORF services from Worksheet J-2, Part III, column 9, line 24.

Line 1.1--Enter the cost of CORF services rendered prior to January 1, 1998 (services reimbursed on a reasonable cost basis) by subtracting the amount on Worksheet J-2, Part III, column 7, line 24 from the amount on Worksheet J-2, Part III, column 5, line 24.

Line 1.2--Enter the cost of CORF services rendered on or after January 1, 1998 (services reimbursed on a cost basis subject to LCC) by subtracting the amount on Worksheet J-2, Part III, column 8, line 24 from the amount on Worksheet J-2, Part III, column 7, line 24.

Line 2--Enter (from your records) the amounts paid and payable by Workers' Compensation and other primary payers.

Line 3--Enter the amount obtained by subtracting line 2 from line 1.

Line 4--Enter the total CORF charges from Worksheet J-2, Part III, column 4, line 24.

Lines 5, 6, 7, and 8--These lines provide for the reduction of Medicare charges where the provider does not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fails to make reasonable efforts to collect such charges from those patients. Enter on line 8 the product of multiplying the ratio on line 7 by line 4. In no instance may the customary charges on line 8 exceed the actual charges on line 4.

Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 5, 6, and 7, but enter on line 8 the amount from line 4. (See 42 CFR 413.13(b).)

Line 8.1--Enter the customary charges for CORF services rendered prior to January 1, 1998 (services reimbursed on a reasonable cost basis) by subtracting the amount on Worksheet J-2, Part III, column 6, line 24 from the amount on Worksheet J-2, Part III, column 4, line 24. If lines 5 and 6 have been completed, multiply the result of line 8.1 by line 7 and enter the result.

Line 8.2--Enter the customary charges for CORF services rendered on or after January 1, 1998 (services reimbursed on a cost basis subject to LCC) from Worksheet J-2, Part III, column 6, line 24. If lines 5 and 6 have been completed, multiply the result of line 8.2 by line 7 and enter the result.

**NOTE:** Line 1 must equal the sum of lines 1.1 and 1.2; line 8 must equal the sum of lines 8.1 and 8.2.

Line 8.3--Enter the excess of total customary charges (line 8.2) over the total reasonable cost (line 1.2). That is, line 8.2 minus line 1.2. When the total charges on line 8.2 are less than the total cost on line 1.2, enter zero (0).

Line 8.4--Enter the excess of total reasonable cost (line 1.2) over total customary charges (line 8.2).



That is, line 1.2 minus line 8.2. When the total cost on line 1.2 is less than the customary charges on line 8.2, enter zero (0).

3223.2 Part II - Computation of Reimbursement Settlement--

Payment to CORFs is based on the reasonable cost of the services. (See 42 CFR 413.13(c).)

Line 9--Enter the cost of CORF services from line 3.

Line 10--Enter the Part B deductibles billed to program patients (from your records) excluding any coinsurance amounts.

Line 11--Enter the amount obtained by subtracting line 10 from line 9.

Line 11.1--Enter the amount from Part I, line 8.4.

Line 12--Enter 80 percent of line 11.2.

Line 13--Enter the actual coinsurance billed program patients from your records.

Line 14--Enter the amount obtained by subtracting line 13 from line 11.

Line 15--Enter (from your records) reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance.

Line 16--Enter the lesser of the amounts on line 12 or 14 plus the amount on line 15.

Line 17--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §132ff.) Enter the amount of any excess depreciation taken in parentheses ( ).

**NOTE:** Effective for changes in ownership that occur on or after December 1, 1997, §4404 of BBA 1997 amends §1861(v)(1)(O) of the Act which states, in part, that "...a provider of services which has undergone a change of ownership, such regulations provide that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record..." That is, no gain or loss is recognized for such transactions on or after December 1, 1997.

Line 18--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136ff.)

Line 19--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 20--Enter the amount on line 16 minus the amounts on lines 17 and 18 plus the amount on line 19.

Line 21--Enter any applicable sequestration adjustment. (See §120.)

Line 23--Enter the total interim payments from Worksheet J-4, line 4. For intermediary final settlement, report on line 23.5 the amount from Worksheet J-4, column 2, line 5.99.

Line 24--Enter the balance due provider/program and transfer this amount to Worksheet S, Part II, column 2, line 2.

Line 25--Enter the program reimbursement effect of nonallowable cost report items which you are  
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disputing. Compute the reimbursement effect in accordance with §115.2. Attach a schedule showing the supporting details and computation.

Line 26--Do not use this line for periods beginning on or after October 1, 1997.

3224. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED CORF FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.) If there is more than one HHA-based CORF, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your fiscal intermediary.

**NOTE:** DO NOT reduce any interim payments by recoveries as a result of medical review adjustments where the recoveries were based on a sample percent applied to the universe of claims reviewed, and the PS&R was not also adjusted.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA-based CORF. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must include amounts withheld from the CORF's interim payments due to an offset against overpayments to the CORF applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts; nor does it include interim payments payable. If the CORF is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to Worksheet J-3, line 23.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR FISCAL INTERMEDIARY.

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

**NOTE:** On lines 3, 5, and 6, when an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4 and 5.99. The amount must equal Worksheet J-3, line 22.



**3225. WORKSHEET CM-1 - ALLOCATION OF GENERAL SERVICE COSTS TO CMHC COST CENTERS**

Use this worksheet only if you operate a certified provider-based CMHC as part of your complex. If you have more than one provider-based CMHC, complete a separate worksheet for each facility.

**3225.1 Part I - Allocation of General Service Costs to CMHC Cost Centers.**--Worksheet CM-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 12) from Worksheet A, column 10, line 26. Obtain the cost center allocation (column 0, lines 1 through 11) from your records. The amounts on line 12, columns 0 through 5, must agree with the corresponding amounts on Worksheet B, columns 0 through 5, line 26. Complete the amounts entered on lines 1 through 11, columns 1 through 8, in accordance with the instructions contained in §3225.3.

**NOTE:** There is no revenue code specifically entitled "Diagnostic Services." Therefore, use revenue code 918 (testing) when billing for these services.

**3225.2 Part II - Computation of Unit Cost Multiplier for Allocation of CMHC Administrative and General Costs.**--Use this part to compute the unit cost multiplier used to allocate CMHC administrative and general costs to the revenue producing CMHC cost centers.

Line 1.--Enter the amount from Part I, column 6, line 12.

Line 2.--Enter the amount from Part I, column 6, line 1.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Divide line 2 by line 3 and enter the result. Multiply each amount in Part I, column 6, lines 2 through 11, by the unit cost multiplier and enter the result on the corresponding line of column 7.

**3225.3 Part III - Allocation of General Service Costs to CMHC Cost Centers - Statistical Basis.**-- Worksheet CM-1, Parts II and III, provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet CM-1, Part I. If there is a difference between the total accumulated costs reported on the Part III statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part III for reporting any adjustments. See §3214 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line must match the reconciliation column number.

To facilitate the allocation process, the general format of Worksheet CM-1, Parts I and III, is identical.

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

**NOTE:** If you wish to change your allocation basis for a particular cost center, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub. 15-I, §2313.)

Lines 1 through 11.--On Worksheet CM-1, Part III, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 12.--Enter the total of lines 1 through 11 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 26.

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Line 13.--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, line 26, from the same column used to enter the statistical base on Worksheet CM-1, Part III (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, column 1, line 26).

Line 14.--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 13 by the total statistic entered in the same column on line 12. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet CM-1, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 12, Part I) must equal the total cost on line 13, Part III.

Perform the preceding procedures for each general service cost center.

In column 6, Part I, enter the total of columns 4A through 5.

In column 7, Part I, for lines 2 through 11, multiply the amount in column 6 by the unit cost multiplier on line 4, Part II, and enter the result in this column. On line 12, enter the total of the amounts on lines 2 through 11. The total on line 12 equals the amount in column 6, line 1.

In column 8, Part I, enter on lines 2 through 11 the sum of the amounts in columns 6 and 7. The total on line 12 equals the total in column 6, line 12.

### 3226. WORKSHEET CM-2 - COMPUTATION OF CMHC COSTS

Use this worksheet only if you operate an HHA-based CMHC. If you have more than one provider-based CMHC, complete a separate worksheet for each facility. Partial hospitalization services provided by CMHCs are reimbursed based on a Prospective Payment System (PPS).

All CMHC services rendered on or after August 1, 2000 are reimbursed based on a PPS subject to a transitional corridor payment. Vaccines furnished CMHCs are reimbursed based on outpatient PPS.

#### 3226.1 Part I - Apportionment of CMHC Cost Centers.--

Column 1.--Enter on each line the total cost for the cost center as previously computed on Worksheet CM-1, Part I, column 8. To facilitate the apportionment process, the line numbers are the same on both worksheets.

Column 2.--Enter the charges for each cost center. Obtain the charges from your records.

Column 3.--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

Column 3.01.-- For each cost center, enter the corresponding charges from your records for total Title XVIII CMHC services rendered during the entire cost reporting period.

Column 3.02.--For each cost center, enter the total Title XVIII CMHC costs by multiplying the charges in column 3.01 by the ratio in column 3.

Column 4.--For each cost center, enter the corresponding charges from your records for Title XVIII CMHC services rendered on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004. For cost reporting periods beginning on or after January 1, 2004, enter zero (0).



Column 5.--For each cost center, enter the costs on or after **August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004**, by multiplying the charges in column 4 by the ratio in column 3.

Column 6.-- For each cost center, enter the costs associated with services rendered prior to August 1, 2000, **January 1, 2002, January 1, 2003, or January 1, 2004**, by subtracting the amount in column 5 from the amount in column **3.02**.

Line 12.--Enter the totals for columns 1, 2, 3.01, 3.02, 4, 5 and 6.

3226.2 Part II - Apportionment of Cost of CMHC Services Furnished by HHA Departments.--Use this part only when the provider complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the HHA's CMHC.

Column 1.--Enter on each line the total cost for the HHA cost center as previously computed on Worksheet B, column 6, for the corresponding cost centers only when CHMC services are furnished by shared HHA departments.

Column 2.--Enter the total facility charges for each cost center. Obtain the charges from your records.

Column 3.--For each of the cost centers listed, enter the ratio of cost to charges (column 1 divided by column 2).

Column 3.01.-- For each cost center, enter the corresponding charges from your records for total Title XVIII CMHC services rendered during the entire cost reporting period.

Column 3.02.--For each cost center, enter the total Title XVIII CMHC costs by multiplying the charges in column 3.01 by the ratio in column 3.

Column 4.--For each cost center, enter the charges from your records for Title XVIII CMHC services rendered on or after August 1, 2000, **January 1, 2002, January 1, 2003, or January 1, 2004**. For cost reporting periods beginning on or after January 1, 2004, enter zero (0).

Column 5.--For each cost center, enter the costs **on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004** obtained by multiplying the charges in column 4 by the ratio in column 3.

Column 6.-- For each cost center, enter the costs associated with services rendered prior to August 1, 2000, **January 1, 2002, January 1, 2003, or January 1, 2004**, by subtracting the amount in column 5 from the amount in column **3.02**.

Line 16.--Enter the sum lines 13 through 15 for columns 1, 2, 3.01, 3.02, 4, 5 and 6.

3226.3 Part III - Total CMHC Costs.--

Columns 3.01, 3.02 and 4-6.--Enter the sum total of Part I, line 12 plus Part II, line 16 for each column, respectively.

Column 6.--Enter the total costs from Part I, column 6, line 12 plus Part II, column 6, line 16. Transfer this amount to Worksheet CM-3, line 1, column 1.

3227. WORKSHEET CM-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT - CMHC SERVICES

Submit a Worksheet CM-3 only if you operate a provider-based CMHC. If you have more than one provider-based CMHC, complete a separate worksheet for each facility.

**NOTE:** Column 1 is subscripted for lines 1 through 18 for cost reporting periods which overlap

August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, to accommodate the transitional corridor payment calculation associated with the portion of the cost reporting period which overlaps any of the aforementioned dates. For cost reporting periods which overlap a transition date enter in column 1 any data applicable to CMHC services rendered prior to the transition and enter in column 1.01 data applicable to CMHC services rendered on or after the transition date. For cost reporting periods that do not overlap transition dates and for cost reporting periods beginning on or after January 1, 2004, only complete column 1.

3227.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--

Line 1.--For cost reporting periods ending prior to August 1, 2000, enter in column 1 the applicable cost from Worksheet CM-2, column 5, line 17. CMHCs with cost reporting periods overlapping August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, enter in the applicable column the cost of services provided prior to the applicable transition date from Worksheet CM-2, column 6, line 17, and enter in the applicable column the cost of services provided on or after the applicable transition date from Worksheet CM-2, column 5, line 17. CMHCs with cost reporting periods beginning on or after January 1, 2004, enter zero (0) as CMHC services are reimbursed under 100% PPS.

Lines 1.01 through 1.05 are to be completed by CMHCs for Title XVIII services rendered on or after August 1, 2000.

Line 1.01.--Enter the gross PPS payments (includes deductible and coinsurance) received including payments for drugs and outliers.

Line 1.02.--Enter the 1996 CMHC specific payment to cost ratio provided by your intermediary.

Line 1.03.--Line 1 times line 1.02.

Line 1.04.--Line 1.01 divided by line 1.03. Express the results as a percentage to 3 decimal places, i.e., 94.824%. If this line is equal to or greater than 100%, enter zero on line 1.05.

Line 1.05.-- Enter the transitional corridor payment amount calculated based on the following:

For services rendered August 1, 2000 through December 31, 2001:

- a. If line 1.04 is => 90% but < 100% enter 80% of line 1.03 minus line 1.01.
- b. If line 1.04 is => 80% but < 90% enter the result of .71 times line 1.03 minus .70 times line 1.01.
- c. If line 1.04 is => 70% but < 80% enter the result of .63 times line 1.03 minus .60 times line 1.01.
- d. If line 1.04 is < 70% enter 21% of line 1.03.

For services rendered January 1, 2002 through December 31, 2002:

- a. If line 1.04 is => 90% but < 100% enter 70% of line 1.03 minus line 1.01.
- b. If line 1.04 is => 80% but < 90% enter the result of .61 times line 1.03 minus .60 times line 1.01.
- c. If line 1.04 is < 80% enter 13% of result line 1.03.

For services rendered January 1, 2003 through December 31, 2003:

- a. If line 1.04 is  $\geq 90\%$  but  $< 100\%$  enter 60% of line 1.03 minus line 1.01.
- b. If line 1.04 is  $< 90\%$  enter 6% of line 1.03.

Do not use lines 2 through 8, 12 and 14, columns as applicable for a) any part of the cost reporting period on or after August 1, 2000 when the reporting period overlaps August 1, 2000; and b) for all cost reporting periods beginning on or after August 1, 2000 as these lines are not applicable for the previously mentioned periods.

Line 2.--For cost reporting periods ending prior to August 1, 2000, enter in column 1 the charges from Worksheet CM-2, column 3.01, line 17. For cost reporting periods which overlap August 1, 2000, enter in column 1 the pre-transition Medicare charges. For cost reporting periods which overlap August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, do not enter charge data for services rendered on or after August 1, 2000, as services are 100 percent OPSS reimbursed and not subject to LCC.

Lines 3 through 6.--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or when you fail to make reasonable efforts to collect such charges from the patients. Enter on line 6 the product of line 5 times line 2. In no instance may the customary charges on line 6 exceed the actual charges on line 2. This line is not applicable for services rendered on or after August 1, 2000.

If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 3, 4, and 5, but enter on line 6 the amount on line 2. (See 42 CFR 413.13(b).)

Line 7.--If line 6 is greater than line 1, column 1, enter the excess of customary charges over reasonable cost. This line is not applicable for services rendered on or after August 1, 2000.

Line 8.--If line 1, column 1 is greater than line 6, enter the excess of reasonable cost over customary charges. This line is not applicable for services rendered on or after August 1, 2000.

Line 9.--Enter the amounts paid and payable by Workers' Compensation and other primary payers (from your records).

#### 3227.2 Part II - Computation of Reimbursement Settlement.--

Line 10.--For cost reporting periods overlapping August 1, 2000, enter in column 1 the cost of CMHC services from Part I, line 1, column 1 minus line 9, column 1 and enter in column 1.01 the cost of CMHC services from Part I, line 1.01, column 1.01 plus line 1.05, column 1.01 minus line 9, column 1.01.

For cost reporting periods beginning on or after August 1, 2000, enter in column 1 the cost of CMHC services from Part I, line 1.01, column 1, plus line 1.05, column 1 minus line 9, column 1. Follow the same procedures for column 1.01.

Line 11.--Enter the Part B deductibles billed to CMHC patients (from your records) excluding any coinsurance amounts.

Line 12.--Enter excess reasonable cost from line 8. This line is not applicable for services

rendered on or after August 1, 2000 as PPS reimbursed services are not subject to LCC.

Line 13.--Enter the result of line 10 minus lines 11 and 12.

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**Line 14.**--Enter in the applicable column 80 percent of the amount shown on line 13. CMHCs enter 0 (zero) for services on or after August 1, 2000 reimbursed under OPPS.

**Line 15.**--For services rendered prior to August 1, 2000, enter in the appropriate column the actual coinsurance billed program patients from your records. For services rendered on or after August 1, 2000, enter in the appropriate column the gross coinsurance amount billed to Medicare beneficiaries.

**Line 17.**--For services rendered prior to August 1, 2000, enter reimbursable bad debts, net of recoveries, for CMHC services. The amount entered for services rendered on or after August 1, 2000 must not exceed the discounted coinsurance applicable to Medicare beneficiaries.

**Line 18.**--For services rendered prior to August 1, 2000, enter in the appropriate column the result of line 17 plus the lesser of lines 14 or 16. For services rendered on or after August 1, 2000, enter in the appropriate column the result of line 16 plus line 17.

**Line 19.**--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §132ff.) Enter the amount of any excess depreciation taken in parenthesis ( ).

**NOTE:** Effective for changes in ownership that occur on or after December 1, 1997, §4404 of BBA 1997 amends §1861(v)(1)(O) of the Act which states, in part, that "...a provider of services which has undergone a change of ownership, such regulations provide that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record..." That is, no gain or loss is recognized for such transactions on or after December 1, 1997.

**Line 20.**--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §136ff.)

**Line 21.**--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

**Line 23.**--Enter any applicable sequestration adjustment. (See §120.)

**Line 25.**--Enter the total interim payments from Worksheet CM-4, column 2, line 4. For intermediary final settlement, report on line 25.5 the amount from Worksheet CM-4, line 5.99.

**Line 26.**--Enter the balance due provider/program and transfer the amount to Worksheet S, Part II, column 2, line 3.

**Line 27.**--Enter the program reimbursable effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with §115.2. Attach a schedule showing the supporting details and computation.

**Line 28.**--Do not use this line for periods beginning on or after October 1, 1997.

3228. WORKSHEET CM-4 - ANALYSIS OF PAYMENTS TO PROVIDER FOR CMHC SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.) If there is more than one HHA-based CMHC, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your fiscal intermediary.

### Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the HHA-based CMHC. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must include amounts withheld from the CMHC's interim payments due to an offset against overpayments to the CMHC applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts; nor does it include interim payments payable. If the CMHC is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2.--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to Worksheet CM-3, line 25.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET CM-4. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR FISCAL INTERMEDIARY.**

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6.--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

**NOTE:** On lines 3, 5, and 6, when an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7.--Enter the sum of the amounts on lines 4 and 5.99. The amount must equal Worksheet CM-3, line 24.



**3229. WORKSHEET RH-1 - ALLOCATION OF GENERAL SERVICE COSTS TO RHC COST CENTERS**

Use this worksheet only if you operate a certified provider-based RHC as part of your complex. If you have more than one provider-based RHC, complete a separate worksheet for each facility.

While this worksheet series calculates RHC service costs rendered prior to January 1, 1998, enter all cost data in the RH worksheet series for the entire cost reporting period. A proration will determine the cost of services rendered prior to January 1, 1998. The RF worksheet series (new RHC/FQHC worksheets) will calculate RHC service costs for services rendered on or after January 1, 1998.

**3229.1 Part I - Allocation of General Service Costs to RHC Cost Centers.**--Worksheet RH-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 11) from Worksheet A, column 10, line 27. Obtain the cost center allocation (column 0, lines 1 through 10) from your records. The amounts on line 11, columns 0 through 5, must agree with the corresponding amounts on Worksheet B, line 27. Complete the amounts entered on lines 1 through 10, columns 0 through 6, in accordance with the instructions contained in §3229.3.

**3229.2 Part II - Computation of Unit Cost Multiplier for Allocation of RHC Administrative and General Costs.**--Use this part to compute the unit cost multiplier used to allocate RHC administrative and general costs to the revenue producing RHC cost centers.

Line 1--Enter the amount from Part I, column 6, line 11.

Line 2--Enter the amount from Part I, column 6, line 1.

Line 3--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4--Divide line 2 by line 3 and enter the result. Multiply each amount in Part I, column 6, lines 2 through 10, by the unit cost multiplier and enter the result on the corresponding line of column 7.

**3229.3 Part III - Allocation of General Service Costs to RHC Cost Centers -Statistical Basis.**--Worksheet RH-1, Parts II and III, provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet RH-1, Part I. If there is a difference between the total accumulated costs reported on the Part III statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part III for reporting any adjustments. See §3214 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line must match the reconciliation column number.

To facilitate the allocation process, the general format of **Worksheet RH-1, Parts I and III**, is identical.

The statistical basis shown at the top of each column on **Worksheet RH-1, Part III**, is the recommended basis of allocation of the cost center indicated.

**NOTE:** If you wish to change your allocation basis for a particular cost center, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub. 15-I, §2313.)

Lines 1 through 10--On **Worksheet RH-1, Part III**, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.



Line 11--Enter the total of lines 1 through 10 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 27.

Line 12--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, line 27, from the same column used to enter the statistical base on **Worksheet RH-1, Part III** (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, column 1, line 27).

Line 13--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 12 by the total statistic entered in the same column on line 11. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on **Worksheet RH-1, Part I**, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 11, Part I) must equal the total cost on line 12, Part III.

Perform the preceding procedures for each general service cost center.

In column 6, Part I, enter the total of columns **4A** through 5.

In column 7, Part I, for lines 2 through 10, multiply the amount in column 6 by the unit cost multiplier on line 4, Part II, and enter the result in this column. On line 11, enter the total of the amounts on lines 2 through 10. The total on line 11 equals the amount in column 6, line 11.

In column 8, Part I, enter on lines 2 through 10 the sum of the amounts in columns 6 and 7. The total on line 11 equals the total in column 6, line 11.

**3230. WORKSHEET RH-2 - APPORTIONMENT OF RHC COSTS**

Use this worksheet only if you operate a provider-based RHC. If you have more than one provider-based RHC, complete a separate worksheet for each facility.

**3230.1 Part I - Apportionment of RHC Cost Centers.--**

**Column 1**--Enter on each line the total cost for the cost center as previously computed on **Worksheet RH-1, Part I, column 8**. To facilitate the apportionment process, the line numbers are the same on both worksheets.

**Column 2**--Enter the charges for each cost center. Obtain the charges from your records.

**Column 3**--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

**Column 4**--For each cost center, enter the charges applicable to title XVIII RHC patients for services rendered prior to January 1, 1998. To determine the applicable charges, prorate the title XVIII charges applicable to RHC services rendered on a per discipline basis, based on the ratio of charges incurred prior to January 1, 1998 to total charges incurred for the entire cost reporting period. To accomplish this, divide (on a per discipline basis) the charges for services rendered prior to January 1, 1998 by the corresponding total charges incurred for the entire cost reporting period (column 2). Multiply the result by the corresponding title XVIII RHC charges. Enter the result. Submit, on a supplemental schedule, the calculations supporting the ratios.

**Column 5**--For each cost center, enter the costs obtained by multiplying the charges in column 4 by the ratio in column 3.

**Line 9**--Enter the totals for column 5.

**Line 10**--Enter the amount in column 5 and transfer the amount to Worksheet D, column 2, line 20.

**3230.2 Part II - Apportionment of Cost of RHC Services Furnished by Shared HHA Departments.--**Use this part only when the provider complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the HHA's RHC.

**Column 1**--Enter on each line the total cost for the HHA cost center as previously computed on Worksheet B, column 6, for the corresponding cost centers.

**Column 2**--Enter the total facility charges for each cost center. Obtain the charges from your records.

**Column 3**--For each of the cost centers listed, enter the ratio of cost to charges derived by dividing the cost in column 1 by the charges in column 2.

**Column 4**--See column 4 instructions above.

**Column 5**--For each cost center, enter the costs obtained by multiplying the charges in column 4 by the ratio in column 3.

**Line 17**--Enter the total for column 5.

**3230.3 Part III - Total RHC Costs.--**

**Column 5**--Enter the total costs from Part I, column 5, line 9 plus Part II, column 5, line 17. Transfer this amount to the Worksheet D, column 3, line 2.





3231. **WORKSHEET FQ-1 - ALLOCATION OF GENERAL SERVICE COSTS TO FQHC COST CENTERS**

Use this worksheet only if you operate a certified provider-based FQHC as part of your complex. If you have more than one provider-based FQHC, complete a separate worksheet for each facility.

While this worksheet series calculates FQHC service costs rendered prior to January 1, 1998, enter all cost data in the FQ worksheet series for the entire cost reporting period. A proration will determine the cost of services rendered prior to January 1, 1998. The RF worksheet series (new RHC/FQHC worksheets) will calculate FQHC service costs for services rendered on or after January 1, 1998.

3231.1 Part I - Allocation of General Service Costs to FQHC Cost Centers.--Worksheet FQ-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 12) from Worksheet A, column 10, line 28. Obtain the cost center allocation (column 0, lines 1 through 11) from your records. The amounts on line 12, columns 0 through 5, must agree with the corresponding amounts on Worksheet B, line 28. Complete the amounts entered on lines 1 through 11, columns 0 through 6, in accordance with the instructions contained in §3231.3.

3231.2 Part II - Computation of Unit Cost Multiplier for Allocation of FQHC Administrative and General Costs.--Use this part to compute the unit cost multiplier used to allocate FQHC administrative and general costs to the revenue producing FQHC cost centers.

Line 1--Enter the amount from Part I, column 6, line 12.

Line 2--Enter the amount from Part I, column 6, line 1.

Line 3--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4--Divide line 2 by line 3 and enter the result. Multiply each amount in Part I, column 6, lines 2 through 11, by the unit cost multiplier and enter the result on the corresponding line of column 7.

3231.3 Part III - Allocation of General Service Costs to FQHC Cost Centers -Statistical Basis.-- Worksheet FQ-1, Parts II and III, provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet FQ-1, Part I. If there is a difference between the total accumulated costs reported on the Part III statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part III for reporting any adjustments. See §3214 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line must match the reconciliation column number.

To facilitate the allocation process, the general format of Worksheet FQ-1, Parts I and III, is identical.

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

**NOTE:** If you wish to change your allocation basis for a particular cost center, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub.15-I, §2313.)

Lines 1 through 11--On Worksheet FQ-1, Part III, for all cost centers to which the general

service cost center is being allocated, enter that portion of the total statistical base applicable to each.

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Line 12--Enter the total of lines 1 through 11 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 28.

Line 13--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, line 28, from the same column used to enter the statistical base on Worksheet FQ-1, Part III (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, column 1, line 28).

Line 14--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 13 by the total statistic entered in the same column on line 12. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet FQ-1, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 12, Part I) must equal the total cost on line 13, Part III.

Perform the preceding procedures for each general service cost center.

In column 6, Part I, enter the total of columns 4A through 5.

In column 7, Part I, for lines 2 through 11, multiply the amount in column 6 by the unit cost multiplier on line 4, Part II, and enter the result in this column. On line 12, enter the total of the amounts on lines 2 through 11. The total on line 12 equals the amount in column 6, line 1.

In column 8, Part I, enter on lines 2 through 11 the sum of the amounts in columns 6 and 7. The total on line 12 equals the total in column 6, line 12.

**3232. WORKSHEET FQ-2 - COMPUTATION OF FQHC COSTS**

Use this worksheet only if you operate a provider-based FQHC. If you have more than one provider-based FQHC, complete a separate worksheet for each facility.

**3232.1 Part I - Apportionment of FQHC Cost Centers.--**

**Column 1**--Enter on each line the total cost for the cost center as previously computed on Worksheet FQ-1, Part I, column 8. To facilitate the apportionment process, the line numbers are the same on both worksheets.

**Column 2**--Enter the charges for each cost center. Obtain the charges from your records.

**Column 3**--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

**Column 4**--For each cost center, enter the charges applicable to title XVIII FQHC patients for services rendered prior to January 1, 1998. To determine the applicable charges, prorate the title XVIII charges applicable to FQHC services rendered on a per discipline basis, based on the ratio of charges incurred prior to January 1, 1998 to total charges incurred for the entire cost reporting period. To accomplish this, divide (on a per discipline basis) the charges for services rendered prior to January 1, 1998 by the corresponding total charges incurred for the entire cost reporting period (column 2). Multiply the result by the corresponding title XVIII FQHC charges. Enter the result. Submit, on a supplemental schedule, the calculations supporting the ratios.

**Column 5**--For each cost center, enter the costs obtained by multiplying the charges in column 4 by the ratio in column 3.

**Line 10**--Enter the totals for column 5.

**Line 11**--Enter the amount in column 5 and transfer this amount to Worksheet D, column 2, line 20.

**3232.2 Part II - Apportionment of Cost of FQHC Services Furnished by Shared HHA Departments.--**Use this part only when the provider complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the HHA's FQHC.

**Column 1**--Enter on each line the total cost for the HHA cost center as previously computed on Worksheet B, column 6, for the corresponding cost centers.

**Column 2**--Enter the total facility charges for each cost center. Obtain the charges from your records.

**Column 3**--For each of the cost centers listed, enter the ratio of cost to charges derived by dividing the cost in column 1 by the charges in column 2.

**Column 4**--See column 4 instructions above.

**Column 5**--For each cost center, enter the costs obtained by multiplying the charges in column 4 by the ratio in column 3.

**Line 18**--Enter the total for column 5.

**3232.3 Part III - Total FQHC Costs.--**

**Column 5**--Enter the total costs from Part I, column 5, line 10 plus Part II, column 5, line 18. Transfer this amount to Worksheet D, column 3, line 2.

3233. WORKSHEET S-4 - HHA-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA

**COMPLETE THE S-4 AND RF SERIES WORKSHEETS FOR SERVICES RENDERED ON OR AFTER JANUARY 1, 1998.**

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 reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based Federally qualified health centers (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility.

Lines 1 and 1.01.--Enter the full address of the RHC/FQHC.

Line 2.--For FQHCs only, enter your appropriate designation (urban or rural). See §505.2 of the RHC/FQHC Manual for information regarding urban and rural designations. If you are uncertain of your designation, contact your intermediary. RHCs do not complete this line.

Lines 3 through 8.--In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 9.--Subscript line 9 as needed to list all physicians furnishing services at the RHC/FQHC. Enter the physician name in column 1, and the physician's Medicare billing number in column 2.

Line 10.--Subscript line 10 as needed to list all supervisory physicians. Enter the physician name in column 1, and the number of hours the physician spent in supervision in column 2.

Line 11.--If the facility provides other than RHC or FQHC services (e.g., laboratory or physician services), answer Y (yes) and enter the type(s) of operation(s) and hour(s) on subscripts of line 12. If the facility does not provide other services, enter N (no) on line 12, and do not complete subscripts of line 12.

Lines 12.--Enter the starting and ending hours in the applicable columns 1 through 14 for the days that the clinic is available to provide RHC/FQHC services. For facilities providing other than RHC or FQHC services, enter on subscripts of line 12, columns 1 through 14 the starting and ending hours in the applicable columns for the days that the facility is available to provide RHC/FQHC services.

Line 13.--If the facility has been approved for an exception to the productivity standard, enter Y (yes) or N (no).

Line 14.--If this facility is filing a consolidated cost report, as defined in CMS Pub. 27, §508(D), enter Y (yes) or N (no). If the response is yes, enter in column 2 the number of providers included in this report.

Line 15.--If the response to question 14 is yes, list all associated provider names and the corresponding provider numbers included in this report.

Line 16.--If this facility is claiming allowable and/or non-allowable Graduate Medical Education (GME) costs as a result of substantial payment for interns and residents, enter Y (yes) or N (no) and enter the number of Medicare visits in column 2 performed by interns and residents. Complete Worksheet RF-1, lines 20 and 27 as applicable.

**3234. WORKSHEET RF-1 - ANALYSIS OF HHA-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS**

Effective for services rendered on or after January 1, 1998, use this worksheet only if you operate a certified rural health clinic (RHC) or Federally qualified health center (FQHC). Only those cost centers that represent services for which the facility is certified are used. If you have more than one provider-based RHC and/or FQHC, complete a separate worksheet for each facility.

This worksheet is for the recording of direct RHC and FQHC costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations.

Column Descriptions

Columns 1 through 6.--The expenses listed in these columns must be in accordance with your accounting books and records. If the cost elements of a cost center are maintained separately on your books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained by you and are subject to review by your intermediary.

Enter on the appropriate lines in columns 1 through 6 the total expenses incurred during the reporting period. Detail the expenses as Compensation (column 1), Employee Benefits (column 2), Contracted Services (column 3), Transportation (column 4) and Other (column 5). The sum of columns 1 through 5 must equal column 6.

Column 7.--Enter any reclassifications among the cost center expenses listed in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. (See §3210 for examples of reclassifications that may be needed.) Submit with the cost report copies of any workpapers used to compute the reclassifications reported in this column. Show reductions to expenses in parentheses ( ).

The net total of the entries in column 7 must equal zero on line 30.

Column 8.--Add column 6 to column 7, and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 30.

Column 9.--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §3211.) Submit with the cost report copies of any workpapers used to compute the adjustments reported in this column.

NOTE: The allowable cost of the services furnished by National Health Service Corp (NHSC) personnel may be included in your facility's costs. Obtain this amount from your intermediary, and include this as an adjustment to the appropriate lines on column 9.

Column 10.--Adjust the amounts in column 8 by the amounts in column 9, and extend the net balance to column 10. The total facility costs on line 30 must equal the net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center.

Line Descriptions

Lines 1 through 9.--Enter the costs of your health care staff .

Line 10.--Enter the sum of the amounts on lines 1 through 9.

Line 11.--Enter the cost of physician medical services furnished under agreement.

Line 12.--Enter the expenses of physician supervisory services furnished under agreement.

Line 14.--Enter the sum of the amounts on lines 11 through 13.

Lines 15 through 20.--Enter the expenses of other health care costs.

Line 20.--If the clinic incurred all or substantially all training costs (Graduate Medical Education (GME)), enter the total allowable direct and indirect GME cost.

Line 21.--Enter the sum of the amounts on lines 15 through 20.

Line 22.--Enter the sum of the amounts on lines 10, 14, and 21. Transfer this amount to Worksheet RF-2, line 10.

Lines 23 through 26.--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 27.--If the clinic does not provide all or substantially all training costs, enter the total non-allowable direct and indirect GME cost.

Line 28.--Enter the sum of the amounts on lines 23 through 27. Transfer the total amount in column 7 to Worksheet RF-2, line 11.

Line 29.--Enter the overhead expenses directly costed to the facility. These expenses may include rent, insurance, interest on mortgage or loans, utilities, depreciation of buildings and fixtures, depreciation of equipment, housekeeping and maintenance expenses, and property taxes. Submit with the cost report supporting documentation to detail and compute the facility costs reported on this line.

Line 30.--Enter the expenses related to the administration and management of the RHC/FQHC that are directly costed to the facility. These expenses may include office salaries, depreciation of office equipment, office supplies, legal fees, accounting fees, insurance, telephone service, fringe benefits, and payroll taxes. Submit with the cost report supporting documentation to detail and compute the administrative costs reported on this line.

Line 31.--Enter the sum of the amounts on lines 29 and 30. Transfer the total amount in column 7 to Worksheet RF-2, line 14.

Line 32.--Enter the sum of the amounts on lines 22, 28 and 31. This is the total facility cost.

### 3235. WORKSHEET RF-2 - ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Use this worksheet only if you operate a certified provider-based RHC or FQHC as part of your complex. If you have more than one provider-based RHC and/or FQHC, complete a separate worksheet for each facility.

3235.1 Visits and Productivity.--This section summarizes the number of facility visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 list the types of practitioners (positions) for whom facility visits must be counted and reported.

Column descriptions

Column 1.--Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility's practice. (See CMS Pub. 27, §503 for a definition of FTEs.)

Column 2.--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2401(b) defining a visit.

Column 3.--Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each nonphysician practitioner. If you were granted an exception to the productivity standards (answered yes to question 13 of Worksheet S-4), enter the number of productivity visits approved by the intermediary on lines 1-3.

Intermediaries have the authority to waive the productivity guideline in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the intermediary could set any number of visits as reasonable (not just your actual visits) if an exception is granted. For example, if the guideline number is 4200 visits and you have only furnished 1000 visits, the intermediary need not accept the 1000 visits but could permit 2500 visits to be used in the calculation.

Column 4.--For lines 1 through 3, enter the product of column 1 and column 3. This is the minimum number of facility visits the personnel in each staff position are expected to furnish.

Column 5.--On line 4, enter the greater of the subtotal of the actual visits in column 2 or the minimum visits in column 4.

On lines 5 through 7 and 9, enter the actual number of visits for each type of position.

Line Descriptions

Line 8.--Enter the total of lines 4 through 7.

Line 9.--Enter the number of visits furnished to facility patients by physicians under agreement with you. Physicians services under agreements with you are (1) all medical services performed at your site by a physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in RHC/FQHC services, physician services furnished in other locations by physicians who are not on your full time staff are paid to you only if your agreement with the physician provides for compensation for such services.

3235.2 Determination of Total Allowable Cost Applicable To RHC/FQHC Services.--This section determines the amount of the overhead costs incurred by both the parent provider and the facility which apply to RHC/FQHC services.

Line 10.--Enter the cost of health care services from Worksheet RF-1, column 10, line 22 less the amount on Worksheet RF-1, column 10, line 20.

Line 11.--Enter the total nonreimbursable costs from Worksheet RF-1, column 10, line 28.

Line 12.--Enter the sum of lines 10 and 11 for the cost of all services (excluding overhead).

Line 13.--Enter the percentage of RHC/FQHC services. This percentage is determined by dividing the amount on line 10 (the cost of health care services) by the amount on line 12 (the cost of all services, excluding overhead).





Line 14.--Enter the total facility overhead costs incurred from Worksheet RF-1, column 10, line 31.

Line 15.--Enter the amount of GME overhead costs. To determine the amount of GME overhead multiply the amount of facility overhead (from line 14) by the ratio of Intern and Resident visits (from Worksheet S-4, column 2, line 16) over total visits (from Worksheet RF-3, line 6).

Line 16.--Enter the net facility overhead costs by subtracting line 15 from line 14.

Line 17.--Enter the overhead cost incurred by the parent provider allocated to the RHC/FQHC. This amount is the difference between the total costs after allocation from the corresponding RHC/FQHC cost center on the B worksheet, column 6 and Worksheet B, column 0.

Line 18.--Enter the sum of lines 16 and 17 to determine the total overhead costs related to the RHC/FQHC.

Line 19.--Enter the overhead amount applicable to RHC/FQHC services. It is determined by multiplying the amount on line 13 (the ratio of RHC/FQHC services to total services) by the amount on line 18 (total overhead costs).

Line 20.--Enter the total allowable cost of RHC/FQHC services. It is the sum of line 10 (cost of RHC/FQHC health care services) and line 19 (total overhead costs).

### 3236. WORKSHEET RF-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet applies to title XVIII only and provides for the reimbursement calculation. Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due you for the reporting period.

3236.1 Determination of Rate For RHC/FQHC Services.--This section calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

#### Line Descriptions

Line 1.--Enter the total allowable cost from Worksheet RF-2, line 20.

Line 2.--Enter the total cost of pneumococcal and influenza vaccine from Worksheet RF-4, line 15.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Enter the greater of the minimum or actual visits by the health care staff from Worksheet RF-2, column 5, line 8.

Line 5.--Enter the visits made by physicians under agreement from Worksheet RF-2, column 5, line 9.

Line 6.--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7.--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

Lines 8 and 9.--Per visit payment limits are revised each January 1, (except calendar year 2003 updates that occurred January 1 and March 1 (see PM A-03-21)). Complete columns 1, 2 and 3, if



applicable (add column 3 for lines 8-14 if the cost reporting period overlaps 3 limit update periods) for lines 8 and 9 to identify costs and visits affected by different payment limits during a cost reporting period. Enter the rates and the corresponding data chronologically in the appropriate column as they occur during the cost reporting period.

Line 8.--Enter your applicable per visit payment limit. Obtain this amount from CMS Pub. 27, §505 or from your intermediary.

Line 9.--Enter the lesser of the amount on line 7 or line 8.

**NOTE:** If only one payment limit is applicable during the cost reporting period, or the cost per visit (line 7) is less than both payment limits (line 8), complete column 2 only.

3236.2 Calculation of Settlement.--Use this section to determine the total Medicare payment due you for covered RHC/FQHC services furnished to Medicare beneficiaries during the reporting period.

Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

#### Line Descriptions

Line 10.--Enter the number of Medicare covered visits excluding visits subject to the outpatient mental health services limitation from your intermediary records.

Line 11.--Enter the subtotal of Medicare cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered Medicare beneficiary visits for RHC/FQHC services during the reporting period).

Line 12.--Enter the number of Medicare covered visits subject to the outpatient mental health services limitation from your intermediary records.

Line 13.--Enter the Medicare covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14.--Enter the limit adjustment. This is computed by multiplying the amount on line 13 by the outpatient mental health service limit of 62 1/2 percent. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15.--Enter the total allowable GME pass-through costs determined by dividing Medicare visits performed by Interns and Residents (from Worksheet S-4, column 2, line 16) by the total visits (from Worksheet RF-2, column 2, sum of lines 8 and 9) and multiply that result by the total allowable GME cost reported on Worksheet RF-1, column 10, line 20. Add the applicable overhead costs associated with GME (from line 15 of Worksheet RF-2) and enter that result on this line. (Note: If there are no allowable GME pass-through costs, this line will be zero.)

Line 15.5.--Enter the amounts paid and payable by Workers' Compensation and other primary payers (from your records).

Line 16.--Enter the total Medicare cost. This is equal to the sum of the amounts on line 11, columns 1, 2, and 3 plus line 14, columns 1, 2 and 3 plus line 15 minus line 15.5.

Line 17.--Enter the amount credited to the RHC's Medicare patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the intermediary from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the intermediaries. FQHCs enter zero on this line as deductibles do not apply.

Line 18.--Enter the net Medicare cost, excluding vaccines. This is equal to the result of subtracting the amount on line 17 from the amount on line 16.

Line 19.--Enter 80 percent of the amount on line 18.

Line 20.--Enter the Medicare cost of pneumococcal and influenza vaccines and their administration from Worksheet RF-4, line 16.

Line 21.--Enter the total reimbursable Medicare cost. This is equal to the sum of the amounts on lines 19 and 20.

Line 22.--Enter your total reimbursable bad debts, net of recoveries, from your records.

Line 23.--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 24.--This is the sum of lines 21, 22 and 23.

Line 25.--Enter the interim payments from Worksheet RF-5, line 4. For intermediary final settlement, report on line 25.5 the amount from Worksheet RF-5, line 5.99.

Line 26.--Enter the total amount due to/from the Medicare program (lines 24 minus line 25.) Transfer this amount to Worksheet S, Part II, column 2, line:

- o 3.50 - 3.58 for RHCs
- o 3.60 - 3.68 for FQHCs

3237. WORKSHEET RF-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccines to Medicare beneficiaries is 100 percent reimbursable by Medicare. This worksheet provides for the computation of these vaccines for services rendered from April 1, 2001 through December 31, 2002. Except for these dates, all vaccines are reimbursed through the parent provider and cannot be claimed by the RHC and FQHC.

Line 1.--Enter the health care staff cost from Worksheet RF-1, column 10, line 10.

Line 2.--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3.--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4.--Enter the cost of pneumococcal and influenza vaccine medical supplies from your records.

Line 5.--Enter the sum of lines 3 and 4.

Line 6.--Enter the amount on Worksheet RF-1, column 10, line 22. This is your total direct cost of the facility.

Line 7.--Enter the amount from Worksheet RF-2, line 17.

Line 8.--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9.--Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10.--Enter the sum of the amounts on lines 5 and 9.

Line 11.--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12.--Enter the cost per pneumococcal and influenza vaccine injection by dividing the amount on line 10 by the number on line 11 and entering the result.

Line 13.--Enter the number of pneumococcal and influenza vaccine injections from your records.

Line 14.--Enter the Medicare cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15.--Enter the total cost of pneumococcal and influenza vaccine and its (their) administration by entering the sum of the amount in column 1, line 10 and the amount in column 2, line 10. Transfer this amount to Worksheet RF-3, line 2.

Line 16.--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration. This is equal to the sum of the amount in column 1, line 14 and column 2, line 14. Transfer the result to Worksheet RF-3, line 20.

**3238. WORKSHEET RF-5 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED RHC/FQHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES**

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.) If there is more than one HHA-based RHC/FQHC, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your fiscal intermediary.

**NOTE:** DO NOT reduce any interim payments by recoveries as a result of medical review adjustments where the recoveries were based on a sample percent applied to the universe of claims reviewed, and the PS&R was not also adjusted.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA-based RHC/FQHC. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must include amounts withheld from the RHC/FQHC's interim payments due to an offset against overpayments to the RHC/FQHC applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts; nor does it include interim payments payable. If the RHC/FQHC is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to Worksheet RF-3, line 25.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET RF-5. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR FISCAL INTERMEDIARY.**

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

**NOTE:** On lines 3, 5, and 6, when an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4 and 5.99. The amount must equal Worksheet RF-3, line 24.

**3239. WORKSHEET S-5 - HOSPICE IDENTIFICATION DATA**

In accordance with 42 CFR 418.310 hospice providers of service participating in the Medicare program are required to submit annual information for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.24 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 HHA-based hospice. Complete a separate S-5 for each HHA-based hospice.

**3239.1 Part I - Enrollment Days.**--Based on level of care.

Lines 1-4.--Enter on lines 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 4, an inpatient care day should be reported only where the hospice provides or arranges to provide the inpatient care.

Line 5.--Enter the total of lines 1 through 4 for columns 1 through 4.

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:

**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.**

**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.

**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.

**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 Descriptions**

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 Medicare 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 3.-- Enter in column 3 only the days applicable to the four types of care for all non-Medicare or other hospice patients. Enter on line 5 the total unduplicated days.

Column 4.--Enter the total days for each type of care, (i.e., sum of columns 1 and 3). The amount entered in column 4, line 5 should represent the total days provided by the hospice.

**NOTE:** Convert continuous home care hours into days so that column 4, line 5 reflects the actual total number of days provided by the hospice.



3239.2 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. Do not include the number of patients receiving care under subsequent election periods. (See CMS Pub. 21 §204.)

The total under this line should equal 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 should be 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 number of services or therapies provided simultaneously within that hour.

Line 8.-- Enter the average length of stay for the reporting period by dividing the amount on line 5 by the amount on line 6. 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)<br>Patient (A, B & C) | 135 days   |
| Medicare Patients                                  | /3         |
|  | ----       |
| Average LOS Medicare                               | 54.67 Days |
| Medicaid Days Patient D (92)                       | 92 Days    |
| Medicaid Patient                                   | 1          |
| Average LOS Medicaid                               | 92 Days    |
| Other (Insurance) Days (87 & 27)                   | 114 Days   |
| Other Payments ( D & E)                            | 2          |
| Average LOS (Other)                                | 54 Days    |
| All Patients (90+45+29+92+87+27)                   | 370 Days   |
| Total number of patients                           | 6          |
| Average LOS for all patients                       | 61.67 Days |

Enter the hospice's average length of stay, without regard to payer source, in column 4, 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 a new admission and included in the count.

### 3240. WORKSHEET K - 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. This worksheet provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for 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 K, K-4, Parts I & II, the line numbers are consistent, and the total line is set at 34). Not all of the cost centers listed apply to all providers using these forms. Complete a separate worksheet K for each HHA-based hospice.

Column 1.--Obtain salaries to be reported from Worksheet K-1, col. 9, lines 3-34.

Column 2.--Obtain employee benefits to be reported from Worksheet K-2 col. 9 lines 3-34.

Column 3.--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center enter them on line 22.

Column 4.--Obtain the contracted services to be reported from Worksheet K-3, col. 9 lines 3-34.

Column 5.--Enter in the applicable lines in column 5 all costs which have not been reported in columns 1 through 4.

Column 6.--Add the amounts in columns 1 through 5 for each cost center and enter the total in column 6.

Column 7.--Enter any reclassifications among cost center expenses in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses as negative amounts.

Column 8.--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 34.

Column 9.--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §3613.)

Column 10.--Adjust the amounts in column 8 by the amounts in column 9, (increases or decreases) and extend the net balances to column 10.

Transfer the amounts in column 10, lines 1 through 34, to the corresponding lines on worksheet K-4, Part I, column 0.

### Line Descriptions

Lines 1 and 2 - Capital Related Cost - Buildings and Fixtures and Capital Related Cost -Movable Equipment.--These cost centers include depreciation, leases and rentals for the use of the facilities and/or equipment, interest incurred in acquiring land and 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 the following costs: costs incurred for the repair or maintenance of equipment or facilities; amounts included in the rentals or lease 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.

Line 3 - Plant Operation and Maintenance.--This cost center contains the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of the plant, and protecting employees, visitors, and agency property.

Plant Operation and Maintenance include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment. This cost center also includes the cost of maintenance and repair of buildings, parking facilities and equipment, painting, elevator maintenance, performance of minor renovation of buildings, and equipment. The maintenance of grounds such as landscape and paved areas, streets on the property, sidewalks, fenced areas, fencing, external recreation areas and parking facilities are part of this cost center. The care or cleaning of the interior physical plant, including the care of floors, walls, ceilings, partitions, windows (inside and outside), fixtures and furnishings, and emptying of trash containers, as well as the costs of similar services purchased from an outside organization which maintains the safety and well-being of personnel, visitors and the provider's facilities, are all included in this cost center.

Line 4 - Transportation - Staff.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5 - Volunteer Service Coordination.--Enter all of the cost associated with the coordination of service volunteers. This includes recruitment and training costs.

Line 6 - Administrative and General.--Use this cost center to record expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs. If the option to componentize administrative and general costs into more than one cost center is elected, eliminate line 6. Componentized A&G lines must begin with subscripted line 6.01 and continue in sequential order (e.g., 6.01 A&G shared costs). (See §3820 for complete instructions.)

Line 7 - Inpatient - General Care.--This cost center includes costs applicable to patients who receive this level of care because their condition is such that they can no longer be maintained at home. Generally, they require pain control or management of acute and severe clinical problems which



cannot be managed in other settings. The costs incurred on this line are those direct costs of furnishing routine and ancillary services associated with inpatient general care for which other provisions are not made on this worksheet.

If a hospice maintains its own inpatient beds, direct patient care costs include 24-hour nursing care within the facility, patient meals, laundry and linen services, and housekeeping. (Plant operation and maintenance costs are recorded on line 3.)

If a hospice does not maintain its own inpatient beds:

Show any costs for furnishing direct patient care services in the Visiting Services section, and;

Show any costs for furnishing inpatient general care services through a contract with another facility on Worksheet K-3.

Line 8 - Inpatient - Respite Care.--This cost center includes costs applicable to patients who receive this level of care on an intermittent, nonroutine, and occasional basis. The costs included on this line are those direct costs of furnishing routine and ancillary services associated with inpatient respite care for which other provisions are not made on this worksheet. Costs incurred by the hospice in furnishing direct patient care services to patients receiving inpatient respite care either directly by the hospice or under a contractual arrangement in an inpatient facility are to be included in visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24-hour nursing care within the facility, patient meals, laundry and linen services and housekeeping. Plant operation and maintenance costs would be recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient respite care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet K-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting service costs section.

Line 9 - Physician Services.--In addition to the palliation and management of terminal illness and related conditions, hospice physician services also include meeting the general medical needs of the patients to the extent that these needs are not met by the attending physician. The amount entered on this line includes costs incurred by the hospice or amounts billed through the hospice for physicians' direct patient care services.

Line 10 - Nursing Care.--Generally, nursing services are provided as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 11 - Physical Therapy.--Physical therapy is the corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 12 - Occupational Therapy.--Occupational therapy is the application of purposeful goal-oriented activity in the evaluation and diagnosis for the persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, and to maintain health. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 13 - Speech/Language Pathology .--These are physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 14 - Medical Social Services.--This cost center includes only direct expenses incurred in providing medical social services. Medical social services consist of counseling and assessment activities which contribute meaningfully to the treatment of a patient's condition. These services must be provided by a qualified social worker under the direction of a physician.

Lines 15-16 - Counseling.--Counseling services must be available to both the terminally ill individual and family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. This includes dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Costs associated with the provision of such counseling are accumulated in the appropriate counseling cost center. (Costs associated with bereavement counseling are recorded on line 30.)

Line 18 - Home Health Aide and Homemaker.--Enter the cost of a home health aide and homemaker services. Home health aide services are provided under the general supervision of a registered professional nurse and may be provided only by individuals who have successfully completed a home health aide training and competency evaluation program or competency evaluation program as required in 42 CFR 484.36.

Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient.

Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Line 19 - Other.--Enter on this line any other visiting cost which cannot be appropriately identified in the services already listed.

Line 20 - Drugs, Biological and Infusion Therapy.--Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. The amount entered on this line includes costs incurred for drugs or biologicals provided to the patients while at home. If a pharmacist dispenses prescriptions and provides other services to patients while the patient is both at home and in an inpatient unit, a reasonable allocation of the pharmacist cost must be made and reported respectively on line 20 (drugs and biologicals) and on line 7 (Inpatient General Care) or line 8 (Inpatient Respite Care) of worksheet K.

A hospice may, for example, use the number of prescriptions provided in each setting to make that allocation, or may use any other method that results in a reasonable allocation of the pharmacist's cost in relation to the service rendered.

Infusion therapy may be used for palliative purposes if you determine that these services are needed for palliation. For the purposes of a hospice, infusion therapy is considered to be the therapeutic introduction of a fluid other than blood, such as saline solution, into a vein.

Line 21 - Durable Medical Equipment/Oxygen.--Durable medical equipment as defined in 42 CFR 410.38 as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness are covered. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

Line 22 - Patient Transportation.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 23 - Imaging Services.--Enter the cost of imaging services including MRI.

Line 24 - Labs and Diagnostics.--Enter the cost of laboratory and diagnostic tests.

Line 25 - Medical Supplies.--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients.

These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Line 26 - Outpatient Services.--Use this line for any outpatient services costs not captured elsewhere. This cost may include the cost of an emergency room department.

Lines 27-28 - Radiation Therapy and Chemotherapy.--Radiation, chemotherapy and other modalities may be used for palliative purposes if you determine that these services are needed for palliation. This determination is based on the patient's condition and your care giving philosophy.

Line 29 - Other.--Enter any additional costs involved in providing visiting services which has not been provided for in the previous lines.

Lines 30-33 - Non Reimbursable Costs.--Enter in the appropriate lines the applicable costs. Bereavement program costs consist of counseling services provided to the individual's family after the individual's death. In accordance with §1814 (i)(1)(A) of the Act, bereavement counseling is a required hospice service, but it is not reimbursable.

### 3241. WORKSHEET K-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

Enter all salaries and wages for the hospice on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs visiting services which account for 25 percent of that person's time, then enter 75 percent of the administrator's salary on line 6 (A&G) and 25 percent of the administrator's salary enter on line 10 (nursing care). Complete a separate worksheet K-1 for each HHA-based hospice.

The records necessary to determine the split in salary between two or more cost centers must be maintained by the hospice and must adequately substantiate the method used to split the salary. These records must be available for audit by the intermediary, and the intermediary can accept or reject the method used to determine the split in salary. When approval of a method has been requested in writing and this approval has been received prior to the beginning of a cost reporting period, the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the intermediary determines that the method is no longer valid due to changes in your operations.

#### Definitions

Salary.--This is gross salary paid to the employee before taxes and other items are withheld, includes deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-I, Chapter 21.)





Administrator (Column 1).--

Possible Titles: President, Chief Executive Officer

Duties: This position is the highest occupational level in the agency. This individual is the chief management official in the agency. The administrator develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating. The administrator is responsible for the application and implementation of established policies. The administrator may act as a liaison among the governing body, the medical staff, and any departments. The administrator provides for personnel policies and practices that adequately support sound patient care, and maintains accurate and complete personnel records. The administrator implements the control and effective utilization of the physical and financial resources of the provider.

Director (Column 2).--

Possible Titles: Medical Director, Director of Nursing, or Executive Director

Duties: The medical director is responsible for helping to establish and assure that the quality of medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques.

The nursing director is responsible for establishing the objectives for the department of nursing. This individual administers the department of nursing and directs and delegates management of professional and ancillary nursing personnel.

Social Worker (Column 3).--The medical social worker is an individual who has at least a bachelor's degree from a school accredited or approved by the council of social work education. These services must be under the direction of a physician and must be provided by a qualified social worker.

Supervisors (Column 4).--Employees in this classification are primarily involved in the direction, supervision, and coordination of the hospice activities.

When a supervisor performs two or more functions, e.g., supervision of nurses and home health aides, the salaries and wages must be split in proportion with the percent of the supervisor's time spent in each cost center, provided the hospice maintains the proper records (continuous time records) to support the split. If continuous time records are not maintained by the hospice, enter the entire salary of the supervisor on line 6 (A&G) and allocate to all cost centers through stepdown. However, if the supervisor's salary is all lumped in one cost center, e.g., nursing care, and the supervisor's title coincides with this cost center, e.g., nursing supervisor, no adjustment is required.

Total Therapists (Column 6).--Include in column 6, on the line indicated, the cost attributable to the following services:

|                           |   |         |
|---------------------------|---|---------|
| Physical therapy          | - | line 11 |
| Occupational therapy      | - | line 12 |
| Speech/language pathology | - | line 13 |

Therapy and speech/language pathology may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skill.

Physical therapy is the provision of corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician.



Occupational therapy is the application of purposeful, goal-oriented activity in the evaluation, diagnosis, and/or treatment of persons whose ability to work is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health.

Speech/language pathology provides services to persons with impaired functional communications skills by or under the direction of a qualified speech-language pathologist as prescribed by a physician. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors.

Aides (Column 7).--Included in this classification are specially trained personnel employed for providing personal care services to patients. These employees are subject to Federal wage and hour laws. This function is performed by specially trained personnel who assist individuals in carrying out physician instructions and established plans of care. The reason for the home health aide services must be to provide hands-on, personal care services under the supervision of a registered professional nurse.

Aides may provide personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Additional services include, but are not limited to, assisting the patient with activities of daily living.

All Other (Column 8).--Employees in this classification are those not included in columns 1-7, e.g., dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Counseling Services must be available to both the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

Total (Column 9).--Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 1, lines as applicable. To facilitate transferring amounts from Worksheet K-1 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets. Not all of the cost centers are applicable to all agencies. Therefore, use only those cost centers applicable to your hospice.

#### 3242. WORKSHEET K-2 - COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

Enter all payroll-related employee benefits for the hospice on this worksheet. See CMS Pub. 15-I, Chapter 20, for a definition of fringe benefits. Use the same basis as that used for reporting salaries and wages on Worksheet K-1. Therefore, using the same example as given for Worksheet K-1, enter 75 percent of the administrator's payroll-related fringe benefits on line 6 (A&G) and enter 25 percent of the administrator's payroll-related fringe benefits on line 10 (nursing care). Payroll-related employee benefits must be reported in the cost center in which the applicable employee's compensation is reported. Complete a separate worksheet K-2 for each HHA-based hospice.

This assignment can be performed on an actual basis or the following basis:

- o FICA - actual expense by cost center;
- o Health insurance (nonunion) and pension and retirement (gross salaries of participating individuals by cost center);

- o Union health and welfare (gross salaries of participating union members by cost center); and;
- o All other payroll-related benefits (gross salaries by cost center). Include non payroll-related employee benefits in the A&G cost center, e.g., cost for personal education, recreation activities, and day care.

Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 2, corresponding lines. To facilitate transferring amounts from Worksheet K-2 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets.

### 3243. WORKSHEET K-3 - COMPENSATION ANALYSIS - CONTRACTED SERVICES/ PURCHASED SERVICES

The hospice may contract with another entity to provide non-core hospice services. However, nursing care, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted in order to meet unusual staffing needs that cannot be anticipated and that occur so infrequently it would not be practical to hire additional staff to fill these needs. You may also contract to obtain physician specialty services. If contracting is used for any services, maintain professional, financial, and administrative responsibility for the services and assure that all staff meet the regulatory qualification requirements. Complete a separate worksheet K-3 for each HHA-based hospice.

Enter on this worksheet all contracted and/or purchased services for the hospice. Enter the contracted/purchased cost on the appropriate cost center line within the column heading which best describes the type of services purchased. Costs associated with contracting for general inpatient or respite care are recorded on this worksheet. For example, where physical therapy services are purchased, enter the contract cost of the therapist in column 6, line 11. If a contracted/purchased service covers more than one cost center, then the amount applicable to each cost center is included on each affected cost center line. Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 4, corresponding lines. To facilitate transferring amounts from Worksheet K-3 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets.

### 3244. WORKSHEET K-4, PART I - COST ALLOCATION – HOSPICE GENERAL SERVICE COSTS AND WORKSHEET K-4, PART II – HOSPICE COST ALLOCATION - STATISTICAL BASIS

Worksheet K-4 provides for the allocation of the expenses of each hospice general service cost center to those hospice 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, reimbursable cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet K, column 10. To facilitate transferring amounts from Worksheet K to Worksheet K-4, part I, the same cost centers with corresponding line numbers (lines 3 through 34) are listed on both worksheets. Complete a separate worksheet K-4, part 1 and 2 for each HHA-based hospice.

Worksheet K-4, part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-4, part I.

To facilitate the allocation process, the general format of Worksheets K-4, part I & II are identical. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each general, reimbursable, nonreimbursable, and special purpose cost centers are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheets K, K-1, K-2, and K-3.



**NOTE:** General service columns 1 through 5 and subscripts thereof must be consistent on Worksheets K-4, parts I & II.

The statistical bases shown at the top of each column on Worksheet K-4, Part II are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

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

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) which states, in part, that the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. This is clarified in CMS Pub. 15-I, §2306.1 which further clarifies the order of allocation for stepdown purposes. Consequently, first close those 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 worksheet. However, the circumstances of an agency 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.

**NOTE:** A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year cost if received by the intermediary, in writing, within 90 days prior to the end of that 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 or, if the allocation is accurate, to simplify maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until approved. If both sets 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. (See CMS Pub. 15-I, §2313.)

If the amount of any cost center on Worksheet K, column 10, has a credit balance, show this amount as a credit balance on Worksheet K-4, part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the 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 allocated, do not allocate the general service cost center. Rather, enter the credit balance on the first line of the column and on line 34. This enables column 7, line 34, to crossfoot to columns 0 and 5A, line 34. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet K-4, part I, column 7, do not carry forward a credit balance to any worksheet.

On Worksheet K-4, part II, enter on the first line in the column of the cost center the total statistics applicable to the cost center being allocated (e.g., in column 1, capital-related cost - buildings and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating administrative and general expenses.

Such statistical base does not include any statistics related to services furnished under arrangements except where both Medicare and non-Medicare costs of arranged-for services are recorded in your records.

For all cost centers (below the cost center being allocated) to which the service rendered is 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 statistics entered on the first line.

Enter on Worksheet K-4, part II line 34, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet K-4, part I from the same column and line number of the same column. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet K-4, part I, column 1, line 1.

Divide the amount entered on line 34 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 35. Round the unit cost multiplier to at least the nearest six decimal places.

Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet K-4, part I in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 34) of all of the cost centers receiving the allocation on Worksheet K-4, part I, must equal the amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Worksheets K-4, part I & II before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet K-4, part I, enter in column 7 the sum of the expenses on lines 7 through 33. The total expenses entered in column 7, line 34, must equal the total expenses entered in column 0, line 34.

#### 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.

Allocate all expenses to the cost centers on the basis of square feet of area occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

Column 2.--Allocate all expenses (e.g., interest or personal property tax) for movable equipment to the appropriate cost centers on the basis of square feet of area occupied or dollar value.

Column 4.--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet K, column 3, is included in this cost center. Allocate this expense to the cost centers to which it applies on the basis of miles applicable to each cost center.

This basis of allocation is not mandatory and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs which are not directly assigned. However, a hospice must request the use of the alternative method in accordance with CMS Pub. 15-I, §2313. The hospice must maintain adequate records to substantiate the use of this allocation.

Column 6.--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments.





Therefore, obtain the amounts to be entered on Worksheet K-4, part II, column 6, from Worksheet K-4, part I, columns 0 through 5.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet K-4, part I, column 0) for purposes of determining the basis of allocation (Worksheet K-4, part II, column 5) of the A&G costs. This procedure may be followed when the hospice contracts for services to be performed for the hospice and the contract identifies the A&G costs applicable to the purchased services.

The contracted A&G costs must be added back to the applicable cost center after allocation of the hospice A&G cost before the reimbursable costs are transferred to Worksheet K-5, part I. A separate worksheet must be included to display the breakout of the contracted A&G Costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Intermediary approval does not have to be secured in order to use the above described method of cost finding for A&G.

Worksheet K-4, Part II, Column 6A.--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet K-4, part I, column 5A, line 34 and the accumulated cost reported on Worksheet K-4, part II, column 6, line 6. Enter any amounts reported on Worksheet K-4, part I, column 5A for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead.

In addition, report on line 6 the administrative and general costs reported on Worksheet K-4, Part I, column 6, line 6 since these costs are not included on Worksheet K-4, Part II, column 6 as an accumulated cost statistic.

Worksheet K-4, Part II, Column 6.--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet K-4, part II, column 6, line 6, is the difference between the amounts entered on Worksheet K-4, part I, column 5A and Worksheet K-4, part II, column 6A. 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.

#### 3245. WORKSHEET K-5 - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Use this worksheet only if you operate a certified HHA-based Hospice as part of your complex. If you have more than one HHA-based Hospice, complete a separate worksheet for each facility.

3245.1 Part I - Allocation of General Service Costs to Hospice Cost Centers.--Worksheet K-5, part I, provides for the allocation of the expenses of each general service cost center of the HHA to those hospice cost centers which receive the services. Worksheet K-5, parts I and II, provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-5, part I.

Obtain the total direct expenses (column 0, line 29) from Worksheet A, column 10, line 25. Obtain the cost center allocation (column 0, lines 1 through 28) from Worksheet K-4, part I, lines as indicated. The amounts on line 29, column 0 through column 5 must agree with the corresponding amounts on Worksheet B, part I, column 0 through column 5, line 25. Complete the amounts entered on lines 1 through 28, columns 1 through 4 and column 5.

Line 30.--Enter the unit cost multiplier (column 6, line 1, divided by the sum of column 6, line 29 minus column 6, line 1, rounded to 6 decimal places). Multiply each amount in column 6, lines 2 through 28, by the unit cost multiplier, and enter the result on the corresponding line of column 7.

3245.2 Part II - Allocation of General Service Costs to Hospice Cost Centers -Statistical Basis.--To facilitate the allocation process, the general format of Worksheet K-5, Parts I and II, are identical.

The statistical basis shown at the top of each column on Worksheet K-5, Part II, is the recommended basis of allocation of the cost center indicated.

**NOTE:** If you wish to change your allocation basis for a particular cost center, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub. 15-I, §2313.)

Except for non-PPS providers, unless there is a change in ownership, the hospital must continue the same cost finding methods (including its cost finding bases) in effect in the hospital's last cost reporting period ending on or before October 1, 1991. (See 42 CFR 412.302(d).) If there is a change in ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices. (See CMS Pub. 15-I, §2313.)

Lines 1 through 28.--On Worksheet K-5, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 29.--Enter the total of lines 1 through 28 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 25.

Line 30.--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, line 25 from the same column used to enter the statistical base on Worksheet K-5, Part II (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, column 1, line 25).

Line 31.--Enter the unit cost multiplier, which is obtained by dividing the cost entered on line 30 by the total statistic entered in the same column on line 29. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet K-5, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 29, Part I) must equal the total cost on line 30, Part II.

Perform the preceding procedures for each general service cost center.

In column 6, Part I, enter the total of columns 4A through 5.

In column 7, Part I, for lines 2 through 28, multiply the amount in column 6 by the unit cost multiplier on line 30, Part I, and enter the result in this column. On line 29, enter the total of the amounts on lines 2 through 28. The total on line 29 equals the amount in column 6, line 1.

In column 8, Part I, enter on lines 2 through 28 the sum of columns 6 and 7. The total on line 29 equals the total in column 6, line 29.

3245.3 Part III- Computation of Total Hospice Shared Costs.--Use this part only when the provider complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the HHA's hospice. This worksheet provides for the shared therapy, drugs, or medical supplies from the HHA to the hospice.

Column Description

Column 2.--Where HHA departments provides services to the hospice, enter in column 2 the cost for each discipline from Worksheet B, col. 6, lines as indicated.

Column 3.--Where HHA departments provide services to the hospice, enter on the appropriate lines the total HHA charges, from the provider's records, applicable to the HHA-based hospice.

Column 4.--Where applicable, determine the cost to charge ratio by dividing column 2 by column 3. Enter the results in column 4.

Column 5.-- Where HHA departments provides services to the hospice, enter on the appropriate lines the total hospice charges, from the provider's records, applicable to the HHA-based hospice.

Column 6.--Multiply the ratio in column 4 by the amount in column 5. Enter the result in column 6.

Line 7.--Enter the sum of column 6, lines 1 through 6.

3246. WORKSHEET K-6 - CALCULATION OF PER DIEM COST

Worksheet K-6 calculates the average cost per days in providing care for a hospice patient. It is only an average and should not be misconstrued as the absolute. If you have more than one HHA-based Hospice, complete a separate worksheet for each facility.

Line 1.--Total cost from Worksheet K-5, Part I, column 8, line 29 less column 8, line 28, plus Worksheet K-5, Part III, column 6, line 7. This line reflects the true cost without any non-hospice related costs.

Line 2.--Total unduplicated days from Worksheet S-5, line 5, col. 4.

Line 3.--Average cost per day. Divide the total cost from line 1 by the total number of days from line 2.

Line 4.--Unduplicated Medicare days from Worksheet S-5, line 5, column 1.

Line 5.--Aggregate Medicare cost. Multiply the average cost from line 3 by the number of unduplicated Medicare days on line 4 to arrive at the aggregate Medicare cost.

Line 6.--**NOT APPLICABLE.**

Line 7.--**NOT APPLICABLE.**

Line 8.--Unduplicated SNF days from Worksheet S-5, line 5, column 2.

Line 9.--Aggregate SNF cost. Multiply the average cost from line 3 by the number of unduplicated SNF days on line 8 to arrive at the aggregate SNF cost.



Line 10.--**NOT APPLICABLE.**

Line 11.--**NOT APPLICABLE.**

Line 12.--Other Unduplicated days from Worksheet S-5, line 5, column 3.

Line 13.--Aggregate cost for other days. Multiply the average cost from line 3 by the number of Unduplicated Other days on line 12 to arrive at the aggregate cost for other days.