3800. GENERAL

The Paperwork Reduction Act of 1995 establishes the requirement that the private sector be told why information is collected and what it will be used for by the government. 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 418.20 requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The information reported on Form CMS-1984-99, must conform to the requirements and principles set forth in the Provider Reimbursement Manual Part I (CMS Pub. 15-I) and the Hospice Manual (CMS Pub. 21). These instructions, Chapter 38, are effective for cost reporting periods beginning on or after **April 1, 1999.**

Providers receiving Medicare reimbursement must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data developed on such basis of accounting is acceptable subject to appropriate treatment of capital expenditures. Under the accrual basis of accounting, revenue is recorded in the period earned regardless of when it is collected, and expenditures for expense and asset items are recorded in the period incurred regardless of when paid. See CFR 413.24(b)(2).

Facilities meeting the conditions set forth in Chapter 1, Section 110 of the Provider Reimbursement Manual Part II (CMS Pub.15-II) can file less than a full cost report.

Form CMS-1984-99 must be used by all freestanding Hospices to which payment is made by Medicare and must be submitted to the Hospice's Medicare fiscal intermediary on or before the last day of the fifth month following the close of the cost reporting period. This form must be used for cost reporting periods beginning on or after **April 1, 1999**.

NOTE: This form is to be used by freestanding hospices only. For provider based hospices, complete the appropriate hospice schedules within those cost reports.

Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. A 30-day extension of the due date may be granted by the intermediary only when the provider's operations are significantly affected due to extraordinary circumstances over which the provider has no control such as fire or flood. (See 42 CFR 413.24 (f)(2)(ii).)

3801 ROUNDING STANDARDS FOR FRACTIONAL COMPUTATIONS

Throughout the Medicare cost report, computations result in fractions. Use the following rounding standards:

1. Round to 2 decimal places:
   - Percentages
   - Averages, standard work week, and payment rates
   - Full time Equivalent employees
   - Per diem
   - Hourly rates

2. Round to 6 decimal places:
   - Ratios (e.g., unit cost multipliers)

Where a difference exists within a column as a result of computing costs using a fraction or decimal, and therefore the sum of the parts do not equal the whole, the highest amount in that column must either be increased or decreased by the difference. If it should happen that there are two high numbers equaling the same amount, adjust the first high number from the top of the worksheet for which it applies.

3802. DEFINITIONS

A freestanding Hospice, as the term is used in this report, refers to a hospice that is not part of any other type of participating provider meeting the requirements of §1861(dd) of the Social Security Act. Refer to the Hospice Manual, CMS-Pub. 21 and the Provider Reimbursement Manual, Part I, CMS-Pub. 15-1, for further definitions of terms. Your intermediary will furnish any revisions to the documents cited.

NOTE: This form is not used by Hospices that are provider based. Instead, they continue to use Form CMS-2552 for hospital based, Form CMS-2540 for the SNF based and Form CMS-1728 for HHA based.

In these reporting instructions the use of the term "Medicare" refers only to Medicare patients currently under a valid Medicare Hospice election. The statistics associated with Medicare patients not covered under the Medicare Hospice election should be included with other payors. Likewise, all references used throughout the reporting instructions which indicate that the "other" equals "non-Medicare" refer to patients not making the hospice election under Medicare or Medicaid.

3803. ACRONYMS AND ABBREVIATIONS

Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

A&G	-	Administrative and General
BBA	-	Balanced Budget Act of 1997 (P.L. 105-33)
CAP-REL	-	Capital-Related
CFR	-	Code of Federal Regulations
COL	-	Column
FR	-	Federal Register
CMS Pub.	-	Health Care Financing Administration Publication
HHA	-	Home Health Agency
INPT	-	Inpatient
LOS	-	Length of Stay
MRI	-	Magnetic Resonance Imaging
NF	-	Nursing Facility
NPI	-	*National Provider Identifier*
OT	-	Occupational Therapy
PBP	-	Provider-Based Physician
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PT	-	Physical Therapy
SNF	-	Skilled Nursing Facility
SP	-	Speech Pathology
WKST	-	Worksheet

3804. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-1984-99

Step No.	Worksheet	Instructions
1	S	Read §3806. Complete entire worksheet.
2	S-1	Read §3807. Complete entire worksheet.
3	A-1 - A-3	Read §3811 - §3813. Complete entire worksheets.
4	A	Read §3810. Complete columns 1 - 3, lines 1 - 100.
5	A-6	Read §3816. Complete, if applicable.
6	A-7	Read §3817. Complete, if applicable.
7	A-8	Read §3818. Complete all lines.
8	A-8-1	Read §3818.1. Complete, if applicable.
9	A	Read §3810. Complete columns 4 - 7, lines 1 - 100.
10	B and B-1	Read §3820. Complete both worksheets entirely.
11	D	Read §3830. Complete entire worksheet.
12	G	Read §3850. This step is completed by all providers maintaining fund type accounting records. Non-proprietary providers which do not maintain fund type records complete the General Fund column only.
13	G-1	Complete entire worksheet.
14	G-2, Parts I & II	Complete entire worksheet.

3805. SEQUENCE OF ASSEMBLY

Submit your annual cost report worksheets in the order indicated below when using Form CMS-1984-99. Include only applicable, completed worksheets. Do not include blank worksheets.

Worksheet	Part
S	I & II
S-1	
A-1 through A-3	
A	
A-6	
A-7	
A-8	
A-8-1	
B	
B-1	
D	
G through G-2	

3806. WORKSHEET S - HOSPICE COST REPORT CERTIFICATION

The information required on this worksheet is needed to properly identify the provider. Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), each provider must submit periodic reports of its operation, which generally cover a consecutive 12 month period.

The intermediary indicates in the appropriate box whether this is the initial cost report, final report due to termination, or a reopening. If it is a reopening, the intermediary indicates the number of times the cost report has been reopened.

3806.1 Certification.--This certification is read, completed, and signed after the cost report has been completed in its entirety.

3807. WORKSHEET S-1 - HOSPICE IDENTIFICATION DATA

3807.1 Part I --The information required on this worksheet is needed to properly identify the provider.

Line 1.--Enter the name, address, city, state and zip code of the hospice.

Line 2.--Enter the county where the Hospice is located.

Line 3.--Enter the date the hospice began operation. Enter the date of State licensure if the hospice is located in a State that requires a state hospice license for operation.

Line 4.--Enter the date the hospice was certified for Title XVIII, Medicare and Title XIX, Medicaid.

Line 5.--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of operations, which generally cover a consecutive 12-month period. (See §§102.1 - 102.3 for situations when you may file a short period cost report.)

Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. The ONLY provision for an extension of the cost report due date is identified in 42 CFR 413.24(f)(2)(ii).

Line 6.--Enter the provider identification number.

Line 6.01.--Reserved for future use.

Line 7.--Indicate the type of control or auspice under which the hospice is conducted as indicated.

1 = Voluntary Nonprofit, Church	8 = Governmental, City-County
2 = Voluntary Nonprofit, Other	9 = Governmental, County
3 = Proprietary, Individual	10 = Governmental, State
4 = Proprietary, Corporation	11 = Governmental, Hospital District
5 = Proprietary, Partnership	12 = Governmental, City
6 = Proprietary, Other	13 = Governmental, Other
7 = Governmental, Federal	

- Voluntary - A voluntary hospice is usually financed by earnings and contributions and governed by a community-based board of directors. The primary function is the care of the terminally ill in the home. Some voluntary hospices are operated under church auspices.

- Proprietary - A proprietary hospice is owned and operated by an individual business corporation. The organization may be a sole proprietorship (individual), a partnership (including limited partnership and joint stock company) or a corporation. Indicate the type of operation.

- Government - A government hospice is operated by a State, county, city or other local unit government.

3807.2 Part II--Enrollment days based on level of care.

Lines 8-11.--Enter on line 8 through 11 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 10, an inpatient care day should be reported only where the hospice provides or arranges to provide the inpatient care.

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

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. **Note: 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.

Line 12.--Enter the total unduplicated days.

COLUMN DESCRIPTIONS

Column 1.--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 12 the total unduplicated Medicare days.

Column 2.--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 12 the total unduplicated Medicaid days.

Column 3.--Enter only the unduplicated days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 12 the total unduplicated days.

Column 4. --Enter only the unduplicated days applicable to the four types of care for all Medicaid hospice patients residing in a nursing facility. Enter on line 12 the total unduplicated days.

Column 5. --Enter in column 5 only the days applicable to the four types of care for all other non- Medicare or Medicaid hospice patients. Enter on line 12 the total unduplicated days.

Column 6.--Enter the total days for each type of care, (i.e., sum of columns 1, 2 and 5). The amount entered in column 6 line 12 should represent the total days provided by the hospice.

NOTE: Convert continuous home care hours into days so that column 6 line 12 reflects the actual total number of days provided by the hospice.

3807.3 Part III --Census data.

Line 13.--Enter on line 13 the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source.

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 should be counted twice.

A patient transferring from another hospice is considered to be a new admission and would be 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 13 and line 16 is that line 13 should equal the actual number of patients served during the reporting period for each program, whereas under line 16, patients are counted once, even if their stay overlaps more than one reporting period.

Line 14.--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 15.--Enter the average length of stay for the cost reporting period. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payer source other than Medicare and Medicaid is not limited to the number of days under a hospice election.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under the 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 benefit for an additional 45 days, under a new benefit period as patient B, then dies. 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, with private insurance, received hospice care for 87 days. Patient E was admitted with private insurance for 27 days, until the private insurance ended, and Medicaid covered an additional 92 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the reporting period) is computed as follow:

Medicare Days (90 & 45 & 29) Patients (A, B & C)	164 Days
Medicare Patients	/3
Average LOS Medicare	54.67 Days
Medicaid Days Patient E (92)	92 Days
Medicaid Patients	/1
Average LOS Medicaid	92 Days

Other (Insurance) Days (87 & 27)	114
Other Patients (D & E)	/2
Average LOS (Other)	57 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 6, line 15.

Line 16.--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 should be counted twice.

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

Line 17.--If the hospice componentized (or fragmented) its administrative and general service costs, enter "1" for option 1 and "2" for option two. Do not respond if A&G services are not fragmented. (See §3820 for an explanation of the A&G componentization options.)

Line 18.—Are there any related organization or home office costs claimed? Enter "Y" for yes or "N" for no in column 1. If yes, enter the Chain Home Office's provider number in column 2. If yes, complete Worksheet A-8-1.

3810. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner, which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, B-1, the line numbers are consistent, and the total line is set at 100). Not all of the cost centers listed apply to all providers using these forms.

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

Standard (i.e., preprinted) CMS line numbers and cost center descriptions may not be changed. If you need to use additional or different cost center descriptions, add additional lines to the cost report. When an added cost center description bears a logical relationship to a standard line description, insert the added label immediately after the related standard line description.

Identify the added line as a numeric (only) subscript of the immediately preceding line, except when subscripting administrative and general (A&G) costs. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02.

But if A&G costs (line 6) are subscripted, eliminate line 6 and begin subscripting with line 6.01. If additional lines are added for general service cost centers to Worksheet A, corresponding columns must be added to Worksheets B and B-1 as well as lines to Worksheet A-1, A-2, A-3, B, and B-1 for cost finding.

Cost center coding is a method for standardizing cost center labels used by health care providers on the Medicare cost reports. Form CMS 1984-99 provides for preprinted cost center descriptions on Worksheet A. The preprinted cost center labels are automatically coded by CMS approved cost reporting software.

These cost center descriptions are hereafter referred to as the standard cost centers. Nonstandard cost center descriptions are identified through analysis of frequently used labels.

Column 1.--Obtain salaries to be reported from Worksheet A-1, col. 9, line 3-100.

Column 2.--Obtain employee benefits to be reported from Worksheet A-2 col. 9 lines 3-100.

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 32.

Column 4.--Obtain the contracted services to be reported from Worksheet A-3, col. 9 lines 3-100.

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.

Worksheet A-6 reflects the reclassifications affecting the cost center expenses. This worksheet 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 in parentheses ( ).

The net total of the entries in column 7 must equal zero on line 100.

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 100.

Column 9.--Enter on the appropriate lines in column 9, the amounts from Worksheet A-8. The total on Worksheet A, column 9, line 100 must equal Worksheet A-8, column 2, line 11.

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.

LINE DESCRIPTIONS

Lines 1 and 2 - Capital Related Cost - Buildings and Fixtures and Capital Related Cost - Movable Equipment.--These cost centers should 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 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 plant, and protecting the 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 building, 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, sidewalk, 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 (i.e., 6.01 A&G shared costs, in this order only.) See §3820. For complete instructions.

Line 10 - 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.

Costs incurred by a hospice in furnishing direct patient care services to patients receiving general inpatient care either directly from the hospice or under a contractual arrangement in an inpatient facility is to be included in the 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 hours nursing care within the facility, patient meals, laundry and linen services, and housekeeping. Plant operation and maintenance cost would be recorded on line 3.

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

Line 11 - 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 hours 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 A-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting service costs section**.**

Line 15 - 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 16 - 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. *Enter the routine, general inpatient and respite portions of costs for nursing services provided by a registered nurse, licensed practical nurse or licensed vocational nurse as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.*

Line 16.01 - Nursing Care -- Continuous Home Care.--Enter the continuous home care portion of costs for nursing services provided by a registered nurse, licensed practical nurse or licensed vocational nurse as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 17 - Physical Therapy.--Physical therapy is the provision of physical or 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 18 - Occupational Therapy.--Occupational therapy is the application of purposeful goal-oriented activity in the evaluation, diagnostic, for the persons whose function is impaired by physical illness or injury, emotional disorder, congenial 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 19 - 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. 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 20 - 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 21-23 - 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 is accumulated in the appropriate counseling cost center. Costs associated with bereavement counseling are recorded on line 50.

Line 24 - Home Health Aide And Homemaker.--Enter *the routine, general inpatient and respite portions of costs for* 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 by only 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 24.01- Home Health Aide And Homemaker – Continuous Home Care.--Enter the continuous care portion of cost for a home health aide and/or homemaker services provided as specified in the plan of care and under the supervision of a registered nurse.

Line 25 - Other.--Enter on this line any other visiting cost which can not be appropriately identified in the services already listed.

Line 30 - 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. *Do not include costs for Analgesics or for Sedatives/Hypnotics; rather include those costs on the designated lines.* 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 30 (drugs and Biologicals) and line 10 (Inpatient General Care) or line 11 (Inpatient Respite Care) of Worksheet A.

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 30.01 - Analgesics.--Enter the cost of analgesics.

Line 30.02 - Sedatives/Hypnotics.--Enter the cost of sedatives/hypnotics.

Line 30.03 - Other -- Specify.--Specify the type and enter the cost of any other drugs which cannot be appropriately identified in the drugs already listed.

Line 31 - 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 32 - 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 33 - Imaging Services.--Enter the cost of imaging services including MRI.

Line 34 - Labs and Diagnostics.--Enter the cost of laboratory and diagnostic tests.

Line 35 - 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 36 - Outpatient Services.--Use this line for any outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department.

Lines 37-38 - 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 39 - Other (Specify).--Enter any additional costs involved in providing visiting services which has not been provided for in the previous lines.

Lines 50-53 - 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 Social security Act bereavement counseling is a required hospice service, but it is not reimbursable.

3811. WORKSHEET A-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 16 (nursing care).

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.

Medical Social Worker (Column 3).--This individual is a person 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 17
Occupational therapy	-	line 18
Speech pathology	-	line 19

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 physical or 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 is the provision of 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. Included in this classification are dietary, spiritual, and other counselors. 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. This includes dietary, spiritual and other counseling services provided while the individual is enrolled in the hospice.

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 A, column 1, lines as applicable. To facilitate transferring amounts from Worksheet A-1 to Worksheet A, 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.

3812. WORKSHEET A-2 - COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

Enter all payroll-related employee benefits for the hospice on this worksheet. See HCFA 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 A-1. Therefore, using the same example as given for Worksheet A-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 16 (nursing care). Payroll-related employee benefits must be reported in the cost center in which the applicable employee's compensation is reported.

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

- FICA - actual expense by cost center;
- Pension and retirement and health insurance (nonunion) (gross salaries of participating individuals by cost center);
- Union health and welfare (gross salaries of participating union members by cost center); and
- 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 A, column 2, corresponding lines. To facilitate transferring amounts from Worksheet A-2 to Worksheet A, the same cost centers with corresponding line numbers are listed on both worksheets.

3813. WORKSHEET A-3 – COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES

The hospice may contract with another entity for the provision of 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.

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 would be recorded on this worksheet. For example, where physical therapy services are purchased, enter the contract cost of the therapist in column 6, line 17. 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 A, column 4, corresponding lines. To facilitate transferring amounts from Worksheet A-3 to Worksheet A, the same cost centers with corresponding line numbers are listed on both worksheets.

3816. WORKSHEET A-6 - RECLASSIFICATIONS AND ADJUSTMENTS TO EXPENSES

This worksheet provides for the reclassification of certain costs to effect proper cost allocation under cost finding. For each reclassification adjustment, assign an alpha character, e.g., A, B, C. DO NOT USE NUMERIC DESIGNATIONS.

Submit with the cost report copies of any work papers used to compute the reclassifications effected on this worksheet.

Identify any reclassifications made as salary and other costs in the appropriate column. However, when transferring to Worksheet A, transfer the sum of the two columns.

Examples of reclassifications that may be needed are:

- Reclassification of related organization rent expenses included in the A & G cost center which are applicable to lines 1 through 4 of Worksheet A. See instructions for Worksheet A-8-1 for treatment of rental expenses for related organizations.

- Reclassification of employee benefits expenses (e.g., personnel department, employee health service, hospitalization insurance, workers compensation, employee group insurance, social security taxes, unemployment taxes, annuity premiums, past service benefits, and pensions) included in the A & G cost center.

3817. WORKSHEET A-7 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

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

Columns 2 through 4.--Enter the cost capital assets acquired by purchase in column 2. In column 3, enter the fair market value, at date acquired, for donated assets. Enter the sum of column 2 and 3 in column 4.

Column 5.--Enter the cost or other basis of all capital assets sold, traded or transferred, retired, or disposed of in any manner during your cost reporting period.

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

3818. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

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

This worksheet provides for the adjustment in support of those expenses listed on Worksheet A, column 9. These adjustments, which are required under Medicare principles of reimbursement, are made on the basis of "cost" or "amount received" (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the "cost." Submit with the cost report a copy of any work papers used to compute a cost adjustment. Once an adjustment to an expense is made on the basis of "cost", you cannot determine the required adjustment to the expense on the basis of "revenue" in future cost reporting periods. The following symbols are entered in column 2 to indicate the basis for adjustment: "A" for cost; "B" for amount received. Line descriptions indicate the more common activities, which affect allowable costs, or result in costs incurred for reasons other than patient care and thus require adjustments.

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

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

Line 1.--Enter the investment income to be applied against interest expense. (See HCFA Pub.15-I, §202.2 for explanation.)

Line 2.--For patient telephones, make an adjustment on this line or establish a nonreimbursable cost center. When line 2 is used, the adjustment must be based on cost. Revenue cannot be used.

Line 3.--Enter allowable home office costs and/or related organizations which have been allocated to the hospice and which are not already included in the provider cost report. Additional lines are used to the extent that various hospice cost centers are affected. (See HCFA Pub. 15-I, §§2150 - 2153.)

Line 4.--Enter the amount received from the sale of meals to employees and guests. This income is used to offset the dietary expense.

Line 5.--Enter the cash received from imposition of interest, finance, or penalty charges on overdue receivables. This income must be used to offset the allowable administration and general costs. (See HCFA Pub. 15-I, §2110.2.)

Line 6.--Enter all bad debts both Medicare and non-Medicare which are included on the trial balance.

Line 7.--Include items a patient purchases from the facility, the cost of which is included in any of the cost centers on Worksheet A such as laundry and linen service.

Line 8.--Enter amounts not previously covered on lines 1 through 7. If there are a number of adjustments, attach a schedule reflecting the miscellaneous adjustment and enter the total on line 8.

Lines 9 -10.--Where depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per the provider's books, enter the difference on line 9, and/or 10. (See HCFA Pub. 15-I, Chapter 1.)

Line 11.- Enter the sum of lines 1 through 10 and transfer all amounts entered on lines 1-10 to the appropriate lines on Worksheet A, column 9.

3818.1 WORKSHEET A-8-1.--Statement of Costs of Services from Related Organizations and Home Office Costs.--In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organization, except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the hospital by organizations related to you or costs associated with the home office.

Part A.--Cost applicable to home office and related organization costs, services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.

Part B.--Use this part to show your relationship to organizations identified in Part A. Show the requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to you, a common ownership with you, or control over you as defined in HCFA Pub. 15-I, chapter 10 in columns 1 through 6, as appropriate.

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

Column 1.--Enter the appropriate symbol which describes your relationship to the related organization.

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

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

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

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

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

3820. WORKSHEET B - COST ALLOCATION - GENERAL SERVICE COSTS AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

Worksheet B provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, reimbursable cost centers, nonreimbursable cost centers. Obtain the total direct expenses from Worksheet A, column 10. To facilitate transferring amounts from Worksheet A to Worksheet B, the same cost centers with corresponding line numbers (lines 1 through 100) are listed on both worksheets.

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

To facilitate the allocation process, the general format of Worksheets B and B-1 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 A, A-1, A-2, and A-3. If the provider has subscripted any lines on these A worksheets, the provider must subscript the same lines on the B worksheets.

NOTE: General service columns 1 through 5 and subscripts thereof must be consistent on Worksheets B and B-1.

The statistical bases shown at the top of each column on Worksheet B-1 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 A the cost of non revenue-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 HCFA 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, it should be changed due to simplification of maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until an approval is made.

If both sets 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 A, column 10, has a credit balance, show this amount as a credit balance on Worksheet B, 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 100. This enables column 6, line 100, to cross foot to columns 0 and 5A, line 100. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, column 6, do not carry forward a credit balance to any worksheet.

On Worksheet B-1, 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 B-1, line 100, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B 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 B, column 1, line 1.

Divide the amount entered on line 100 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 101. 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 B 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 100) of all of the cost centers receiving the allocation on Worksheet B 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 B and B-1 before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet B, enter in column 7 the sum of the expenses on lines 10 through 99. The total expenses entered in column 7, line 100, must equal the total expenses entered in column 0, line 100.

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, 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 A, 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 B-1, column 6, from Worksheet B, 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 B, column 0) for purposes of determining the basis of allocation (Worksheet B-1, 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 D. 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 B-1, Column 6A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, column 5A, line 100 and the accumulated cost reported on Worksheet B-1, column 6, line 6. Enter any amounts reported on Worksheet B, column 5A for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. *Enter a negative one (-1) in the accumulated cost column to identify the cost center that should be excluded from receiving any A&G costs. If some of the costs from that cost center are to receive A&G costs, then enter in the reconciliation column the amount not to receive A&G costs to assure that only those costs to receive overhead receive the proper allocation.* Including *a statistical cost which does not relate to the allocation of* administrative and general expenses causes an improper distribution of overhead. In addition, report on line 6 the administrative and general costs reported on Worksheet B, column 6, line 6 since these costs are not included on Worksheet B-1, column 6 as an accumulated cost statistic.

For fragmented or componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 6 (A&G), the reconciliation column designation must be 6A.

If A& G is not fragmented or componentized, the reconciliation column designation must be 6A.

Worksheet B-1, Column 6--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-l, column 6, line 6, is the difference between the amounts entered on Worksheet B, column 5A and Worksheet B-1, 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.

Hospices may establish multiple A&G cost centers (referred to as componentized or fragmented) by using one of two methods. The rationale for allocating the shared A&G service cost center first is that shared A&G cost centers service all other cost centers, while 100 percent of the hospice A&G reimbursable and 100 percent of hospice A&G nonreimbursable only service their respective cost centers. That is consistent 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.

Under the first method (also referred to as option 1), the hospice must classify all A&G costs as either A&G shared costs, A&G reimbursable costs, or A&G nonreimbursable costs. That is, 100 percent of the componentized A&G costs relate exclusively to either the hospice reimbursable or the hospice nonreimbursable cost centers. The remaining costs are classified as A&G shared costs. The componentized A&G costs are allocated through cost finding to their respective cost centers in aggregate.

First, allocate A&G shared costs to all applicable cost centers, including to the A&G reimbursable and A&G nonreimbursable cost centers on the basis of accumulated costs. Then allocate hospice A&G reimbursable costs to all applicable Hospice reimbursable cost centers (not including special purpose cost centers) on the basis of accumulated costs, and allocate hospice A&G nonreimbursable costs to all applicable hospice nonreimbursable cost centers on the basis of accumulated costs. Only A&G shared costs are allocated to the special purpose cost centers.

The following three A&G cost center categories will be created: (1) A&G shared costs, (2) 100 percent hospice reimbursable costs, and (3) 100 percent Hospice nonreimbursable costs, in this order only. Do not allocate A&G reimbursable costs to the A&G nonreimbursable cost center. Calculate the accumulated cost statistics as follows:

A&G Cost Center	Sum of Worksheet B	Transfer to Worksheet B-1
A&G Shared Costs	Col. 0-5, lines 6.02-100	Col. 6.01, lines 6.02-100
A&G Reimb. Costs	Col. 0-6.01, lines 7-40	Col. 6.02, lines 7-40
A&G Nonreimb. Costs	Col. 0-6.01, lines 50-100	Col. 6.03, lines 50-100

Under the second method (also referred to as option 2), unique A&G cost centers may be created (see CMS Pub. 15-I, §2313.1) to further refine the allocation process. The statistical basis upon which to allocate fragmented A&G costs must represent, as accurately as possible, the consumption or usage of A&G services by the benefiting cost centers.

Hospices wishing to use an alternative allocation method (i.e., a change in allocation basis or the sequence of cost center allocation) must do so in accordance with CMS Pub. 15-I, §2313. The fragmentation of A&G costs constitutes a direct assignment of A&G costs and as such must follow the policy established under §2307 of CMS Pub. 15-I.

3830. WORKSHEET D - CALCULATION OF PER DIEM COST

Worksheet D 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.

Line 1.--Total cost from Worksheet B, line 100, column 7, less line 53, column 7. This line reflects the true cost without any non-hospice-related cost.

Line 2.--Total unduplicated days from Worksheet S-1, line 12, col. 6.

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-1, line 12, column 1.

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

Line 6.---Unduplicated Medicaid days from Worksheet S-1, line 12, column 2.

Line 7.---Average Medicaid cost. Multiply the average cost from line 3 by the number of unduplicated Medicaid days on line 6 to arrive at the average Medicaid cost.

Line 8.--Unduplicated SNF days from Worksheet S-1, line 12, column 3.

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

Line 10.--Unduplicated NF days from Worksheet S-1, line 12, column 4.

Line 11.--Average NF cost. Multiply the average cost from line 3 by the number of unduplicated NF days on line 10 to arrive at the average NF cost.

Line 12.---Unduplicated Other days from Worksheet S-1, line 12, column 5.

Line 13.--Average Other cost. Multiply the average cost from line 3 by the number of unduplicated Other days on line 12 to arrive at the average Other cost.

DO NOT COMPLETE LINE 14 OR 15 FOR COST REPORTING PERIODS ENDING ON OR AFTER 9/30/2000.

Line 14.--Total cost add lines 5, col. 1 plus line 7 col. 2 and line 13, col. 3. Line 14 must equal line 1 col. 4. Line 9, col. 1 average SNF cost is already accounted for in the total Medicare cost for Title XVIII. Similarly line 11, col. 2, is already accounted for on line 7, col. 2 for Medicaid cost for Title XIX.

Line 15.---Total days add lines 4, col. 1 plus line 6 col. 2 and line 12, col. 3. Line 15 must equal line 2 col. 4. Line 8, col. 1 unduplicated SNF days is already accounted for in the total Medicare cost for Title XVIII. Similarly line 10, col. 2, is already accounted for on line 6, col. 2 for Medicaid cost for Title XIX.

3850. WORKSHEET G - BALANCE SHEET

3850.1 Worksheet G-1 - Statement of Changes in Fund Balances.

3850.2 Worksheet G-2 - Statement of Patient Revenues and Net Income.

Part I.--General Inpatient and Home Care Service Locations—Lines 1 through 4 reflects patients revenues from the various locations where a patient may reside. Attach schedule to reflect the following: hospice inpatient revenue and any other revenues received from other sources such as donations or contributions.

Part II.--Operating Expenses.—Reflects the operating expenses for the cost reporting period.

Prepare these worksheets from your accounting books and records. Additional Worksheets may be submitted, if necessary.

All providers maintaining fund-type accounting records complete worksheets G and G-1. Nonproprietary providers who do not maintain fund-type accounting records complete general fund columns

EXHIBIT I - Form HCFA-1984-99 Worksheets

The following is a listing of the Form HCFA-1984-99 worksheets and the page number location.

Worksheets	Pages(s)
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