4010. WORKSHEET S-8 - HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain separate 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. RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-4, chapter 9, §30.8.

Lines 1 and 2--Enter the full address of the RHC/FQHC.

Line 3--For FQHCs only, enter your appropriate designation of "R" for rural or "U" for urban. See §505.2 of the RHC/FQHC Manual for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor. RHCs do not complete this line.

Lines 4 through 9--In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 10--If the facility provides other than RHC or FQHC services (e.g., laboratory or physician services), answer "Y" for yes and enter the type of operation on subscripts of line 13 otherwise enter "N" for no.

Line 11 --Enter in 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. Enter the starting and ending hours in the applicable columns 1 through 14 for the days that the facility is available to provide other than RHC/FQHC services. When entering time do so as military time, e.g., 2:00 p.m. is 1400.

Line 12--Have you received an approval for an exception to the productivity standards? Enter a "Y" for yes or an "N" for no.

Line 13--Is this a consolidated cost report as defined in the Rural Health Clinic Manual? If yes, enter in column 2 the number of providers included in this report, complete line 16, and complete only one worksheet series M for the consolidated group. If no, complete a separate worksheet S-8 for each component accompanied by a corresponding worksheet M series.

Line 14--Identify provider's name and CCN number filing the consolidated cost report.

Line 15--Are you claiming allowable GME costs as a result of your substantial payment for interns and residents. If yes, enter the number of program visits in the appropriate column performed by interns and residents.

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4011. WORKSHEET S-9 - 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 418.20 requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a hospital-based hospice. Complete a separate Worksheet S-9 for each hospital-based hospice.

4011.1 Part I - Enrollment Days Based on Level of Care.--

NOTE: Columns 1 and 2 contain the days identified in column 3 and 4. Column 3 and 4 identify the SNF and NF days out of the total for title XVIII and XIX.

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 columns 1 through 6 for lines 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. **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.

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

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

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

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

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

NOTE: Convert continuous home care hours into days so that column 6 line 8 reflects the actual total number of days provided by the hospice.

4011.2 Part II - Census Data.--

NOTE: Columns 1 and 2 contain the days identified in columns 3 and 4. Columns 3 and 4 identify the SNF and NF days out of the total for title XVIII and XIX.

Line 6--Enter 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 6 and line 9 is that line 6 should equal 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. 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. Line 5 divided by Line 6.

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 follow:

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Medicare Days (90 & 45 & 29) Patient (A, B & C)	164 days
Medicare Patients	/3

Average LOS Medicare	54.67 Days
Medicaid Days Patient D (92)	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 8, line 11.

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 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.

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4012. Worksheet S-10 - Hospital Uncompensated and Indigent Care Data--Section 112(b) of the Balanced Budget Refinement Act (BBRA) requires that short-term acute care hospitals (§1886(d) of the Act) submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated. Charity care charge data, as referenced in section 4102 of American Recovery and Reinvestment Act of 2009, may be used to calculate the EHR technology incentive payments made to §1886(d) hospitals and critical access hospitals (CAHs). CAHs, as well as §1886(d) hospitals, will be required to complete this worksheet. Note that this worksheet does not produce the estimate of the cost of treating uninsured patients required for disproportionate share payments under the Medicaid program.

Definitions:

Uncompensated care--Defined as charity care and bad debt which includes Non-Medicare bad debt and Non-Reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances or discounts given to patients.

Charity care--Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. (Additional guidance provided in the instruction for line 19.)

Non-Medicare bad debt--Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim. (Additional guidance provided in the instruction for line 25.)

Non-Reimbursable Medicare bad debt--The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are **not** reimbursed by Medicare under the requirements of §413.89 of the regulations and of Chapter 3 of the Provider Reimbursement Manual Part 1. (Additional guidance provided in the instruction for line 25.)

Net revenue--Actual payments received or expected to be received from a payer (including co-insurance payments from the patient) for services delivered during this cost reporting period. Net revenue will typically be charges (gross revenue) less contractual allowance. (Applies to lines 2, 9, and 13.)

Instructions:

Cost to charge ratio:

Line 1--Enter the of cost-to-charge ratio from Worksheet C, Part I, line 200, column 3 divided by line 200, column 8.

Medicaid

NOTE: The amount on line 18 should not include the amounts on lines 2 and 5. That is, the amounts on lines 2 and 5 are mutually exclusive from the amount on line 18.

Line 2--Enter the inpatient and outpatient payments received or expected for Title XIX covered services delivered during this cost reporting period. Include payments for an expansion SCHIP

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program, which covers recipients who would have been eligible for coverage under Title XIX. Include payments for all covered services except physician or other professional services, and include payments received from Medicaid managed care programs. If not separately identifiable, disproportionate share (DSH) and supplemental payments should be included in this line. For these payments, report the amount received or expected for the cost reporting period, net of associated provider taxes or assessments.

Line 3--Enter "Y" for yes if you received or expect to receive any DSH or supplemental payments from Medicaid relating to this cost reporting period. Otherwise enter "N" for no.

Line 4--If you answered yes to question 3, enter "Y" for yes if all of the DSH or supplemental payments you received from Medicaid are included in line 2. Otherwise enter "N" for no and complete line 5.

Line 5--If you answered no to question 4, enter the DSH or supplemental payments the hospital received or expects to receive from Medicaid relating to this cost reporting period that were not included in line 2, net of associated provider taxes or assessments.

Line 6--Enter all charges (gross revenue) for Title XIX covered services delivered during this cost reporting period. These charges should relate to the same set of services for which payments were reported on line 2.

Line 7--Calculate the Medicaid cost by multiplying line 1 times line 6.

Line 8--Enter the difference between net revenue and costs for Medicaid by adding line 2 plus line 5 minus line 7.

State Children's Health Insurance Program:

Line 9--Enter all payments received or expected for services delivered during this cost reporting period that were covered by a stand-alone SCHIP program. Stand-alone SCHIP programs cover recipients who are not eligible for coverage under Title XIX. Include payments for all covered services except physician or other professional services, and include any payments received from SCHIP managed care programs.

Line 10--Enter all charges (gross revenue) for services delivered during this cost reporting period that were covered by a stand-alone SCHIP program. These charges should relate to the same set of services for which payments were reported on line 9.

Line 11--Calculate the stand-alone SCHIP cost by multiplying line 1 times line 10.

Line 12--Enter the difference between net revenue and costs for stand-alone SCHIP by line 11 from line 9.

Other state or local indigent care program:

Line 13--Enter all payments received or expected for services delivered during this cost reporting period for patients covered by a state or local government indigent care program (other than Medicaid or SCHIP), where such payments and associated charges are identified with specific patients and documented through the provider's patient accounting system. Include payments for all covered services except physician or other professional services, and include payments from managed care programs.

Line 14--Enter all charges (gross revenue) for services delivered during this cost reporting period for patients covered by a state or local government program, where such charges and associated payments are documented through the provider's patient accounting system. These charges should relate to the same set of services for which payments were reported on line 13.

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Line 15--Calculate the costs for patients covered by a state or local government program by multiplying line 1 times line 14.

Line 16--Calculate the difference between net revenue and costs for patients covered by a state or local government program by subtracting line 15 from line 13.

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Uncompensated care:

Line 17--Enter the value of all non-government grants, gifts and investment income received during this cost reporting period that were restricted to funding uncompensated or indigent care. Include interest or other income earned from any endowment fund for which the income is restricted to funding uncompensated or indigent care.

Line 18--Enter all grants, appropriations or transfers received or expected from government entities for this cost reporting period for purposes related to operation of the hospital, including funds for general operating support as well as for special purposes (including but not limited to funding uncompensated care). Include funds from the Federal Section 1011 program, if applicable, which helps hospitals finance emergency health services for undocumented aliens. While Federal Section 1011 funds where allotted for federal fiscal years 2005 through 2008, any unexpended funds will remain available after that time period until fully expended even after federal fiscal year 2008. If applicable, report amounts received from charity care pools net of related provider taxes or assessments. Do not include funds from government entities designated for non-operating purposes, such as research or capital projects.

Line 19--Calculate the total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs by entering the sum of lines 8, 12 and 16.

Line 20--Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria (measured at full charges), for care delivered during this cost reporting period for the entire facility. For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider (column 1), this is the patient's total charges. For patients covered by a public program or private insurer with which the provider has a contractual relationship (column 2), these are the deductible and coinsurance payments required by the payer. Include charity care for all services except physician and other professional services. Do not include charges for either uninsured patients given discounts without meeting the hospital's charity care criteria or patients given courtesy discounts. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.

Line 21--Calculate the cost of initial obligation of patients approved for charity care by multiplying line 1 times line 20. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 22--Enter payments received or expected from patients who have been approved for partial charity care for services delivered during this cost reporting period. Include such payments for all services except physician or other professional services. Payments from payers should not be included on this line. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 23--Calculate the cost of charity care by subtracting line 22 from line 21. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

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Line 24--Enter "Y" for yes if any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported in line 20, column 2, and complete line 25. Otherwise enter "N" for no.

Line 25--If you answered yes to question 24, enter charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program for services delivered during this cost reporting period. The amount must match the amount of such charges included in line 20, column 2.

Line 26--Enter the total facility charges for bad debts (bad debt expense) written off or expected to be written off on balances owed by patients for services delivered during this cost reporting period. Include such charges for all services except physician and other professional services. Include the sum of all Medicare allowable bad debts appearing in the Worksheet E, H, I, J, and M series including: E, Part A, line 64; E, Part B, line 34; E-2, line 17; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; H-4, Part II, line 31; I-5, line 5; J-3, line 21; and M-3, line 23. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.

Line 27--Enter the sum of all 1886(d) Medicare reimbursable bad debts appearing in Worksheet E, Part A, line 65; and E, Part B, line 35; or CAHs from Worksheet E-3, Part V, line 26.

Line 28--Calculate the non-Medicare and non-reimbursable Medicare bad debt expense by subtracting line 27 from line 26.

Line 29--Calculate the cost of non-Medicare and non-reimbursable Medicare bad debt expense by multiplying line 1 times line 28.

Line 30--Calculate the cost of non-Medicare uncompensated care by entering the sum of lines 23, column 3 and line 29.

Line 31--Calculate the cost of unreimbursed and uncompensated care and by entering the sum of lines 19 and 30.

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4013. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve using data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, C, and D, the line numbers are consistent). While providers are expected to maintain their accounting books and general ledger in a manner consistent with the standard cost centers/departments identified on this worksheet, not all of the cost centers listed apply to all providers using these forms. For example, IPPS providers may contain a Burn Intensive Care Unit, where CAHs may not furnish this type of service.

Do not include on this worksheet items not claimed in the cost report because they conflict with the regulations, manuals, or instructions but which you wish nevertheless to claim and contest. Enter amounts on the appropriate settlement worksheet (Worksheet E, Part A, line 75; Worksheet E, Part B, line 44; Worksheet E-2, line 23; and Worksheet E-3, Parts I, II, III, IV, V, VI, and VII lines 22, 35, 36, 26, 34, 19, and 35, respectively). For provider based facilities enter the protested amounts on line 39 of Worksheet H-4, Part II for home health agencies; line 30 of Worksheet J-3 for CMHCs; and line 30 of Worksheet M-3 for RHC/FQHC providers.

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

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If you need to use additional or different cost center descriptions, add (subscript) additional lines to the cost report. Where an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line. The added line is identified as a numeric subscript of the immediately preceding line. For example, if two lines are added between lines 7 and 8, identify them as lines 7.01 and 7.02. If additional lines are added for general service cost centers, add corresponding columns for cost finding.

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

Do not use lines 24 through 29, 47 through 49, 77 through 87, 102 through 104, 119 through 189, and 195 through 199.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. Form CMS-2552-10 provides for preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. 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. Additionally, nonstandard cost center descriptions have been identified through analysis of frequently used labels.

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The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The five digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. You are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §4095, table 5**.**

Columns 1, 2, and 3--**The expenses listed in these columns are the same as listed in your accounting books and records and/or trial balance.**

List on the appropriate lines in columns 1, 2, and 3 the total expenses incurred during the cost reporting period. These expenses are detailed between salaries (column 1) and other than salaries (column 2). The sum of columns 1 and 2 equals column 3. Record any needed reclassifications and/or adjustments in columns 4 and 6, as appropriate.

Column 4--Enter any reclassifications among the cost center expenses in column 3 which are needed to effect proper cost allocation with the exception of the reclassification of capital related costs which are reclassified from Worksheet A-7.

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 that the reclassifications are needed and appropriate in the particular circumstance. Show reductions to expenses as negative numbers.

The net total of the entries in column 4 must equal zero on line 200.

Column 5--Adjust the amounts entered in column 3 by the amounts in column 4 (increase or decrease) and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 200.

Column 6--Enter on the appropriate lines in column 6 of Worksheet A the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The total on Worksheet A, column 6, line 200, equals Worksheet A-8, column 2, line 50.

Column 7--Adjust the amounts in column 5 by the amounts in column 6 (increase or decrease), and extend the net balances to column 7.

Transfer the amounts in column 7 to the appropriate lines on Worksheet B, Part I, column 0.

Line Descriptions

The trial balance of expenses is broken down into general service, inpatient routine service, ancillary service, outpatient service, other reimbursable, special purpose, and nonreimbursable cost center categories to facilitate the transfer of costs to the various worksheets. The line numbers on Worksheet A are used on subsequent worksheets. For example, the categories ancillary service cost centers, outpatient service cost centers, and other reimbursable cost centers appear on Worksheet C, Part I, using the same line numbers as on Worksheet A.

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

Lines 1 - 23--These lines are for the General Service cost centers. These costs are expenses incurred in operating the facility (mortgage, rent, plant operations, administrative salaries, utilities, telephone charges, computer hardware and software costs, etc.) that is not directly associated with furnishing patient care.

Lines 1 and 2--The capital cost centers on lines 1 and 2 include depreciation, leases and rentals for the use of facilities and/or equipment, and interest incurred in acquiring land or depreciable assets used for patient care.

In addition, in accordance with 42 CFR 412.302(b)(4), enter all other capital-related costs, including but not limited to taxes, insurance, and license and royalty fees on depreciable assets.

NOTE: **Do not** include in these cost centers costs incurred for the repair or maintenance of equipment or facilities; amounts specifically included in rentals or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. However, if no amount of the lease payment is identified in the lease agreement for maintenance, you are not required to carve out a portion of the lease payment to represent the maintenance portion. Thus, the entire lease payment is considered a capital-related cost subject to the provisions of 42 CFR 413.130(b).

When you are dealing with a related organization, you are essentially dealing with yourself and Medicare considers the costs to you equal to the cost to the related organization. Therefore, for costs applicable to services, facilities, and supplies furnished by organizations related by common ownership or control (see 42 CFR 413.17 and CMS Pub. 15-1, chapter 10), the reimbursable cost includes the costs for these items at the cost to the supplying organization unless the exception provided in 42 CFR 413.17(d) and CMS Pub. 15-1, §1010 is applicable. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost does not exceed the market price.

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

Unless the services, facilities, or supplies furnished by a related organization are otherwise considered capital-related costs, no part of the market price is considered a capital-related cost. If the exception in 42 CFR 413.17(d) and CMS Pub. 15-1, §1010 applies, no part of the cost to you of the services, facilities, or supplies is considered a capital-related cost unless the services, facilities, or supplies are otherwise considered capital-related. In the case of leased equipment, some factors that weigh in favor of treating a particular agreement as capital-related (see 56 FR 43388) include the following:

- The equipment is operated by personnel employed by the provider or an organization related to the provider within the meaning of 42 CFR 413.17.

- The physicians who perform the services with or interpret the tests from the equipment are associated with the provider.

- The agreement is memorialized in one document rather than in two or more documents (e.g., one titled a "Lease Agreement" and one titled a "Service Agreement").

- The document memorializing the agreement is titled a lease agreement. If one or more of the documents memorializing the agreement are titled "Service Agreements", this indicates a purchase of services.

- The provider holds the certificate of need (CON) for the services furnished with the equipment.

o The basis for determining the lease payment is units of time and is not volume sensitive (e.g., numbers of scans).

o The provider attends to such matters as utilization review, quality assurance, and risk management for the services involving the equipment.

o The provider schedules the patients for services involving the equipment.

o The provider furnishes any supplies required to be used with the equipment.

o The provider's access to the equipment is not subject to interruption without notice or interruption on very short notice.

If the supplying organization is not related to you (see 42 CFR 413.17), no part of the charge to you is a capital-related cost unless the services, facilities, or supplies are capital-related in nature.

Under certain circumstances, costs associated with minor equipment are considered capital-related costs. See CMS Pub. 15-1, §106 for three methods of writing off the cost of minor equipment. Amounts treated as expenses under method (a) are not capital-related costs because they are treated as operating expenses. Amounts included in expense under method (b) are capital-related costs because such amounts represent the amortization of the cost of tangible assets over a projected useful life. Amounts determined under method (c) are capital-related costs because method (c) is a method of depreciation.

Section 1886(g) of the Act, as implemented by 42 CFR, Part 412, Subpart M, requires that the reasonable cost-based payment methodology for hospital inpatient capital-related costs be replaced with an inpatient prospective payment methodology for hospitals paid under IPPS, effective for cost reporting periods beginning on or after October 1, 1991. Hospitals and hospital distinct part units (IPFs, IRFs, and LTCH) excluded from IPPS pursuant to 42 CFR, Part 412, Subpart B, are paid for capital-related costs under their respective PPS payment systems. Also, CAHs are reimbursed on a reasonable cost basis under 42 CFR 413.70.

Lines 1 and 2--Capital costs are defined as all allowable capital-related costs for land and depreciable assets, with additional recognition of costs for capital-related items and services that are legally obligated by an enforceable contract (See PRM-1, §2800.) Betterment or improvement costs related to capital are included in capital assets. (See 42 CFR 412.302.) Capital costs incurred as a result of extraordinary circumstances are new capital. (See 42 CFR 412.348(e).) Direct assignment of capital costs must be done in accordance with CMS Pub. 15-1, §2313.

Capital costs include the following:

1. Allowable depreciation on assets based on the useful life guidelines used to determine depreciation expense in the hospital's base period, which cannot be subsequently changed.

2. Allowable capital-related interest expense. Except as provided in subsections a through c below, the amount of allowable capital-related interest expense recognized as capital is limited to the amount the hospital was legally obligated to pay.

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a. An increase in interest expense is recognized if the increase is due to periodic fluctuations of rates in variable interest rate loans or to periodic fluctuations of rates at the time of conversion from a variable rate loan to a fixed rate loan when no other changes in the terms of the loan are made.

b. If the terms of a debt instrument are revised, the amount of interest recognized associated with the original capital cannot exceed the amount that would have been recognized during the same period prior to the revision of the debt instrument.

c. Investment income (excluding income from funded depreciation accounts and other exclusions from investment income offset cited in CMS Pub. 15-1, §202.2) is used to reduce capital interest expense based in each cost reporting period.

3. Allowable capital-related lease and rental costs for land and depreciable assets.

a. The cost of lease renewals and the acquisition of assets continuously leased (e.g., capitalized leases) are recognized provided that the same asset remains in use, the asset has a useful life of at least 3 years, and the annual lease payment is $1000 or more for each item or service.

b. If a hospital-owned asset is sold or given to another party and that same asset is then leased back by the hospital, the amount of allowable capital-related costs recognized as capital costs is limited to the amount allowed for that asset in the last cost reporting period during which it was owned by the hospital.

4. The appropriate portion of the capital-related costs of related organizations under 42 CFR 413.17 that would be recognized as capital costs if these costs had been incurred directly by the hospital.

5. Obligated capital costs recognized as capital costs in accordance with the provisions discussed in the following paragraph.

If the hospital has a multi-phase capital project, the provisions of this section apply independently to each phase of the project.

a. Fixed Assets.--The costs of capital-related items and services defined in 42 CFR 413ff, Subpart G, for which there was a contractual obligation entered into by a hospital or related party with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a fixed asset may be recognized as capital costs if all the following conditions are met:

(1) The obligation must arise from an executed binding written agreement that obligates the hospital in the acquisition of fixed assets;

(2) The capital asset must be put in use for patient care except as provided below;

(3) The hospital notifies the intermediary of the existence of obligated capital costs (see 42 CFR 412.302(c)); and

(4) The amount recognized as capital cost is limited to the lesser of the actual allowable costs when the asset is put in use or the estimated costs of the capital expenditure at the time it was obligated.

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b. Moveable Equipment.--Moveable equipment is recognized as capital only if all of conditions (1) through (4) are met and one of conditions (5) or (6) is met:

(1) The obligation must arise from a executed binding written agreement that obligates the hospital in the acquisition of movable equipment.

(2) The capital asset must be put in use for patient care.

(3) The hospital notifies the intermediary of the existence of obligated capital costs. (See 42 CFR 412.302(c).)

(4) The amount recognized as capital cost is limited to the lesser of the actual allowable costs when the asset is put in use or the estimated costs of the capital expenditure at the time it was obligated.

(5) There was a binding contractual agreement for the lease or purchase of the item of equipment.

(6) There was a binding contractual agreement for financing the acquisition of the equipment, the item of equipment costs at least $100,000, and the item was specifically listed in an equipment purchase plan approved by the Board of Directors. The amount recognized as capital costs cannot exceed the estimated cost identified in the equipment purchase plan approved by the hospital's Board of Directors.

c. Lengthy Certificate of Need Process.--If a hospital does not meet the criteria under the fixed asset or moveable equipment provisions above but meets all of the following criteria, the estimated cost for the project may be recognized as capital costs.

(1) The hospital is required under State law to obtain preapproval of the capital project or acquisition by a designated State or local planning authority in the State in which it is located;

(2) The hospital filed an initial application for a certificate of need that includes a detailed description of the project and its estimated cost and had not received approval or disapproval;

(3) The hospital expended the lesser of $750,000 or 10 percent of the estimated cost of the project; and

(4) The hospital put the asset into patient use on or before 4 years from the date the certificate of need was approved.

d. Construction in Process.--If a hospital that initiates construction on a capital project does not meet the requirements under the fixed asset, moveable equipment, or lengthy certificate of need provisions, the project costs may be recognized as capital costs if all the following conditions are met:

(1) The hospital received any required certificate of need approval;

(2) The hospital's Board of Directors formally authorized the project with a detailed description of its scope and costs;

(3) The estimated cost of the project exceeds 5 percent of the hospital's total patient revenues during its base year;

(4) The capitalized cost incurred for the project exceeded the lesser of $750,000 or 10 percent of the estimated project cost;

(5) The hospital began actual construction or renovation (groundbreaking); and

(6) The project is completed on or before the last day of the provider's cost reporting period.

e. Planning, Design or Feasibility Agreements.--If these agreements do not commit the hospital to undertake a project, they are not recognized as obligating capital expenditures.

f. Cost Limitation - Leases, Rentals, or Purchases.--The amount of obligated capital costs recognized as old capital costs cannot exceed the amount specified in the lease, rental, or purchase agreement.

g. Cost Limitation - Construction Contracts.--The amount of obligated capital costs recognized as capital costs cannot exceed the estimated construction costs for the project. Additional costs are recognized as old capital costs only if the additional costs are directly attributable to changes in life safety codes or other building requirements established by government ordinance that became effective after the project was obligated.

h. Cost Limitation - Financing Costs.--The amount of obligated interest expense recognized as capital costs cannot exceed the amount for which the hospital was legally obligated or, in the case of financing arranged for a capital acquisition that was legally obligated, the amount specified in a detailed financing plan approved by the hospital's Board of Directors.

i. Amount Recognized As Capital Cost.--The actual amount recognized as capital costs is based on the lesser of the allowable costs for the asset when it is put into patient use or the amounts determined under the cost limitations above.

The hospital must follow consistent cost finding methods for classifying and allocating capital-related costs. (See 42 CFR 412.302 (d).)

Unless there is a change of ownership, the hospital must continue the same cost finding methods for capital costs. This includes its practices for the direct assignment of capital-related costs and its cost allocation bases in. If there is a change of ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices.

If a hospital desires to change its cost finding method for the direct assignment of capital costs, the request for change must be made in writing to the intermediary prior to the beginning of the cost reporting period for which the change is to apply. The request must include justification as to why the change will result in more accurate and more appropriate cost finding. The intermediary does not approve the change unless it determines that there is reasonable justification for the change.

Line 3--In accordance with 42 CFR 412.302(b)(4), enter all other capital-related costs, including but not limited to taxes, insurance, and license and royalty fees on depreciable assets. This line also includes any directly allocated home office other capital cost. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

PPS providers paid 100 percent Federal complete line 3, column 2 and Worksheet A-7, Parts I (if applicable), II, and III.

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Line 5--Enter administrative and general (A & G) costs on this line. If this line is componentized into more than one cost center, eliminate line 5. Componentized A & G lines must begin with subscripted line 5.01 and continue in sequential order (e.g., 5.01 Nonpatient Telephones; 5.02 Data Processing; 5.03 Purchasing, Receiving, Stores; 5.04 Admitting; 5.05 Cashiering, Accounts; and 5.06 Other A & G).

Line 13--This cost center normally includes only the cost of nursing administration. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks.

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

Line 16--This cost center includes the direct costs of the medical records cost center including the medical records library. The general library and the medical library are not included in this cost center but are reported in the A & G cost center.

Line 19--The services of a nonphysician anesthetist generally are paid for by the Part B carrier based on a fee schedule rather than on reasonable cost basis through the cost report. As such, the salary and fringe benefit costs included on line 19 generally are not reimbursed through the cost report.

NOTE: Only such salary and fringe benefit costs are included on this line.

However, payment for the nonphysician anesthetists on a fee basis may not apply to a qualified rural hospital or CAH if the facility employed or contracted with not more than one FTE (2080 hours) nonphysician anesthetist and, if (1) the hospital had 800 or fewer surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services and (2) each nonphysician employed by or under contract with the hospital has agreed not to bill under Part B of title XVIII for professional services furnished. 42 CFR 412.113(c)(2)(i)

Further, payment under the fee schedule applies to qualified hospitals and CAHs unless the hospital establishes, before the beginning of each of these years, that it did not exceed 800 surgical procedures requiring anesthesia in the previous year. 42 CFR 412.113(c)(2)(ii)

Hospitals which do not qualify for the exception and are therefore subject to the fee schedule payment method must remove the salary and fringe benefit costs from line 19. The total amount is reported on Worksheet A-8, line 28 and in column 6, line 19 of this worksheet. This removes these costs from the cost reported in column 7.

Lines 20 and 23--If you operate an approved nursing or allied health education program that meets the criteria of 42 CFR 413.85 and 412.113(b), both classroom and clinical portions of the costs are allowable as pass through costs as defined in 42 CFR 413.85.

Classroom costs are those costs associated with formal, didactic instruction on a specific topic or subject in a classroom that meets at regular, scheduled intervals over a specific time period (e.g., semester or quarter) and for which a student receives a grade.

Clinical training is defined as involving the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. While it may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques, it involves no classroom instruction.

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If you do not operate the program, the classroom portion of the costs are not allowable as pass through costs and therefore not reported on lines 20 and 23 of the Form CMS-2552-10. They may, however, be allowable as routine service operating cost. (See CMS Pub. 15-1, §404.2.) The clinical portions of these costs are allowable as pass through costs if the following conditions as set forth in §4004(b) of OBRA 1990 are met:

1. The hospital must have claimed and have been paid for clinical costs (described below) during its latest cost reporting period that ended on or before October 1, 1989.

2. The proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program and allowable under §4004(b)(1) of OBRA 1990 during a cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the hospital's most recent cost reporting period ending on or before October 1, 1989.

3. The hospital receives a benefit for the support it furnishes to the education program through the provision of clinical services by nursing and allied health students participating in the program.

4. The clinical training costs must be incurred by the provider or by an educational institution related to the provider by common ownership or control as defined by 42 CFR 413.17b (cost to related organizations). Costs incurred by a third party, regardless of its relationship to either the provider or the educational institution, are not allowed.

5. The costs incurred by the hospital for the program do not exceed the costs that would have been incurred by the hospital if the program had been operated by the hospital.

Line 20--Enter the cost for the nursing school.

Line 21--Enter the cost of intern and resident salaries and salary-related fringe benefits. Do not include salary and salary-related fringe benefits applicable to teaching physicians which are included in line 22.

Line 22--Enter the other costs applicable to interns and residents in an approved teaching program.

Line 23--This line is used for a hospital or subprovider which operates an approved paramedical education program that meets the criteria of 42 CFR 413.85 and 412.113(b). Establish a separate cost center for each paramedical education program (e.g., one for medical records or hospital administration). If additional lines are needed, subscript line 23 consecutively and sequentially. If the direct costs are included in the costs of an ancillary cost center, reclassify them on Worksheet A-6 to line 23. Appropriate statistics are required on Worksheet B-1 to ensure that overhead expenses are properly allocated to this cost center.

Identify all other all other medical education costs on line 23.99. These costs, if present and applicable, may be used on worksheets D, Parts III and IV.

Lines 24 - 29--Reserved for future use.

Lines 30 - 46--These lines are for the inpatient routine service cost centers.

Line 30--The purpose of this cost center is to accumulate the incurred routine service cost applicable to adults and pediatrics (general routine care) in a hospital. Do not include incurred costs applicable to subproviders or any other cost centers which are treated separately.

Lines 30 - 35--Use lines 30 through 35 to record the cost applicable to intensive care type inpatient hospital units. (See 42 CFR 413.53(b).) Label line 35 appropriately to indicate the purpose for which it is being used.

Lines 36 - 39--Reserved for future use.

Line 40--Use this line to record the IPF service costs of a subprovider. Hospital units that are excluded units from IPPS are treated as subproviders for cost reporting purposes.

Line 41--Use this line to record the IRF service costs of a subprovider. Hospital units that are excluded units from IPPS are treated as subproviders for cost reporting purposes.

Line 44--Use this line to record the costs of SNFs certified for titles V, XVIII, or XIX if your State accepts one level of care.

Line 45--Use this line to record the cost of NFs certified for title V or title XIX but not certified as an SNF for title XVIII. Subscript this line to record the cost of ICF/MR. Do not report nursing facility costs on this subscripted line.

Line 46--Use this cost center to accumulate the direct costs incurred in maintaining long term care services not specifically required to be included in other cost centers. A long term care unit refers to a unit where the average length of stay for all patients is greater than 25 days. The beds in this unit are not certified for title XVIII.

Lines 47-49--Reserved for future use.

Lines 50 - 76--Use for ancillary service cost centers.

Line 57--Use this line to record direct costs associated with computed tomography (CT).

Line 58--Use this line to record direct costs associated with magnetic resonance imaging (MRI).

Line 59--Use this line to record direct costs associated with cardiac catheterization.

Line 61--Use this line to record costs when a pathologist continues to bill non-program patients for clinical laboratory tests and is compensated by you for services related to such tests for program beneficiaries. When you pay the pathologist an amount for administrative and supervisory duties for the clinical laboratory for program beneficiaries only, include the cost in this cost center.

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NOTE: No overhead expenses are allocated to this cost center since it relates to services for program beneficiaries only. The cost reporting treatment is similar to that of services furnished under arrangement to program beneficiaries only. (See CMS Pub. 15-1, §2314.)

These costs are apportioned among the various programs on the basis of program charges for provider clinical laboratory tests for all programs for which you reimburse the pathologist.

Line 62--Include the direct expenses incurred in obtaining blood directly from donors as well as whole blood and packed red blood cells from suppliers. Do not include in this cost center the processing fee charged by suppliers. The processing charge is included in the blood storing, processing, and transfusion cost center. Identify this line with the appropriate cost center code (Table 5 - electronic reporting specifications) for the cost of administering blood clotting factors to hemophiliacs. (See §4452 of BBA 1997, OBRA 1989 & 1993.)

Line 63--Include the direct expenses incurred for processing, storing, and transfusing whole blood, packed red blood cells, and blood derivatives. Also include the processing fee charged by suppliers.

Line 71--Include the expense of medical supplies charged to patients. These items are generally low cost medical supplies generally not traceable to individual patients. Do not include high cost implantable devices on this line. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 14 (central service and supply) based on the recommended statistic of costed requisitions.

Line 72--Include the expense of implantable devices charged to patients. The types of items includable on this line are high cost implantable devices that remain in the patient upon discharge and are chargeable and traceable to individual patients. Do not include low cost medical supplies on this line. When determining what costs are reported in this cost center, providers should use costs associated with implantable devices bearing revenue codes identified in the FR, Vol. 73, No. 161, page 48462, dated August 19, 2008. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 14 (central service and supply) based on the recommended statistic of costed requisitions. Identify this line with the appropriate cost center code according to Table 5 of the electronic reporting specifications.

NOTE: Hospitals maintain the option to directly assign costs to a specific cost center (PRM-1, §2307) or, if such costs are overhead costs, they can be placed in the appropriate overhead cost center and allocated to the applicable cost centers. This applies generally to all cost centers, but is re-emphasized for medical supplies charged to patients (line 71) and implantable devices charged to patients (line 72).

Line 74--If you furnish renal dialysis treatments, account for such costs by establishing a separate ancillary service cost center. In accumulating costs applicable to this cost center, include no other ancillary services even though they are routinely administered during the course of the dialysis treatment. However, if you physically perform a few minor routine laboratory services associated with dialysis in the renal dialysis department, such costs remain in the renal dialysis cost center. Outpatient maintenance dialysis services are reimbursed under the composite rate reimbursement system. For purposes of determining overhead attributable to the drugs Epoetin and Aranesp include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

NOTE: ESRD physician supervisory are not included as your costs under the composite rate reimbursement system. Supervisory services are included in the physician's monthly capitation rate.

Line 75--Enter the cost of ASCs that are not separately certified as a distinct part but which have a separate surgical suite. Do not include the costs of the ancillary services provided to ASC patients. Include only the surgical suite costs (i.e., those used in lieu of operating or recovery

rooms).

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Lines 77 - 87--Reserved for future use.

Lines 88 - 93--Use these lines for outpatient service cost centers.

NOTE: For lines 88 and 93, any ancillary service billed as clinic, RHC, and FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.

Line 88--Use this line to report the costs of provider-based RHCs. If more than one are maintained, subscript the line. See Table 5 in §4095 for the proper cost center code for RHCs.

In accordance with CMS Pub. 100-02, chapter 13, §30.4A, compensation paid to a physician for RHC services rendered in a hospital-based RHC is cost reimbursed. Where the physician agreement compensates for RHC services as well as non-RHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B carrier. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Line 89--Use this line to report the costs of provider-based FQHCs. If more than one are maintained, subscript the line. See Table 5 in §4095 for the proper cost center code for FQHCs.

In accordance with CMS Pub. 100-02, chapter 13, §30.4A, compensation paid to a physician for FQHC services rendered in a hospital-based FQHC is cost reimbursed. Where the physician agreement compensates for FQHC services as well as non- FQHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B carrier. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Line 90--Enter the cost applicable to the clinic not included on lines 88 and 89. If you have two or more clinics which are separately costed, separately report each such clinic. Subscript this line to report each clinic. Carry forward these subscripted lines to all applicable worksheets. If you do not separately cost each clinic, you may combine the cost of all clinics on the clinic line.

Line 91--Enter the costs of the emergency room cost center.

Line 92--Do not use this line on this worksheet. If you have an area specifically designated for observation (e.g., observation patients are not placed in a general acute care area bed), report this on a subscripted line 92.01.

NOTE: It is possible to have both a distinct observation bed area and a non-distinct part. For example, your distinct part observation bed area is only staffed from 7:00 a.m. - 10:00 p.m. Patients entering your hospital needing observation bed care after 10:00 p.m. and before 7:00 a.m. are placed in a general inpatient routine care bed. If patients entering the distinct part observation bed area are charged differently than the patients placed in the general inpatient routine care bed, separate the costs into distinct observation bed costs and non-distinct observation bed costs. However, if the charge is the same for both patients, report all costs and charges as distinct part observation beds.

Line 93--Use this line to report the costs of other outpatient services not previously identified on lines 88 through 90. If more than one are maintained and/or other services are reported on this line, subscript the line. See Table 5 in §4095 for the proper cost center code for this line.

Lines 94 - 98 and 100--Use these lines for other reimbursable cost centers (other than HHA and CMHC).

Line 94--Use this line to accumulate the direct costs incurred for self-care home dialysis. For purposes of determining overhead attributable to the drugs Epoetin and Aranesp include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

A Medicare beneficiary dialyzing at home has the option to deal directly with the Medicare program and make individual arrangements for securing the necessary supplies and equipment to dialyze at home. Under this arrangement, the beneficiary is responsible for dealing with the various suppliers and the Medicare program to arrange for payment. The beneficiary is also responsible to the suppliers for the deductible and 20 percent Medicare coinsurance requirement. You do not receive composite rate payment for a patient who chooses this option. However, if you provide any direct home support services to a beneficiary who selects this option, you are reimbursed on the same reasonable cost basis for these services as for other outpatient services. These costs are entered on line 63 and are notated as cost reimbursed. You may service Medicare beneficiaries who elect this option and others who deal directly with you. In this case, set up two home program dialysis cost centers (using a subscript for the second cost center) to properly classify costs between the two categories of beneficiaries (those subject to cost reimbursement and those subject to the composite rate).

Line 95--Report all ambulance costs on this line for both owned and operated services and services under arrangement. No subscripting is allowed for this line.

Lines 96 and 97--Use these lines to report durable medical equipment rented or sold, respectively. Enter the direct expenses incurred in renting or selling durable medical equipment (DME) items to patients. Also, include all direct expenses incurred by you in requisitioning and issuing DME to patients.

For the hospital-based SNF, report support surfaces by subscripting line 97 and use the proper cost center code.

Line 99--This cost center accumulates the direct costs for outpatient rehabilitation providers (CORFs and OPTs) and CMHCs. However, only CMHCs complete the J series worksheets. If you have multiple components, subscript this line using the proper cost center code.

Line 100--Use this line if your hospital operates an intern and resident program not approved by Medicare.

Line 101--This cost center accumulates costs specific to HHA services. If you have more than one certified hospital-based HHA, subscript line 101 for each HHA.

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

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

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

When the provider-based HHA can identify discrete management and administrative costs from its books and records, these costs are included on line 101.

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

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

NOTE: This cost report provides separate HHA cost centers for all therapy services. If services are provided to HHA patients from a shared hospital ancillary cost center, make the cost allocation on Worksheet H-1, Part II.

Lines 102 - 104--Reserved for future use.

Lines 105 - 116--Use these lines for special purpose cost centers. Special purpose cost centers include kidney, heart, liver, lung, pancreas, intestinal, and islet acquisition costs as well as costs of other organ acquisitions which are nonreimbursable but which CMS requires for data purposes, cost centers which must be reclassified but which require initial identification, and ASC and hospice costs which are needed for rate setting purposes.

NOTE: Prorate shared acquisition costs (e.g., coordinator salaries, donor awareness programs) among the type of organ acquisitions. Generally, this is done based on the number of organs procured. Further, if multiple organs have been procured from a community hospital or an independent organ procurement organization, prorate the cost among the type of acquisitions involved.

These cost center includes the cost of services purchased under arrangement or billed directly to the hospital in connection with the acquisition of organs. Such direct costs include but are not limited to:

- Fees for physician services (preadmission for transplant donor and recipient tissue-typing and all tissue-typing services performed on cadaveric donors);
- Cost for organs acquired from other providers or organ procurement organizations;
- Transportation costs of organs;
- Organ recipient registration fees;

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- o Surgeons' fees for excising cadaveric donor organs; and
- o Tissue-typing services furnished by independent laboratories.

NOTE: No amounts or fees paid to a donor, their estate, heirs, or assigns in exchange for an organ or for the right to remove or transplant an organ are included in organ acquisition costs. Also, such amounts or fees are not included in any other revenue producing or general service cost center.

Only hospitals which are certified transplant centers are reimbursed directly by the Medicare program for organ acquisition costs. All such costs are accumulated on Worksheet D-4.

Hospitals which are not certified transplant centers are not reimbursed by the Medicare program for organ acquisition costs. Such hospitals sell any organs excised to a certified transplant center or an organ procurement organization. The costs are accumulated in this cost center and flow through cost finding to properly allocate overhead costs to this cost center. However, only a certified transplant center completes Worksheet D-4.

Line 105--Record any costs in connection with kidney acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 106--Record any costs in connection with heart acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 107--Record any costs in connection with liver acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 108--Record any costs in connection with lung acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 109--Record any costs in connection with pancreas acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 110--Record any costs in connection with intestinal acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 111--Record the costs associated with the acquisition of the pancreas that is used to isolate the islet cells that are used for transplant. Do not include in this cost any costs associated with the isolation of the islet cells as these costs will be included as an add-on to the DRG payment. (See CR 5505, dated March 2, 2007).

Line 112--Record any costs related to organ acquisitions, which are not already recorded on lines 105 through 111 and subscripts. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 113--Enter all interest paid by the facility. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

NOTE: If capital-related and working capital interest are commingled on this line, reclassify working capital interest to A & G expense. Reclassify capital-related interest to lines 1 and 2, as appropriate, in accordance with the instructions for those lines.

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Line 114--Include only utilization review costs of the hospital-based SNF. All costs are either reclassified or adjusted in total depending on the scope of the review. If the scope of the review covers all patients, all allowable costs are reclassified in column 4 to A & G expenses (line 5). If the scope of the review covers only Medicare patients or Medicare, title V, and title XIX patients, then (1) in column 4, reclassify to A & G expenses all allowable costs other than physicians' compensation and (2) deduct in column 6 the compensation paid to the physicians for their personal services on the utilization review committee. The amount reported on Worksheet E-2, column 1, line 7 must equal the amount adjusted on Worksheet A-8.

Line 115--Enter the direct costs of an ASC as defined in 42 CFR 416.2. An ASC operated by a hospital must be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital. In addition, the ASC must have an agreement with CMS as required by 42 CFR 416.25. Under this restriction, hospital outpatient departments providing ambulatory surgery (among other services) are not eligible to be classified as ASCs. Those ASCs which meet the definition in 42 CFR 416.2 and are currently treated as an outpatient cost center on the hospital's Medicare cost report are reimbursed through a prospectively determined standard overhead amount. For cost reporting purposes, an eligible ASC is treated as a nonreimbursable cost center to ensure that overhead costs are properly allocated since the cost is not reimbursable in this cost report.

Line 116--42 CFR Part 418 provides for coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice.

Line 117--Enter other special purpose cost centers not previously identified. Review Table 5 in §4095 for the proper cost center code.

Lines 119 - 189--Reserved for future use.

Lines 190 - 194--Record the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers other than those shown, subscript one or more of these lines with a numeric code. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, when the expense (direct and all applicable overhead) attributable to any nonallowable cost area is so insignificant as not to warrant establishment of a nonreimbursable cost center and the sum total of all such expenses is so insignificant as not to warrant the establishment of a composite nonreimbursable cost center, these expenses are adjusted on Worksheet A-8. (See CMS Pub. 15-1, §2328.)

Line 194--Establish a nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice. Such costs include depreciation costs for the space occupied, movable equipment used by the physicians' offices, administrative services, medical records, housekeeping, maintenance and repairs, operation of plant, drugs, medical supplies, and nursing services. Do not include costs applicable to services rendered to hospital patients by hospital-based physicians since such costs may be included in hospital costs.

Lines 195 - 199--Reserved for future use.

Line 200--Sum of lines 118 through 199.

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4014. WORKSHEET A-6 - RECLASSIFICATIONS

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 in column 1 to identify each reclassification entry, e.g., A, B, C. DO NOT USE NUMERIC DESIGNATIONS. In column 10, indicate the column of Worksheet A-7 impacted by the reclassification. All reclassification entries must have a corresponding Worksheet A line number reference in columns 3 and 7. If more than one column is impacted by one reclassification, report each entry as a separate line to properly report each column impacted on Worksheet A-7. If you directly assign the capital-related costs, i.e., insurance, taxes, and other, reclassify these costs to line 3. Do not reclassify other capital-related costs reported or reclassified to line 3 of Worksheet A back to the other capital lines 1-2 of Worksheet A. This is accomplished through Worksheet A-7.

Submit with the cost report copies of any workpapers 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.

If there is any reclassification to general service cost centers for compensation of provider-based physicians, make the appropriate adjustment for RCE limitation on Worksheet A-8-2. (See §4015.)

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 and 2 of Worksheet A. See instructions for Worksheet A-8-1 for treatment of rental expenses for related organizations.

- Reclassification of interest expense included on Worksheet A, column 3, line 113, which is applicable to funds borrowed for A & G purposes (e.g., operating expenses) or for the purchase of buildings and fixtures or movable equipment. Allocate interest on funds borrowed for operating expenses with A & G expenses.

- 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.

- Reclassification of utilization review cost applicable to the hospital-based SNF to A & G costs. If the scope of the utilization review covers the entire population, reclassify the total allowable utilization review cost included on Worksheet A, column 3, line 114. However, if the scope of the utilization review in the hospital-based SNF covers only Medicare patients or Medicare and title XIX patients, only the allowable utilization review costs included on Worksheet A, column 3, line 114 (other than the compensation of physicians for their personal services on utilization review committees) are reclassified to A & G costs.

The appropriate adjustment for physicians' compensation is made on Worksheet A-8. For further explanations concerning utilization review in skilled nursing facilities, see CMS Pub. 15-1, §2126.2.

- Reclassification of any dietary cost included in the dietary cost center which is applicable to the cafeteria, nursery, and to any other cost centers such as gift, flower, coffee shops, and canteen.

- Reclassification of any direct expenses included in the central service and supply cost center which are directly applicable to other cost centers such as intern-resident service, intravenous therapy, and oxygen (inhalation) therapy.

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o Reclassification of any direct expenses included in the laboratory cost center which are directly applicable to other cost centers such as whole blood and packed red blood cells or electrocardiology.

o Reclassification of any direct expenses included in the radiology-diagnostic cost center which are directly applicable to other cost centers such as radiology-therapeutic, radioisotope, or electrocardiology.

o When you purchase services (e.g., physical therapy) under arrangements for Medicare patients but do not purchase such services under arrangements for non-Medicare patients, your books reflect only the cost of the Medicare services. However, if you do not use the grossing up technique for purposes of allocating overhead and if you incur related direct costs applicable to both Medicare and non-Medicare patients (e.g., paramedics or aides who assist a physical therapist in performing physical therapy services), reclassify the related costs on Worksheet A-6 from the ancillary service cost center. Allocate them as part of A & G expense. However, when you purchase services that include performing administrative functions such as completion of medical records, training, etc. as described in CMS Pub. 15-1, §1412.5, the overall charge includes the provision of these services. Therefore, for cost reporting purposes, these related services are NOT reclassified to A & G.

o If a beneficiary receives outpatient renal dialysis for an extended period of time and you furnish a meal, the cost of this meal is not an allowable cost for Medicare. Make an adjustment on Worksheet A-8. However, the dietary counseling cost attributable to a dialysis patient is an allowable cost. Reclassify this cost from the dietary cost center, line 10, to the renal dialysis cost center, line 74.

o When interns and residents are employed to replace anesthetists, you must reclassify the related direct costs from the intern and resident cost center to the anesthesiology cost center. (See 42 CFR 413.85(d)(7) and 49 FR 208 dated January 3, 1984.)

NOTE: These interns and residents do not qualify for the indirect medical education adjustment and must be excluded for the intern and resident FTE for that purpose. (See 42 CFR 412.113(c).)

o If you incur costs for an unpaid guarantee for emergency room physician availability, attach a separate worksheet showing the computation of the necessary reclassification. (See CMS Pub. 15-1, §2109.)

o Reclassification of the costs of malpractice insurance premiums, self-insurance fund contributions, and uninsured malpractice losses incurred either through deductible or coinsurance provisions, as a result of an award in excess of reasonable coverage limits, or as a government provider to the A & G cost center.

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4015. WORKSHEET A-7 - ANALYSIS OF CAPITAL ASSETS

This worksheet consists of three parts:

Part I - Analysis of Changes in Asset Balances.
Part II - Reconciliation of amounts from worksheet A, column 2, lines 1 and 2.
Part III - Computation of Capital for Insurance, Taxes, and Other Capital-Related Costs.

See the instructions for Worksheet A for a definition of capital. All providers must complete Parts I, II, and III.

NOTE: Include assets which are directly allocated to the provider from the home office or related organization and the related other capital costs in Parts I and II of this worksheet.

The intent of Worksheet A-7, Part I, is to reflect assets which relate to the hospital. However, examine the cost finding elections made at the time you submit the cost report to consider the cost finding treatment of SNF, HHA, hospice, subproviders, CORF, CMHC, the physician office building, and any other nonallowable cost centers.

Where you have elected to cost find any of these areas through the cost report, related assets must be included in Worksheet A-7, Part I, as appropriate, to properly allocate the related insurance, taxes, etc. This cost finding treatment must comply with the consistency rule in 42 CFR 412.302(d).

4015.1 Part I - Analysis of Changes Capital Asset Balances.--This part enables the Medicare program to analyze the changes that occurred in your capital asset balances during the current reporting period. Complete this worksheet only once for the entire hospital complex (certified and non-certified components). However, only include in Part I assets that relate to hospital services or are commingled and cannot be separated.

Columns 1 and 6--Enter the balance recorded in your books of accounts at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6). You must submit a reconciliation demonstrating that the sum of Part I, column 6, line 10, agree with the total fixed assets on Worksheet G, plus any directly allocated assets from the home office or related organization, less any assets not allocated through the cost finding method on Worksheet B. Include fully depreciated assets still used for patient care.

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

NOTE: The amounts in Part I, column 2, represent transfers from obligated capital and/or a transfer of assets from a change of ownership.

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

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

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Line Descriptions

Line 7--If you acquired certified HIT assets and are an EHR technology meaning user (Worksheet S-2, Part I, line 167 is yes) in accordance with ARRA 2009, section 4102, enter the corresponding amounts on this line.

Line 9--If you have included in lines 1 through 7 of Part I any of the following, enter those amounts on line 9.

- o Capitalized a lease in accordance with generally accepted accounting principles (GAAP) and included it in the assets reported on Worksheet G,

- o Excess of amounts paid for the acquisition of assets over their fair values or the amount recognized under §2314 of DEFRA for transactions after July 18, 1984, or

- o Construction in progress at the end of the cost reporting period.

Line 10--Enter line 8 minus line 9.

4015.2 Part II - Reconciliation of Amounts From Worksheet A, Column 2, Lines 1 and 2.--The purpose of this worksheet is to segregate and specifically identify the depreciation and capital related costs which are directly assigned to Worksheet A, column 2, lines 1 and 2.

Columns 9 - 14--Enter in columns 9 through 14, the depreciation and other capital related costs. (Do not report in columns 12 through 14 any amounts previously reported in Part III, columns 5 through 7). The sum of columns 9 through 14 of this part, which is reported in column 15, lines 1 through 4 must agree with the amounts reported on Worksheet A, column 2, lines 1 and 2.

4015.3 Part III - Reconciliation of Capital Cost Centers.--Use this part to allocate allowable insurance, taxes, and other capital expenditures (not including depreciation, lease, and interest expense) to the capital-related cost centers. This part also summarizes the amounts in the capital-related cost centers on Worksheet A, lines 1 and 2, column 7.

Lines 1 and 2--The allowable costs for other capital-related expenses (including but not limited to taxes, insurance, and license and royalty fees on depreciable assets) are apportioned by applying the ratio of the hospital's capital related building and fixtures and capital related movable equipment gross asset value to total asset value in each cost reporting period. These lines compute the appropriate gross asset ratios used in allocating other capital-related costs in columns 5 through 7.

Line 3--Enter the sum of lines 1 and 2. Column 4 must equal 1.000000.

Columns 1 - 4, Lines 1 and 2--Use these columns and lines to compute ratios of capital related building and fixtures and capital related movable equipment gross asset values to total gross asset values. Use these ratios on columns 5 through 7 to allocate other capital costs (insurance, taxes, and other) to the capital-related cost center lines (Worksheet A, lines 1 and 2).

Column 1--Enter on line 1 your gross asset value (asset value before accumulated depreciation) for buildings and fixtures (which also includes old land and land improvements). Enter on line 2 your gross asset value for movable equipment.

NOTE: Part III, column 1, line 3, must agree with the sum of Part I, column 6, line 7.

Column 2--Enter in column 2, line as appropriate, any amounts that you have included in column 1, lines 1 and 2, and which were reported on line 8 of Part I, as appropriate.

Column 3--Enter column 1 less column 2.

Column 4--Enter on lines 1 and 2 the amount in column 3, lines as applicable, divided by the amount in column 3, line 3. Round the resulting ratio to six decimal places.

Columns 5 - 7--These columns provide for the allocation of other capital-related costs (taxes, insurance, and other) to the capital-related cost center lines (Worksheet A, lines 1 and 2).

Line 3--Enter in column 5 capital expenditures relating to insurance. Enter in column 6 capital expenditures relating to State and local taxes on property and equipment. Enter in column 7 other capital expenditures (not including taxes, insurance, depreciation, lease, and interest expense). Enter in column 8 the sum of the amounts reported in columns 5 through 7.

Lines 1 and 2--Apply the ratios developed in column 4, line as applicable, to allocate the other capital costs reported in line 3.

Column 8--Line 3 must be equal to or less than the amount on Worksheet A, line 3, column 3. The amount reported becomes the reclassification entry on Worksheet A, column 4 which will zero-out the balance on line 3. If you directly assign the capital related costs, see Part II for proper disclosure of these costs.

Columns 9 - 15--These lines summarize the amounts in the capital-related cost centers (Worksheet A, lines 1 and 2, column 7).

NOTE: The amount entered in these columns must be net of reclassifications and adjustments identified on Worksheets A-6, A-8 and A-8-1.

Column 9--Enter the amount reported in Part II above, from column 9, lines 1 and 2, adjusted by the amounts identified on Worksheets A-6, A-8 and A-8-1.

Column 10--Enter the amount reported in Part II, column 10, lines 1 and 2, relating to capital-related lease expense, adjusted by the amounts identified on Worksheets A-6, A-8, and A-8-1. (See CMS Pub. 15-1, §2806.1.) Report insurance, taxes, and license and royalty fees associated with leased assets in columns 12, 13, and 14 of this worksheet, respectively.

Column 11--Enter the amount reported in Part II, column 11, lines 1 and 2, relating to capital-related interest expense, adjusted by the amounts identified on Worksheets A-6, A-8, and A-8-1

Column 12--Enter the amount from column 5 plus any additional amounts reported in Part II, column 12 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 13--Enter the amount from column 6 plus any additional amounts reported in Part II, column 13 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 14--Enter the amount from column 7 plus any additional amounts reported in Part II, column 14 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 15--Enter the sum of columns 9 through 14. The amounts from column 15, lines 1 and 2, must equal the amounts on Worksheet A, column 7, lines 1 and 2.

4016. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

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

This worksheet provides for the adjustments in support of those listed on Worksheet A, column 6. These adjustments, required under the Medicare principles of reimbursement, are made on the basis of cost or amount received (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the cost. Submit with the cost report a copy of any work papers used to compute a cost adjustment. Once an adjustment to an expense is made on the basis of cost, you may not determine the required adjustment to the expense on the basis of revenue in future cost reporting periods. Enter the following symbols in column 1 to indicate the basis for adjustment: "A" for cost or "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 include (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, etc.; (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process.

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

NOTE: When adjustments affect capital, they must be appropriately identified as impacting capital related building and fixtures or capital related movable equipment. If these adjustments affect other capital-related costs, indicate in column 5 the capital related cost category shown on Worksheet A-7, Part III, columns 9 through 14.

Enter additional costs as positive amounts. Enter reductions of cost as a negative number. Enter a net total (if a reduction of cost) as a negative number.

Line Descriptions

Lines 1 - 3--Enter the investment income to be applied against interest expense. (See CMS Pub. 15-1, §202.2 for an explanation.)

Line 7--For patient telephones, make an adjustment on this line or establish a nonreimbursable cost center. When this line is used, base the adjustment on cost. Revenue is not used. (See CMS Pub. 15-1, §2328.)

Line 10--Enter the total provider-based physician adjustments for personal patient care services and RCE limitations. Obtain this amount from Worksheet A-8-2, column 18, sum of all lines.

NOTE: Make the adjustment to Worksheet A, column 6 for each applicable cost center from Worksheet A-8-2, column 18, line as appropriate.

Line 12--Obtain this amount from section A, column 6 of Worksheet A-8-1. **NOTE** that Worksheet
A-8-1 represents the detail of the various cost centers on Worksheet A which must be adjusted.

Line 21--Enter the cash received from the imposition of interest, finance, or penalty charges on overdue receivables. Use this income to offset the allowable administration and general costs. (See CMS Pub. 15-1, §2110.2.)

Line 22--Enter the interest expense imposed by the intermediary on Medicare overpayments. Also, enter interest expense on borrowing made to repay Medicare overpayments.

Line 23--Enter, if applicable, the amount from Worksheet A-8-3, line 65. For reporting the adjustment for providers within the complex, subscript this line in accordance with the prescribed subscripting instructions on Worksheet A-8-3, line 65.

Line 24--Enter, if applicable, the amount from Worksheet A-8-3, line 66. (See line 23 above for proper subscripting of this line.)

Line 25--This line pertains to the hospital-based SNF only. When the utilization review covers only Medicare patients or Medicare and title XIX patients, allocate 100 percent of the reasonable compensation paid to the physicians for their services on utilization review committees to the health care programs. Apportion all other allowable costs applicable to utilization review which cover only health care program patients among all users of the hospital-based SNF. Reclassify such other costs on Worksheet A-6. Enter the physicians' compensation for service on utilization review committees which cover only health care program patients in the hospital-based SNF. The amount entered equals the amount shown on Worksheet A, column 6, line 114. (See CMS Pub. 15-1, §2126.2.) If the utilization review costs pertain to more than one program, the amount entered on Worksheet E-2, column 1, line 7 must equal the amount adjusted on Worksheet A-8.

Lines 26 and 27--When depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on lines 26 and 27, as applicable. Use line 26 capital related buildings and fixtures costs and line 27 for new capital related movable equipment costs. Personal use of assets requires adjustment to depreciation expense, e.g., automotive used 50% for business and 50% personal.

Line 28--This adjustment is required for salaries and fringe benefits paid to nonphysician anesthetists reimbursed on a fee schedule. (See the instructions for Worksheet A, line 19.)

Line 29--Sections 1861(s)(2)(K), 1842(b)(6)(C), and 1842(b)(12) of the Act provide for coverage of and separate payment for services performed by a physician assistant. The physician assistant is an employee of the hospital and payment is made to the employer of the physician assistant. Make an adjustment on Worksheet A-8 for any payments made directly to the physician assistant for services rendered. This avoids any duplication of payments.

Line 30--Enter, if applicable, the amount from Worksheet A-8-3, line 67 for occupational therapy services rendered. (See line 23 above for proper subscripting of this line.)

Line 31--Enter, if applicable, the amount from Worksheet A-8-3, line 68 for speech pathology services rendered. (See line 23 above for proper subscripting of this line.)

Line 32--For CAHs, where applicable, remove the current year depreciation expense for those assets fully expensed in the current year. Also, in subsequent years remove any current year depreciation expense over the useful life of the asset for those assets fully expensed in a previous year.

Lines 33 - 49--Enter any additional adjustments which are required under the Medicare principles of reimbursement. Label the lines appropriately to indicate the nature of the required adjustments. If the number of blank lines is not sufficient, subscript lines 32 through 49. The grossing up of costs in accordance with provisions of CMS Pub. 15-1, §2314 is an example of an adjustment entered on these lines and is explained below.

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

In the foregoing situation, do not allocate indirect costs to the cost center unless your intermediary determines that you are able to gross up both the costs and the charges for services to non-health care program patients so that both costs and charges for services to non-health care program patients are recorded as if you had provided such services directly. See the instructions for Worksheet C, Part I for grossing up of your charges.

Meals furnished by you to an outpatient receiving dialysis treatment also require an adjustment. These costs are nonallowable for title XVIII reimbursement. Therefore, the cost of these meals must be adjusted.

In accordance with CMS Pub. 27, §501, compensation paid to a physician for RHC services rendered in a hospital-based RHC is cost reimbursed. Where the physician agreement compensates for RHC services as well as non-RHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B carrier. If not specified in the agreement, a time study must be used to allocate the physician compensation.

If the hospital performs ESRD services and costs are reported on either lines 74, 94, or both, these costs should include the cost of the drugs Epoetin and Aranesp. Do not report the cost of these drugs claimed in any other cost center. These costs will be removed later on Worksheet B-2.

If the hospital is paying membership dues to an organization which perform lobbying and political activities, the portion of the dues associated with these non-allowable activities must be removed from costs.

Line 50--Enter the sum of lines 1 through 49. Transfer the amounts in column 2 to Worksheet A, column 6, line as appropriate.

4017. 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. In addition, it shows certain information concerning the related organizations with which you have transacted business as well as home office costs. (See CMS Pub. 15-1, chapter 10, and §2150 respectively.)

Part A--Cost applicable to home office 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 CMS Pub. 15-1, 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).

Column 7--Enter the specific column of Worksheet A-7, Part III columns 9 through 14 impacted by the adjustment.

4018. WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 415.55, 42 CFR 415.60, 42 CFR 415.70, and 42 CFR 415.102(d), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider or which represent availability services in a hospital emergency room under specified conditions. (See 42 CFR 415.150 and 42 CFR 415.164 for an exception for teaching physicians under certain circumstances.) 42 CFR 415.70 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost you incur. 42 CFR 415.60 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services such as research. Only provider services are reimbursable to you through the cost report. This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 415.70. The methodology used in this worksheet applies the RCE limit to the total physician compensation attributable to provider services reimbursable on a reasonable cost basis. Enter the total provider-based physician adjustment for personal care services and RCE limitations applicable to the compensation of provider-based physicians directly assigned to or reclassified to general service cost centers. RCE limits are not applicable to a medical director, chief of medical staff, or to the compensation of a physician employed in a capacity not requiring the services of a physician, e.g., controller. RCE limits also do not apply to critical access hospitals, however the professional component must still be removed on this worksheet. CAHs need only complete columns 1 through 5 and 18. Transfer for CAHs the amount from column 4 to column 18.

NOTE: 42 CFR 415.70(a)(2) provides that limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services paid for under the prospective payment system implemented under 42 CFR Part 412.

Limits established under this section apply to inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40), outpatient services for all titles, and to title XVIII, Part B inpatient services.

Since the methodology used in this worksheet applies the RCE limit in total, make the adjustment required by 42 CFR 415.70(a)(2) on Worksheet C, Part I. Base this adjustment on the RCE disallowance amounts entered in column 17 of Worksheet A-8-2.

Where several physicians work in the same department, see CMS Pub. 15-1, §2182.6C for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

NOTE: The adjustments generated from this worksheet for physician compensation are limited to the cost centers on Worksheet A, lines 4-99, 105-112, and 115 and subscripts as allowed.

Column Descriptions

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

Columns 2 and 11--Enter the description of the cost center used on Worksheet A. When RCE limits are applied on an individual basis to each physician in a department, list each physician on successive lines directly under the cost center description line, or list the first physician on the same line as the cost center description line and then each successive line below for each additional physician in that cost center.

List each physician using an individual identifier (not the physician's name, NPI, UPIN or social security number of the individual), but rather, Dr. A, Dr. B, …, Dr. AA, Dr. BB, etcetera. However, the identity of the physician must be made available to your contractor/contractor upon audit. When RCE limits are applied on a departmental basis, insert the word "aggregate" (instead of the physician identifiers) on the line below the cost center description.

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

Column 3--Enter the total physician compensation paid by you for each cost center. Physician compensation means monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services) that you or other organizations furnish a physician in return for the physician's services. (See 42 CFR 415.60(a).) Include the compensation in column 3 of Worksheet A or, if necessary, through appropriate reclassifications on Worksheet A-6 or as a cost paid by a related organization through Worksheet A-8-1.

Column 4--Enter the amount of total remuneration included in column 3 applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B carrier in accordance with 42 CFR 415.102(a). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 415.60(f).)

Column 5--Enter the amount of the total remuneration included in column 3, for each cost center, applicable to general services to you (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 415.60(f).)

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

Column 6--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the **Federal Register** before any allowable adjustments. The final notice on the annual update to RCE limits published in the Federal Register, Vol. 50, No. 34, February 20, 1985, on page 7126 contains Table 1, Estimates of FTE Annual Average Net Compensation Levels for 1984. An update was published in the Federal Register on August 1, 2003, Vol. 68, No. 148 on page 45459. Obtain the RCE applicable to the specialty from this table. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable: non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million.

Column 7--Enter for each line of data the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040 in this column. The hours entered are the actual hours for which the physician is compensated by you for furnishing services of a general benefit to your patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered. Time records or other documentation that supports this allocation must be

available for verification by your intermediary upon request. (See CMS Pub. 15-1, §2182.3E.)

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

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

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

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

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

Column 14--You may also adjust upward the computed RCE limit in column 8 to reflect the actual malpractice expense incurred by you for the services of a physician or group of physicians to your patients.

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

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

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

Column 17--Compute the RCE disallowance for each cost center by subtracting the RCE limit in column 16 from your component remuneration in column 5. If the result is a negative amount, enter zero. Transfer the amounts for each cost center to Worksheet C, Part I, column 4 for all hospitals subject to PPS. (See 42 CFR Part 412.)

Column 18--The adjustment for each cost center entered represents the PBP elimination from costs entered on Worksheet A-8, column 2, line 10 and on Worksheet A, column 6 to each cost center affected. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 16 (adjusted RCE limit) from the total remuneration recorded in column 3.

NOTE: If you incur cost for unpaid guarantee for emergency room physician availability, attach a separate worksheet showing the computation of the necessary reclassification. (See CMS Pub. 15-1, §2109.)

Line Descriptions

Line 200--Enter the total of lines 1 through 11 for columns 3 through 5, 7 through 9, and 12 through 18.

4019. 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 therapy services furnished by outside suppliers in CAHs. Therapy services rendered by non-CAH providers are either subject to fee schedule reimbursement or the corresponding PPS reimbursement. Consequently, only CAHs complete this worksheet. 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.

If you contract with an outside supplier for therapy services, the potential for limitation and the amount of payment you receive depend 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., at your site or an alternate site.
- o Whether detailed time and mileage records are maintained by the contractor;
- 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.

4019.1 Part I - General Information--This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Line 1--Enter the number of weeks that services were performed on site. Count only those weeks during which a supervisor, therapist or an assistant was on site. (See PRM-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 days in which the supervisor or therapist (only report the therapists for respiratory therapy) was on site. Count only one day when both the supervisor and therapist were at the site during the same day.

Line 4--Enter the number of days in which the therapy assistant (PT, OT, or SP only) was on site. Do not include days when either the supervisor or therapist was also at the site during the same day.

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

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

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

Line 7--Enter the standard travel expense rate applicable. (See CMS Pub. 15-1, chapter 14.)

Line 8--Enter the optional travel expense rate applicable. (See CMS Pub. 15-1, chapter 14.) Use this rate only for services for which time records are available.

Line 9--Enter in the appropriate columns the total number of hours worked for each category.

Line 10--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 15-1, 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. 15-1, 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 PRM-I, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants, aides, and trainees respectively) the AHSEA from either the appropriate exhibit found in CMS Pub. 15-1, 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. 15-1, §1412.2.)

Line 11--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 10. Enter in column 3 one half of the amount in column 3, line 10. (See CMS Pub 15-1, §1402.4.)

Lines 12 and 13--Enter the number of travel hours and number of miles driven, respectively, if time records of visits are kept. (See CMS Pub. 15-1, §§1402.5 and 1403.1.) Subscript this line into two categories of, provider site and provider offsite.

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

4019.2 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 health care program patients but simply arrange for such services for non health care program patients and do not pay the non health care program portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of CMS Pub. 15-1, §2314, complete Part II, lines 14 through 20 and 23 in all cases and lines 21 and 22 where appropriate. See §2810 for instructions regarding grossing up costs and charges. However, where you cannot gross up costs and charges, complete lines 14 through 20 and 23.

Line 14 - 20--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 9) by the adjusted hourly salary equivalency amount for supervisors, therapists, assistants, aides and trainees (for respiratory therapy only).

Line 17--Enter the sum of lines 14 and 15 for respiratory therapy or sum of lines 14 through 16 for all others.

Line 20--Enter the sum of lines 17 through 19 for respiratory therapy or sum of lines 17 and 18 for all other.

Lines 21 and 22--If the sum of hours in columns 1 and 2 for respiratory therapy or 1 through 3 for all others, line 9 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 21--Enter the result of line 17 divided by the sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others.

Line 22--Enter the result of line 2 times line 21.

Line 23--If there are no entries on lines 21 and 22, enter the amount on line 20. Otherwise, enter the sum of the amounts on lines 18, 19, and 22 for respiratory therapy or lines 18 and 22 for all others.

4019.3 Part III - Standard and Optional Travel Allowance and Travel Expense Computation - Provider Site--This part provides for the computation of the standard and optional travel allowance and travel expense for services rendered on site.

Lines 24 - 28--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed at your site. One standard travel allowance is recognized for each day an outside supplier performs skilled therapy services at your site. For example, if a contracting organization sends three therapists to you each day, only one travel allowance is recognized per day. (See CMS Pub. 15-1, §1403.1 for a discussion of standard travel allowance and §1412.6 for a discussion of standard travel expense.)

Line 24--Include the standard travel allowance for supervisors and therapists. This standard travel allowance for supervisors does not take into account the additional allowance for administrative and supervisory responsibilities. (See CMS Pub. 15-1, §1402.4.)

Line 25--Include the standard travel allowance for assistants for physical therapy, occupational therapy, and speech pathology.

Line 26--Enter the amount from line 24 for respiratory therapy or the sum of lines 24 and 25 for physical therapy, occupational therapy, or speech pathology.

Line 27--Enter the result of line 7 times line 3 for respiratory therapy or line 7 times the sum of lines 3 and 4 for all others.

Lines 29 - 35--Complete these lines for computing the optional travel allowance and expense when proper records are maintained.

Line 31--Enter the amount on line 29 for respiratory therapy or the sum of lines 29 and 30 for all others.

Line 32--Enter the result of line 8 times the sum of columns 1 and 2, line 13 for respiratory therapy or columns 1, 2, and 3, line 13 for all other.

Lines 33 through 35--Enter an amount in one of these lines depending on the method utilized.

4019.4 Part IV - Standard Travel Allowance and Standard Travel Expense - Provider offsite 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. 15-1, §§1402ff, 1403.1 and 1412.6.)

Lines 36-39--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with offsite visits. Only use these lines 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 40 - 43--Complete the optional travel allowance and optional travel expense computations for physical therapy, occupational therapy, and speech pathology services in conjunction with home health services only. Compute the optional travel allowance on lines 40 through 42. Compute the optional travel expense on line 43.

Lines 44 - 46--Choose and complete only one of the options on lines 44 through 46. However, use lines 45 and 46 only if you maintain time records of visits. (See CMS Pub 15.I, §1402.5.)

4019.5 Part V - Overtime Computation--This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for you in excess of your standard work week. No overtime allowance is given to a therapist who receives an additional allowance for supervisory or administrative duties. (See CMS Pub 15.I, §1412.4.)

Line 47--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 5 are either zero or, equal to or greater than 2080, the overtime computation is not applicable. Make no further entries on lines 48 through 55 (If there is a short period prorate the hours). Enter zero in each column of line 56. Enter in column 5 the sum of the hours recorded in columns 1, 3 and 4 for respiratory therapy, and columns 1 through 3 for physical therapy, speech pathology, and occupational therapy.

Line 48--Enter in the appropriate column the overtime rate (the AHSEA from line 10, column as appropriate, multiplied by 1.5).

Line 50--Enter the percentage of overtime hours by class of employee. Determine this amount by dividing each column on line 47 by the total overtime hours in column 5, line 47.

Line 51--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 5. Multiply the standard workyear in column 5 by the percentage on line 50 and enter the result in the corresponding columns.

Line 52--Enter in columns 1 through 3 for physical therapy, speech pathology, and occupational therapy the AHSEA from Part I, line 10, columns 2 through 4, as appropriate. Enter in columns 1, 3 and 4 the AHSEA from Part I, line 10, columns 2, 4 and 5, for respiratory therapy.

Line 56--Enter in column 5 the sum of the amounts recorded in columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for physical therapy, speech pathology, and occupational therapy.

4019.6 Part VI - Computation of Therapy Limitation and Excess Cost Adjustment--This part provides for the calculation of the adjustment to the therapy service costs in determining the reasonableness of therapy cost.

Line 58--Enter the amount reported on lines 33, 34, or 35.

Line 59--Enter the amount reported on lines 44, 45, or 46.

Lines 61 and 62--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 15-1, §1412.1) is considered an additional allowance in computing the limitation.

Line 64--Enter the amounts paid and/or payable to the outside suppliers for the hospital, if applicable, 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. Add all subscripted lines together for purposes of calculating the amount to be entered on this line.

Line 65--Enter the excess cost over the limitation, i.e., line 64 minus line 63. If the amount is negative, enter a zero. Transfer this amount to Worksheet A-8, line 23 for respiratory therapy; line 24 for physical therapy; line 30 for occupational therapy; and line 31 for speech pathology.