4040. FINANCIAL STATEMENT WORKSHEETS

Prepare these worksheets from your accounting books and records.

Complete all worksheets in the "G" series. Complete Worksheets G and G-1 if you maintain fund-type accounting records, complete separate amounts for General, Specific Purpose, Endowment and Plant funds on Worksheets G and G-1. If you do not maintain fund-type accounting records, complete the general fund column only. Cost reports received with incomplete G worksheets are returned to you for completion. If you do not follow this procedure, you are considered as having failed to file a cost report. Where applicable, Worksheets G, G-1, G-2 and G-3 must be consistent with financial statements prepared by Certified Public Accountants or Public Accountants.

4040.1 Worksheet G - Balance Sheet--If the lines on the Worksheet G are not sufficient, use lines 5 (Other receivables), 9 (Other current assets), 44 (Other current liabilities), and 49 (Other long term liabilities), as appropriate, to report the sum of account balances and adjustments. Maintain supporting documentation or subscript the appropriate lines.

Enter accumulated depreciation as a negative amount.

Column 1--General Fund--Use only this fund column when you do not maintain fund-type accounting records. This fund is similar to a general ledger account and records all assets and liabilities of the entity

Column 2--Specific Purpose Fund--These accounts are used for funds held for specific purposes such as research and education.

Column 3--Endowment Fund--These accounts are for amounts restricted for endowment purposes.

Column 4--Plant Fund--These accounts are for amounts restricted for the replacement and expansion of the plant.

Line 1--Cash on Hand and in Banks--The amounts on this line represent the amount of cash on deposit in banks and immediately available for use in financing activities, amounts on hand for minor disbursements and amounts invested in savings accounts and certificates of deposit. Typical accounts would be cash, general checking accounts, payroll checking accounts, other checking accounts, imprest cash funds, saving accounts, certificates of deposit, treasury bills and treasury notes and other cash accounts.

Line 2--Temporary Investments--The amounts on this line represent current securities evidenced by certificates of ownership or indebtedness. Typical accounts would be marketable securities and other current investments.

Line 3--Notes Receivable--The amounts on this line represent current unpaid amounts evidenced by certificates of indebtedness.

Line 4--Accounts Receivable--Include on this line all unpaid inpatient and outpatient billings. Include direct billings to patients for deductibles, co-insurance and other patient chargeable items if they are not included elsewhere.

Line 6--Less: Allowance for Uncollectable Notes and Accounts--These are valuation (or contra-asset) accounts whose credit balances represent the estimated amount of uncollectible receivables from patients and third-party payers. Enter this amount as a negative.

Line 7--Inventory--Enter the costs of unused hospital supplies. Perpetual inventory records may be maintained and adjusted periodically to physical count. The extent of inventory control and detailed record-keeping will depend upon the size and organizational complexity of the hospital. Hospital inventories may be valued by any generally accepted method, but the method must be consistently applied from year to year.

Line 8--Prepaid Expenses--Enter the costs incurred which are properly chargeable to a future accounting period.

Line 9--Other Current Assets --These balances include other current assets not included in other asset categories.

Line 10--Due from Other Funds--There are four funds: General Fund, Specific Purpose Fund, Endowment Fund and Plant Fund. These are represented in columns 1 through 4, respectively. Amounts reported in each column should be the amount due from other funds in another column on Worksheet G, line 43 (Due to Other Funds).

The sum of the amounts on line 10, columns 1 through 4 must equal the sum of the amounts on line 43, columns 1 through 4.

Line 12--Land--This balance reflects the cost of land used in hospital operations. Included here is the cost of off-site sewer and water lines, public utility, charges for servicing the land, governmental assessments for street paving and sewers, the cost of permanent roadways and of grading of a non-depreciable nature. Unlike building and equipment, land does not deteriorate with use or with the passage of time, therefore, no depreciation is accumulated.

The cost of land includes (1) the cash purchase price, (2) closing costs such as title and attorney's fees, (3) real estate broker's commission, and (4) accrued property taxes and other liens on the land assumed by the purchaser.

Land 13--Land Improvements--Amounts on this line include structural additions made to land, such as driveways, parking lots, sidewalks; as well as the cost of shrubbery, fences and walls, landscaping, on-site sewer and water lines, and underground sprinklers. The cost of land improvements includes all expenditures necessary to make the improvements ready for their intended use.

Line 15--Buildings--This line includes the cost of all buildings and subsequent additions used in hospital operations (including purchase price, closing costs, (attorney fees, title insurance, etc.), and real estate broker commission). Included are all architectural, consulting and legal fees related to the acquisition or construction of buildings, and interest paid for construction financing.

Line 17--Leasehold Improvements--All expenditures for the improvement of a leasehold used in hospital operations are included on this line.

Line 19--Fixed Equipment--Include the cost of building equipment that has the following general characteristics:

1. Affixed to the building, not subject to transfer or removal.
2. A life of more than one year, but less than that of the building to which it is affixed.
3. Used in hospital operations.

Fixed equipment includes such items as boilers, generators, engines, pumps, and refrigeration machinery, wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc.

Line 21--Automobiles and Trucks--Enter the cost of automobiles and trucks used in hospital operations.

Line 23--Major movable Equipment--Costs of equipment included on this line has the following general characteristics:

1. Ability to be moved, as distinguished from fixed equipment (but not automobiles or trucks).
2. A more or less fixed location in the building.
3. A unit cost large enough to justify the expense incident to control by means of an equipment ledger and greater than or equal to $5,000.
4. Sufficient individuality and size to make control feasible by means of identification tags.
5. A minimum life of usually three years or more.
6. Used in hospital operations.

Line 25--Minor Equipment-Depreciable--Costs of equipment included on this line has the following general characteristics:

1. Ability to be moved, as distinguished from fixed equipment.
2. A more or less fixed location in the building
3. A unit cost large enough to justify the expense incident to control by means of an equipment ledger but less than $5,000.
4. Sufficient individuality and size to make control feasible by means of identification tags.
5. A minimum life of usually three years or more.
6. Used in hospital operations.

Line 27--Health Information Technology (HIT) Designated Assets--The amounts included here are the acquisition costs of HIT acquired assets in accordance with ARRA 2009, section 4102. Acute care hospitals are required to depreciate such assets in accordance with their applicable depreciation schedules. CAHs are required to identify such assets on this line, but do not depreciate such assets as they will be fully expensed during the year of acquisition.

Line 29--Minor Equipment-Nondepreciable--Costs of equipment included on this line has the following general characteristics:

1. Location generally not fixed; subject to requisition or use by various departments of the hospital.
2. Relatively small size.
3. Subject to storeroom control.
4. Fairly large number in use.
5. Generally a useful life of usually approximately three years or less.
6. Used in hospital operations.

Minor equipment includes such items as, but are not limited to wastebaskets, bed pans, syringes, catheters, basins, glassware, silverware, pots and pans, sheets, blankets, ladders, and surgical instruments.

Lines 14, 16, 18, 20, 22, 24, 26 and 28--Less Accumulated Depreciation--These balances, respectively, include the depreciation accumulated on the related assets used in hospital operations. Enter this amount as a negative.

Line 31--Investments--This field contains the cost of investments purchased with hospital funds and the fair market value (at date of donation) of securities donated to the hospital.

Line 32--Deposits on Leases--Report the amount of deposits on leases. This includes security deposits.

Line 33--Due to Owners/Officers--Report the amount loaned to the hospital by owners and/or officers.

Line 34--Other Assets--This is the amount of assets not reported on line 9 (other current assets) or any other line 1 through 33. This could include intangible assets such as goodwill, unamortized loan costs and other organization costs.

Line 35--Total Other Assets--Sum of lines 31 through 34.

Line 36--Total Assets--Sum of lines 11, 30 and 35.

Line 37--Accounts Payable--This amount reflects the amounts due trade creditors and others for supplies and services purchased.

Line 38--Salaries, Wages and Fees Payable--This amount reflects the actual or estimated liabilities of the hospital for salaries and wages/fees payable.

Line 39--Payroll Taxes Payable--This amount reflects the actual or estimated liabilities of the hospital for amounts payable for payroll taxes withheld from salaries and wages, payroll taxes to be paid by the hospital and other payroll deductions, such as hospitalization insurance premiums.

Line 40--Notes and Loans Payable (Short-Term)--The amounts on this line represent current amounts owing as evidenced by certificates of indebtedness coming due in the next 12 months.

Line 41--Deferred Income--Deferred income is received or accrued income which is applicable to services to be rendered within the next accounting period. Deferred income applicable to accounting periods extending beyond the next accounting period is included as other current liabilities. These amounts also reflect the effects of any timing differences between book and tax or third-party reimbursement accounting.

Line 42--Accelerated Payments--Accelerated payments are payments not yet due to be repaid to the contractor.

Line 43--Due to Other Funds--There are four funds: General Fund, Specific Purpose Fund, Endowment Fund and Plant Fund. These are in columns 1 through 4 respectively. Amounts are reported in the fund owing the amount. Each amount recorded as “due to” must also be reported on Worksheet G, line 10 (Due From Other Funds).

The sum of the amounts on line 10, columns 1 through 4 must equal the sum of the amounts on line 41, columns 1 through 4.

Line 44--Other Current Liabilities--This line is used to record any current liabilities not reported on lines 37 through 43.

Line 45--Total Current Liabilities--Enter the sum of lines 37 through 44.

Line 46--Mortgage Payable--This amounts reflects the long-term financing obligation used to purchase real estate/property.

Line 47--Notes Payable--These amounts reflect liabilities of the hospital to vendors, banks and other, evidenced by promissory notes due and payable longer than one year.

Line 48--Unsecured Loans--These amounts are not loaned on the basis of collateral.

Line 49--Other Long-Term Liabilities--This line is used to record any long-term liabilities not reported on lines 46 through 48.

Line 50--Total Long-Term Liabilities--Enter the sum of lines 46 through 49.

Line 51--Total Liabilities--Enter the sum of lines 45 and 50.

Line 52--General Fund Balance--This represents the difference between the total of General Fund assets and General Fund Liabilities in column 1. This amount usually equals the end of period fund balance on Worksheet G-1, column 2, line 19.

Line 53--Specific Purpose Fund--This represents the difference between the total of Specific Purpose Fund assets and Specific Purpose Fund Liabilities in column 2.

Line 54--Donor Created - Endowment Fund Balance - Restricted--The sum of the amounts on lines 54, 55 and 56, represent the difference between the total of Endowment Fund assets and Endowment Fund Liabilities in column 3.

Line 55--Donor Created - Endowment Fund Balance - Unrestricted.

Line 56--Governing Body Created - Endowment Fund Balance.

Line 57--Plant Fund Balance - Invested in Plant--The sum of the amounts on lines 57 and 58, represent the difference between the total of Plant Fund assets and Plant Fund Liabilities in column 4.

Line 58--Plant Fund Balance - Reserves for Plant Improvement, Replacement and Expansion--The credit balances of the restricted funds reported on lines 54 through 56, represent the net amount of each restricted fund's assets available for its designated purpose. The accounts should be credited for all income earned on restricted fund assets, as well as gains on the disposal of such assets. If, however, such items are treated as General Fund income (considering legal requirements and donor intent), the restricted Fund Balance account is charged, and the Due to General Fund account credited, for such income.

For Investor-Owned Corporations, the accounts on lines 53 through 58 include stock, paid in capital and retained earnings. For Investor-Owned Partnerships, the amounts on lines 53 through 58 include capital and partner's draw. For Investor-Owned - Division of a Corporation, the amounts on lines 53 through 58 include the division's or subsidiary's stock, paid in capital and divisional equity.

Line 59--Total Fund Balances--Enter the sum of lines 52 through 58.

Line 60--Total Liabilities and Fund Balances--Enter the sum of lines 51 and 59.

For each Fund, the amount on line 36 equals the amount on line 60.

4040.2 Worksheet G-1 - Statement of Changes in Fund Balances--

Columns 1 and 2--General Fund.

Columns 3 and 4--Specific Purpose Fund--These accounts are used for funds held for specific purposes such as research and education.

Columns 5 and 6--Endowment Fund--These accounts are for amounts restricted for endowment purposes.

Columns 7 and 8--Plant Fund--These accounts are for amounts restricted for the replacement and expansion of the plant.

Line 1--Fund Balance at Beginning of Period--The fund balance at the beginning of the period comes from the prior year cost report Worksheet G-1, line 19, columns 2, 4, 6 and 8, respectively.

Line 2--Net Income--Transfer to column 2, the amount from Worksheet G-3, line 29. Columns 1, 3, 4, 5, 6, 7 and 8 are not completed.

Line 3--Total--For column 2, enter the sum of lines 1 and 2. Leave columns 1, 3, 5 and 7 blank. For columns 4, 6 and 8, bring down the amount on line 1.

Lines 4 through 9--Additions--Most income is included in the net income reported on line 2. Any increases affecting the fund balance not included in net income are reported on these lines. A description (not exceeding 36 characters) is entered for each entry on lines 4 through 9.

Line 10--Total Additions--In columns 2, 4, 6 and 8, enter the sum of lines 4 through 9 columns 1, 3, 5 and 7, respectively.

Line 11--Subtotals--Enter the sum of lines 3 and 10 for columns 2, 4, 6 and 8. Leave columns 1, 3, 5 and 7 blank.

Lines 12 through 17--Deductions--Most expenses are included in the net income reported on line 2. Any decreases affecting the fund balance not included in net income are reported on these lines. A description (not exceeding 36 characters) is entered for each entry on lines 12 through 17.

Line 18--Total Deductions--In columns 2, 4, 6 and 8, enter the sum of lines 12 through 17, columns 1, 3, 5 and 7, respectively.

Line 19--Fund Balance at the end of Period per Balance Sheet--Enter the result of line 11 minus line 18 for columns 2, 4, 6 and 8. Leave columns 1, 3, 5 and 7 blank. The amount in line 19, column 2 must agree with Worksheet G, line 52, column 1. The amount on line 19, column 4 must agree with Worksheet G, line 53, column 2. The amount on line 19, column 6 must agree with the sum of Worksheet G, column 3, lines 54 through 56. The amount on line 19, column 8 must agree with the sum of Worksheet G, column 4, lines 57 and 58.

These amounts will also be used to start next year's Worksheet G-1.

4040.3 Worksheet G-2, Parts I & II - Statement of Patient Revenues and Operating Expenses--
The worksheets require the reporting of total patient revenues for the entire facility and operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statement, submit a reconciliation report with the cost report submission. If you have more than one hospital-based HHA and/or more than one outpatient rehabilitation provider, subscript the appropriate lines on Worksheet G-2, Part I, to report the revenue for each multiple based facility separately.

Part I - Patient Revenues--Enter total patient revenues associated with the appropriate cost centers on lines 1-9, 11-15, and 18-25.

Line 1--Hospital--Enter revenues generated by the hospital component of the complex. Obtain these amounts from your accounting books and/or records.

Line 2--Subprovider - IPF--Enter revenues generated by the IPF (also referred to as the IPF excluded unit) of the complex. Obtain this amount from your accounting books and/or records.

Line 3--Subprovider - IRF--Enter revenues generated by the IRF (also referred to as the IRF excluded unit) of the complex. Obtain this amount from your accounting books and/or records.

Line 4--Subprovider - Other--Enter revenues generated by components identified as subproviders of the complex that were not identified on lines 2 or 3. Subscript this line as necessary. Obtain these amounts from your accounting books and/or records.

Line 5--Swing Bed - SNF--Enter the swing bed - SNF revenue from your accounting books and/or records.

Line 6--Swing Bed - NF--Enter the swing bed - NF revenue from your accounting books and/or records.

Line 7--Skilled Nursing Facility--Enter the skilled nursing facility revenue from your accounting books and/or records.

Line 8--Nursing Facility--Enter the nursing facility revenue from your accounting books and/or records.

Line 9--Other Long Term Care-- Enter the revenue generated from other long term care subproviders from your accounting books and/or records. Subscript this line as necessary.

Line 10--Total General Inpatient Routine Care--Sum of lines 1 through 9.

Line 11--Intensive Care Unit--Enter the intensive care unit revenue from your accounting books and/or records.

Line 12--Coronary Care Unit--Enter the coronary care unit revenue from your accounting books and/or records.

Line 13--Burn Intensive Care Unit--Enter the burn intensive care unit revenue from your accounting books and/or records.

Line 14--Surgical Intensive Care Unit--Enter the surgical intensive care unit revenue from your accounting books and/or records.

Line 15--Other Special Care-- Enter all other intensive care unit revenue not identified on lines 11 through 14 from your accounting books and/or records. Subscript this line as necessary.

Line 16--Total Intensive Care Type Inpatient Hospital--Sum of lines 11 through 15.

Line 17--Total Inpatient Routine Care Services--Sum of lines 10 and 16.

Line 18--Ancillary Services--Enter in the appropriate column revenue from inpatient ancillary services and outpatient ancillary services from your accounting books and/or records.

Line 19--Outpatient Services--Enter in the appropriate column revenue from outpatient ancillary services from your accounting books and/or records.

Line 20--Home Health Agency-- Enter home health agency revenue from your accounting books and/or records. If there is more than one home health agency, include the revenues for all home health agencies on this line.

Line 21--Ambulance Services--Enter from your accounting books and/or records the revenue relative to the ambulance service cost reported on Worksheet A, line 95.

Line 22--Outpatient Rehabilitation Providers--Enter in column 2 only, the revenue generated from CMHC, CORF, outpatient therapy providers (OPTs, OOTs and OSPs), and any other outpatient rehabilitation providers. Subscript this to identify each outpatient rehabilitation provider separately. Obtain this information from your accounting books and/or records.

Line 23--Ambulatory Surgical Center(s)--Enter from your accounting books and/or records the revenue relative to the Ambulatory Surgical Center costs report on Worksheet A, lines 75 and 115.

Line 24--Hospice--Enter from your accounting books and/or records in the appropriate column, the revenue generated from hospice services rendered. If there is more than one hospice, include the revenues for all hospices on this line.

Line 25--Enter in the appropriate column all other revenues not identified on lines 18 through 24.

Line 26--Total Patient Revenues--Enter the sum of lines 17 through 25.

Column 3--For lines 1 - 26, enter the sum of columns 1 and 2, as applicable, in column 3.

Part II - Operating Expenses--Enter the expenses incurred that arise during the ordinary course of operating the hospital complex.

Line 27--Operating Expenses--This amount is transferred from Worksheet A, line 200, column 3.

Lines 28-33--Add (Specify)--Identify on these lines additional operating expenses not included in line 27.

Line 34--Total Additions--Enter on line 34, column 2, the sum of lines 28 to 33, column 1.

Lines 35-39--Deduct (specify)-- Identify on these lines deductions from operating expenses not accounted for included in line 27.

Line 40--Total Deductions--Enter on line 40, column 2, the sum of lines 35 to 39, column 1.

Line 41--Total Operating Expenses--Enter on line 41, column 2, the result of line 27, column 2 plus line 34, column 2, less line 40, column 2.

4040.4 Worksheet G-3 - Statement of Revenues and Expenses--
The worksheets require the reporting of total revenues for the entire facility and total operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statement, submit a reconciliation report with the cost report submission.

Line 1--Total Patient Revenue--Transfer from Worksheet G-2, Part I, line 26, column 3.

Line 2--Less: Allowance and Discounts on Patient's Accounts--Enter on this line total patient revenues not received. This includes:

Provision for Bad Debts,
Contractual Adjustments,
Charity Discounts,
Teaching Allowances,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Line 3--Net Patient Revenues--Subtract line 2 from line 1.

Line 4--Less: Total Operating Expenses--Transfer from Worksheet G-2, Part II, line 41.

Line 5--Net Income from Service to Patients--Subtract line 4 from line 3.

Lines 6-23--Enter on the appropriate line 6 through 23 all other revenue not reported on line 1. Obtain these amounts from your accounting books and/or records.

Line 24--Other (Specify)--Enter from hospital books. Enter all other revenue not reported on lines 6 through 23. Obtain this from your accounting books and/or records. Subscript this line as necessary.

Line 25--Total Other Income--Enter the sum of lines 6 through 24.

Line 26--Total--Enter the sum of lines 5 and 25.

Line 27--Other Expenses (Specify)--Enter all other expenses not reported on lines 6 through 24.

Line 28--Total Other Expenses--Enter the sum of lines 27 and subscripts.

Line 29--Net Income (or Loss) for the Period--Enter the result of line 26 minus line 28.

4041. WORKSHEET H - ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

This worksheet provides for the recording of direct HHA costs such as salaries, fringe benefits, transportation, and contracted services as well as other costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. Obtain these direct costs from your records in columns 1, 2 and 4. All of the cost centers listed do not apply to all agencies**.**

The HHA must maintain the records necessary to determine the split in salary (and employee-related benefits) between two or more cost centers and must adequately substantiate the method used to split the salary and employee-related benefits. These records must be available for audit by your intermediary. Your intermediary can accept or reject the method used to determine the split in salary. Any deviation or change in methodology to determine splits in salary and employee benefits must be requested in writing and approved by your intermediary before any change is effectuated. Where approval of a method has been requested in writing and this approval has been received (prior to the beginning of the cost reporting period), the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until your intermediary determines that the method is no longer valid due to changes in your operations.

Column 1--Enter all salaries and wages (a salary is gross amount paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-1, chapter 21.)) For the HHA in this column for the actual work performed within the specific area or cost center. For example, if the administrator spends 100 percent of his/her time in the HHA and performs skilled nursing care which accounts for 25 percent of that person's time, then 75 percent of the administrator's salary (and any employee-related benefits) is entered on line 5 (administrative and general-HHA) and 25 percent of the administrator's salary (and any employee-related benefits) is entered on line 6 (skilled nursing care). Enter the sum of column 1, lines 1 through 23 on line 24.

Column 2--Enter all payroll-related employee benefits for the HHA in the appropriate cost center in this column. See CMS Pub. 15-1, §§2144 - 2145 for a definition of fringe benefits. Entries are made using the same basis as that used for reporting salaries and wages in column 1. Therefore, 75 percent of the administrator's payroll-related fringe benefits is entered on line 5 (administrative and general - HHA) and 25 percent of the administrator's payroll-related fringe benefits is entered on line 6 (skilled nursing care). Enter the sum of column 2, lines 1 through 23 on line 24.

Report payroll-related employee benefits in the cost center where the applicable employee's compensation is reported. This assignment is performed on an actual basis or upon the following basis:

- FICA based on actual expense by cost center;
- Pension and retirement and health insurance (non union) based on gross salaries of participating individuals by cost centers;
- Union health and welfare based on gross salaries of participating union members by cost center; and
- All other payroll-related benefits based on gross salaries by cost center.

Include nonpayroll-related employee benefits in the administrative and general-HHA cost center. Costs for such items as personal education, recreation activities, and day care are included in the administrative and general - HHA cost center.

Column 3--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly assigned to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identifiable to a particular cost center, enter them on line 4. Enter the sum of column 3, lines 1 through 23 on line 24.

Column 4--Enter the contracted and purchased services amounts in the appropriate cost center in this column. If a contracted/purchased service covers more than one cost center, then include the amount applicable to each cost center on each affected cost center line. Enter the sum of column 4, lines 1 through 23 on line 24.

Column 5--From your books and records, enter on the applicable lines all other identifiable costs which have not been reported in columns 1 through 4. Enter the sum of column 5, lines 1 through 23 on line 24.

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

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

Column 8--Add column 7 to column 6, and extend the net balances to column 8.

Column 9--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §4016.)

Column 10--Adjust the amounts in column 8 by the amounts in column 9, and extend the net balance to column 10.

Transfer the amounts in column 10, lines 1 through 24, to the corresponding lines on Worksheet H-1, Part I, column 0.

Line Descriptions

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

Line 3--Enter the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of the plant, and protecting employees, visitors, and agency property.

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

Line 5--Use this cost center to record the expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs.

Line 6--Skilled nursing care is a service that must be provided by or under the supervision of a registered nurse. The complexity of the service, as well as the condition of the patient, are factors to be considered when determining whether skilled nursing services are required. Additionally, the skilled nursing services must be required under the plan of treatment.

Line 7--Enter the direct costs of physical therapy services by or under the direction of a registered physical therapist as prescribed by a physician. The therapist provides evaluation, treatment planning, instruction, and consultation.

Line 8--These services include (1) teaching of compensatory techniques to permit an individual with a physical impairment or limitation to engage in daily activities; (2) evaluation of an individual's level of independent functioning; (3) selection and teaching of task-oriented therapeutic activities to restore sensory-integrative function; and (4) assessment of an individual's vocational potential, except when the assessment is related solely to vocational rehabilitation.

Line 9--These are services for the diagnosis and treatment of speech and language disorders that create difficulties in communication.

Line 10--These services include (1) assessment of the social and emotional factors related to the individual's illness, need for care, response to treatment, and adjustment to care furnished by the facility; (2) casework services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and (3) assessment of the relationship of the individual's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from facility care.

Line 11--Enter the cost of home health aide services. The primary function of a home health aide is the personal care of a patient. The services of a home health aide are given under the supervision of a registered professional nurse and, if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a case must be made in accordance with a written plan of treatment established by a physician which indicates the patient's need for personal care services. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse and not by the home health aide.

Line 12--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients and for which a separate charge is made. These supplies are generally specified in the patient’s plan of treatment and furnished under the specific direction of the patient’s physician.

Medical supplies which are not reported on this line are those minor medical and surgical supplies which would not be expected to be specifically identified in the plan of treatment or for which a separate charge is not made. These supplies (e.g., cotton balls, alcohol prep) are items that are frequently furnished to patients in small quantities (even though in certain situations, these items may be used in greater quantity) and are reported in the administrative and general (A&G) cost center.

Line 13--Enter the costs of vaccines exclusive of the cost of administering the vaccines. A visit by an HHA nurse for the sole purpose of administering a vaccine is not covered as an HHA visit under the home health benefit, even though the patient may be an eligible home health beneficiary receiving services under a home health plan of treatment. Section 1862(a)(1)(B) of the Act excludes Medicare coverage of vaccines and their administration other than the Part B coverage contained in §1861 of the Act.

If the vaccine is administered in the course of an otherwise covered home health visit, the visit is covered as usual, but the cost and charges for the vaccine and its administration must be excluded from the cost and charges of the visit. The HHA is entitled to separate payment for the vaccine and its administration under the Part B vaccine benefit.

The cost of administering pneumococcal, influenza, and hepatitis B vaccines is reimbursed under the outpatient prospective payment system (OPPS), but the actual cost of the pneumococcal, influenza, and hepatitis B vaccines are cost reimbursed. Additionally, the cost of administering the osteoporosis drugs are included in the skilled nursing visit while the actual cost of the osteoporosis drug is reimbursed at reasonable cost.

Enter on this line the vaccine and drug cost (exclusive of the cost to administer these vaccines) incurred for pneumococcal, influenza, and hepatitis B vaccines as well as osteoporosis drugs.

Some of the expenses includable in this cost center are the costs of syringes, cotton balls, bandages, etc., but the cost of travel is not permissible as a cost of administering vaccines, nor is the travel cost includable in the A&G cost center. The travel cost is non-reimbursable. Attach a schedule detailing the methodology employed to develop the administration of these vaccines. These vaccines are reimbursable under Part B only.

Line 14--Enter the direct expenses incurred in renting or selling durable medical equipment (DME) items to the patient for the purpose of carrying out the plan of treatment. Also, include all the direct expenses incurred by you in requisitioning and issuing the DME to patients.

Lines 15-23--Lines 15-23 identify nonreimbursable services commonly provided by a home health agency. These include home dialysis aide services (line 15), respiratory therapy (line 16), private duty nursing (line 17), clinic (line 18), health promotion activities (line 19), day care program (line 20), home delivered meals program (line 21), and homemaker service (line 22). The cost of all other nonreimbursable services are aggregated on line 23. If you are reporting costs for telemedicine, these costs are to be reported on line 23.50. Use this line throughout all applicable worksheets.

4042. WORKSHEET H-1 - COST ALLOCATION HHA STATISTICAL BASIS

Worksheet H-1, Part I, provides for the allocation of the expenses of each HHA general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the home health agency, i.e., other general service cost centers, reimbursable cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet H, column 10. To facilitate transferring amounts from Worksheet H to Worksheet H-1, Part I, the same cost centers with corresponding line numbers (lines 1 through 24) are listed on both worksheets.

Worksheet H-1, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the home health agency general service cost centers on Worksheet H-1, Part I. If there is a difference between the total accumulated costs reported on the Part II statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part II for reporting any adjustments. See §4020 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number.

To facilitate the allocation process, the general format of Parts I and II are identical. The column and line numbers for each general service cost center are identical on both parts. In addition, the line numbers for each general, reimbursable, and nonreimbursable cost centers are identical on the two parts of the worksheet. The cost centers and line numbers are also consistent with Worksheet H.

The statistical bases shown at the top of each column on Worksheet H-1, Part II, are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

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

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

NOTE: An HHA wishing to change its allocation basis for a particular cost center or the order in which the cost centers are allocated must make a written request to its intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub. 15-1, chapter 23.) In requesting the change, the agency must establish that the alternate basis or sequence of allocation is more accurate than that indicated on the official form. A mere demonstration that a cost allocation is different is not adequate to establish that it is more accurate.

EXCEPTION: A small HHA, as defined in 42 CFR 413.24(d), does not have to request written permission to use the procedures outlined for small HHAs below.

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

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

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

Enter on Worksheet H-1, Part II, line 25, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet H-1, Part I, from the same column, line 24. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet H-1, Part I, column 1, line 1. On Worksheet H-1 exclude from line 24 for each column the first line of that column which is used to compute the unit cost multiplier on line 26 of Worksheet H-1, Part II. On Worksheet H-1, Part I, the first line of each column and the corresponding line 24 of the column must match.

Divide the amount entered on Worksheet H-1, Part II, line 25 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 26. Round the unit cost multiplier to six decimal places.

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

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 24) of all of the cost centers receiving the allocation on Worksheet H-1, Part I, must equal the amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Part I and Part II before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet H-1, Part I, enter in column 6, line 24 the sum of the expenses on lines 6 through 23. The total expenses entered in column 6, line 24, equals the total expenses entered in column 0, line 24.

Column Descriptions

Column 1--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation. Allocate all expenses to the cost centers on the basis of square feet of area occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

If an HHA occupies more than one building (e.g., several branch offices), it may allocate the depreciation and related expenses by building, using a supportive worksheet showing the detail allocation and transferring the accumulated costs by cost center to Worksheet B, column 2.

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

Column 3--Allocate all expenses for plant operation and maintenance based on square feet or dollar value.

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

This basis of allocation is not mandatory and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs which are not directly assigned. However, an HHA must request the use of the alternative method in accordance with CMS Pub. 15-1, §2313. The HHA must maintain adequate records to substantiate the use of this allocation.

Column 5--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments. Therefore, obtain the amounts to be entered on Worksheet H-1, Part II, column 5, from Worksheet H-1, Part I, columns 0 through 4.

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

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet H-1, Part I, column 0) for purposes of determining the basis of allocation (Worksheet H-1, Part II, column 5) of the A&G costs. This procedure may be followed when the HHA contracts for services to be performed for the HHA and the contract identifies the A&G costs applicable to the purchased services. The contracted A&G costs must be added back to the applicable cost center after allocation of the HHA A&G cost before the reimbursable costs are transferred to Worksheet H-2. A separate worksheet must be included to display the breakout of the contracted A&G costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Contractor approval does not have to be secured in order to use the above described method of cost finding for A&G.

Column 6--For lines 6 through 23, add the amounts on each line in columns 4A and 5, and enter the result for each line in this column.

Line 24--Add lines 1 through 23 of columns 0 and 6.

Transfer the amounts in column 6 to Worksheet H-2, Part I, column 0, as follows:

From Worksheet H-1 Part I, Column 6	To Worksheet H-2, Part I, Column 0
Line 6	Line 2
7	3

From Worksheet H-1 Column 6	To Worksheet H-2, Part I Column 0
8	4
9	5
10	6
11	7
12	8
13	9
14	10
15	11
16	12
17	13
18	14
19	15
20	16
21	17
22	18
23	19

4043. WORKSHEET H-2 - ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

4043.1 Part I - Allocation of General Service Costs to HHA Cost Centers.--Worksheet H-2, Part I, provides for the allocation of the expenses of each general service cost center of the hospital to those cost centers which receive the services. Worksheet H-2, Part II provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet H-2, Part I.

Obtain the total direct expenses (column 0, line 20) from Worksheet A, column 7, line 101. Obtain the cost center allocation (column 0, lines 1 through 19) from Worksheet H-1, lines as indicated. The amounts on line 20, columns 0 through 23 and column 25 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 23 and column 25, line 101. Complete the amounts entered on lines 1 through 19, columns 1 through 23 and column 25.

NOTE: Worksheet B, Part I, established the method used to reimburse direct graduate medical education cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 25, excluded the costs of interns and residents, column 25 on this worksheet must also exclude these costs.

Line 21--Enter the unit cost multiplier (column 26, line 1, divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Multiply each amount in column 26, lines 2 through 19, by the unit cost multiplier, and enter the result on the corresponding line of column 27.

4043.2 Part II - Allocation of General Service Costs to HHA Cost Centers -Statistical Basis--To facilitate the allocation process, the general format of Worksheet H-2, Parts I and II, is identical.

The statistical basis shown at the top of each column on Worksheet H-2, Part II, is the recommended basis of allocation of the cost center indicated.

NOTE: If you wish to change your allocation basis for a particular cost center, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub. 15-1, §2313.)

If there is a change in ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices. (See CMS Pub. 15-1, §2313.)

Lines 1 through 19--On Worksheet H-2, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 20--Enter the total of lines 1 through 19 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 101.

Line 21--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, line 101, from the same column used to enter the statistical base on Worksheet H-2, Part II (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 101).

Line 22--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 21 by the total statistic entered in the same column on line 20. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet H-2, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 20, Part I) must equal the total cost on line 21, Part II.

Perform the preceding procedures for each general service cost center.

In column 24, Part I, enter the total of columns 4A through 23.

In column 27, Part I, for lines 2 through 19, multiply the amount in column 26 by the unit cost multiplier on line 21, Part I, and enter the result in this column. On line 20, enter the total of the amounts on lines 2 through 19. The total on line 20 equals the amount in column 26, line 1.

In column 28, Part I, enter on lines 2 through 19 the sum of columns 26 and 27. The total on line 20 equals the total in column 27, line 20.

4044. WORKSHEET H-3 - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs to titles V, XVIII, and XIX. Titles V and XIX use the columns identified as Part A for each program.

4044.1 Part I - Computation of the Aggregate Program Cost.--This part provides for the computation of the total cost and reasonable program cost by discipline based on program patient care visits as required by 42 CFR 413.20, 42 CFR 413.24 and 42 CFR 484.200. HHA services rendered on or after October 1, 2000, §1895 of the Social Security Act requires a home health agency to be paid based on a prospective payment system subject to periodic updates.

Cost Per Visit Computation

Column Descriptions

Column 1--Enter the cost for each discipline from Worksheet H-2, Part I, column 28, lines as indicated. Enter the total on line 7.

Column 2--Where the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the hospital's HHA, complete the amounts entered on lines 2 through 4 in accordance with the instructions contained in §4044.2. Enter the total on line 7.

Column 3--Enter the sum of columns 1 and 2.

Column 4--Enter the total agency visits from your records for each type of discipline on lines 1 through 6. Total visits reported in column 4 reflect visits rendered for the entire fiscal year and equal the visits reported on S-3, Part I, regardless of when the episode was completed.

Column 5--Compute the average cost per visit for each type of discipline. Divide the number of visits (column 4) into the cost (column 3) for each discipline.

Columns 6 and 9--To determine title XVIII, Part A, V, and XIX cost of service, multiply the number of Medicare covered visits in completed episodes made to beneficiaries (column 6) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 9.

NOTE: Statistics in column 7, lines 1 through 7, reflect statistics for services that are part of a home health plan, and thus not subject to deductibles and coinsurance. OBRA 1990 provides for the limited coverage of injectable drugs for osteoporosis. While covered as a home health benefit under Part B, these services are subject to deductibles and coinsurance. Report charges for osteoporosis injections in column 8, line 16, in addition to statistics for services that are not part of a home health plan.

Columns 7 and 10--To determine the Medicare Part B cost of service, not subject to deductibles and coinsurance, multiply the number of Medicare covered visits made in completed episodes to Part B beneficiaries (column 7) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 10. Note if the PS&R reports Part B services separately as "subject to and not subject to" deductibles and coinsurance, add the two reports together for each discipline.

Columns 6, 7, 9, 10 and 12--Enter visits and costs as applicable in columns 6, 7, 9, 10, and 12.

NOTE: The sum of visits reported in columns 6 and 7 must equal the corresponding amounts on Worksheet S-4, column 5, lines 21, 23, 25, 27, 29 and 31, respectively. These visits are reported for episodes completed during the fiscal year.

Columns 8 and 11--Do not use these columns.

Column 12--Enter the total program cost for each discipline (sum of columns 9 and 10). Add the amounts on lines 1 through 6, and enter this total on line 7.

Visits by CBSA--Lines 8 through 14-- Enter for each CBSA by discipline the CBSA code for Medicare program visits reimbursed under HHA PPS for each discipline for lines 8 through 13. Subscript each discipline line to accommodate multiple CBSAs serviced by your home health agency.

Column Descriptions

Column 1--Enter the CBSA code in which the corresponding HHA visits were rendered for each discipline on lines 8 through 13.

Columns 2 and 3--Enter the visit count for each of the corresponding disciplines for each CBSA.

Column 4, lines 8 through 14--These lines are shed to prevent data input.

Line 14--Enter the total program visits for each discipline by adding lines 8 through 13 and subscripts, and enter this total on line 14.

Supplies and Drugs Cost Computation.--Certain services covered by the program and furnished by a home health agency are not included in the cost per visit for apportionment purposes. Since an average cost per visit and HHA PPS do not apply to these items, develop and apply the ratio of total cost to total charges to program charges to arrive at the program cost for these services.

Column 1--Enter the facility costs in column 1, lines 15 and 16, from Worksheet H-2, Part I, column 28, lines 8 and 9, respectively.

Column 2--Enter the shared ancillary costs from Worksheet H-3, Part II, column 3, lines 4 and 5, respectively.

Columns 3 through 5--In column 3, enter the sum total of columns 1 and 2 on lines 15 and 16, respectively. Enter in column 4, lines 15 and 16, respectively, the total charges for such services in accordance with the instructions in §4041, lines 12 and 13. Develop a ratio of total cost (column 3) to total charges (column 4) (from your records), and enter this ratio in column 5.

Columns 6 through 8--Enter in the appropriate column the program charges for drugs and medical supplies charged to patients subject to cost reimbursement. The actual vaccine/drug cost for pneumococcal, influenza, hepatitis B and osteoporosis are cost reimbursed.

Do not enter charges for drugs and medical supplies subject to reimbursement on the basis of a fee schedule.

Line Descriptions for Columns 6 through 8

Line 15--Enter the program covered charges for medical supplies charged to patients for items not reimbursed on the basis of a fee schedule. Do not enter medical supply charges in columns 6, 7, and 8 subject to reimbursement on the basis of a fee schedule or OPPS as all medical supplies are covered under the HHA PPS benefit. If charges are reported on this line, only them for the services rendered in the current fiscal year regardless of when the episode is concluded.

Line 16--This line represents pneumococcal, influenza, and hepatitis B vaccine costs and injectable osteoporosis drugs, but not the administration of these medications. Enter the program covered charges for drugs charged to patients for items not reimbursed on the basis of a fee schedule or OPPS. Enter in column 7 the program charges for pneumococcal vaccine and influenza vaccine exclusive of their respective administration costs. Enter in column 8 the program charges for hepatitis B vaccine and injectable osteoporosis drugs exclusive of their respective administration costs.

Columns 6 and 9--To determine the Medicare cost, multiply the program charges (column 6) by the ratio (column 5) for each line. Enter the product in column 9.

Columns 7 and 10--To determine the Medicare Part B cost, multiply the Medicare charges (column 7) by the ratio (column 5) for each line. Enter the product in column 10.

Columns 8 and 11--To determine the Medicare Part B cost, multiply the Medicare charges (column 8) by the ratio (column 5) for each line. Enter the result in column 11.

4044.2 Part II - Apportionment of Cost of HHA Services Furnished by Shared Hospital Departments.--Use this part only where the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the hospital's HHA. Subscript lines 1-5, as applicable, if subscripted on Worksheet C, Part I.

Column 1--Where applicable, enter in column 1 the cost to charge ratio from Worksheet C, Part I, column 9, lines as indicated.

Column 2--Where hospital departments provide services to the HHA, enter on the appropriate lines the charges applicable to the hospital-based home health agency.

Column 3--Multiply the amounts in column 2 by the ratios in column 1, and enter the result in column 3. Transfer the amounts in column 3 to Worksheet H-3, Part I as indicated. If lines 1-5 are subscripted, transfer the aggregate of each line.

4045. WORKSHEET H-4 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

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

Worksheet H-4 consists of the following two parts:

Part I - Computation of the Lesser of Reasonable Cost or Customary Charges
Part II - Computation of HHA Reimbursement Settlement

4045.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--Services not paid based on a fee schedule or OPPS are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the providers for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in the 42 CFR 413.13(e).

NOTE: Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider only completes lines 1, 2, and 9 of Part I. Transfer the resulting cost to line 10 of Part II.

Line Descriptions

Line 1--This line provides for the computation of reasonable cost reimbursed program services. Enter the cost of services from Worksheet H-3, Part I as follows:

To Worksheet H-4, Line 1	From Worksheet H-3,
Col. 1, Part A	Part I, col. 9, line 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, line 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, line 16

The above table reflects the transfer of the cost of pneumococcal and influenza vaccines from Worksheet H-3, Part I, column 10, line 16, to column 2 of this worksheet, and the cost of hepatitis B vaccines and injectable osteoporosis drugs from worksheet H-3, Part I, column 11, line 9 to column 3 of this worksheet.

Lines 2 through 6--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1. Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-1, chapter 21) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-1, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Enter only the charges for applicable Medicare covered pneumococcal, influenza and hepatitis B vaccines and injectable osteoporosis drugs which are all cost reimbursed.

Line 2--Enter from your records in the applicable column the program charges for Part A, Part B not subject to deductibles and coinsurance, and Part B subject to deductibles and coinsurance.

Enter in column 2 the charges for Medicare covered pneumococcal and influenza vaccines (from worksheet H-3, line 16, column 7). In column 3, enter the charges for Medicare covered hepatitis B vaccines and osteoporosis drugs (from worksheet H-3, line 16, column 8).

Lines 3 through 6--These lines provide for the reduction of program charges when the provider does not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fails to make reasonable efforts to collect such charges from those patients. If line 5 is greater than zero, multiply line 2 by line 5, and enter the result on line 6. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 3, 4, and 5, but enter on line 6 the amount from line 2. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 6 exceed the actual charges on line 2.

Line 7--Enter in each column the excess of total customary charges (line 6) over the total reasonable cost (line 1). In situations when, in any column, the total charges on line 6 are less than the total cost on line 1 of the applicable column, enter zero on line 7.

Line 8--Enter in each column the excess of total reasonable cost (line 1) over total customary charges (line 6). In situations when, in any column, the total cost on line 1 is less than the customary charges on line 6 of the applicable column, enter zero on line 8.

Line 9--Enter the amounts paid or payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer. There are several situations under which program payment is secondary to a primary payer. Some of the most frequent situations in which the Medicare program is a secondary payer include:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are considered to be nonprogram services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. The provider notes this on no-pay bills submitted in these situations.) The patient visits and charges are included in total patient visits and charges, but are not included in program patient visits and charges. In this situation, no primary payer payment is entered on line 9.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payer payment does not satisfy the beneficiary's liability, include the covered days and charges in both program visits and charges and total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 9 the primary payer payments that are credited toward the beneficiary's deductible and coinsurance. The primary payer rules are more fully explained in 42 CFR 411.

4045.2 Part II - Computation of HHA Reimbursement Settlement.--

Line 10--Enter in column 1 the amount in Part I, column 1, line 1 less the amount in column 1, line 9. Enter in column 2 the sum of the amounts from Part I, columns 2 and 3, line 1 less the sum of the amounts in columns 2 and 3 on line 9. This line will only include pneumococcal, influenza, hepatitis B and injectable osteoporosis drugs reduced by primary payor amounts.

Lines 11 through 24--Enter in column 1 only for lines 11 through 14, as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 only on lines 15 and 16, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter on lines 18 through 20 the total DME, oxygen, prosthetics and orthotics payments, respectively, associated with home health PPS services (bill types 32 and 33). For lines 18 through 20 do not include any payments associated with services paid under bill type 34X. Obtain these amounts from your PS&R report.

Line 21--Enter in column 2 the Part B deductibles billed to program patients. Include any amounts of deductibles satisfied by primary payer payments.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 21 and primary payment amounts in column 3, line 9 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 23--If there is an excess of reasonable cost over customary charges in any column on line 8, enter the amount of the excess in the appropriate column.

Line 25--Enter in column 2 all coinsurance billable to program beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of the costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 25 and primary payment amounts in column 3, line 9 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 27--Enter the allowable bad debts in the appropriate columns. If recoveries exceed the current year's bad debts, line 27 will be negative.

Line 28--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 27.

Line 29--Enter the result of line 26 plus 27.

Line 30--Enter any other adjustments. For example, enter an adjustment from changing the recording of vacation pay from the cash basis to accrual basis. (See CMS Pub. 15-1, §2146.4.)

Line 31--Enter the result of line 29 plus or minus line 30.

Line 32--Enter the interim payment amount from Worksheet H-5, line 4. For contractor final settlement, report on line 33 the amount from Worksheet H-5, line 5.99. For titles V and XIX, enter the interim payments from your records.

Line 34--The amounts show the balance due the provider or the program. Transfer to Worksheet S, Part III, line 9 as applicable.

Line 35--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) A schedule showing the supporting details and computations for this line must be attached.

4046. WORKSHEET H-5 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

The column headings designate two categories of payments: Part A and Part B.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor. Do not include on this worksheet any payments made for DME or medical supplies charged to patients that are paid on the basis of a fee schedule.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA for cost and HHA PPS reimbursed services. The amount entered reflects payments for all episodes concluded in this fiscal year. **Do not include any payments received for fee scheduled services.** The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from your interim payments due to an offset against overpayments applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

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

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

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to the appropriate column on Worksheet H-5, Part II, line 40.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET H-5. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR CONTRACTOR.

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

Line 6--Enter in column 2 the amount on Worksheet H-4, Part II, column 1, line 42. Enter in column 4 the amount on Worksheet H-4, Part II, column 2, line 42.

Line 7--Enter the net settlement amount (balance due to you or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening. Enter the total of the amounts on lines 4, 5.99, and 6.

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

Line 8--Enter the contractor name and the contractor number in columns 1 and 2, respectively.

4047. ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

This worksheet provides for the analysis of the direct and indirect expenses related to the renal dialysis cost centers, allocation of cost between inpatient and outpatient renal dialysis services where separate cost centers are not maintained, and the allocation of the cost to the various modes of outpatient dialysis treatment. The ancillary renal dialysis cost center is serviced by the general cost centers and includes all reimbursable cost centers within the provider organization which provide services to the renal dialysis department. The cost used in the analysis for the renal dialysis department is obtained, in part, from Worksheets A; B, Part I; and C. Complete a separate Worksheet I series for lines 74 and 94 of Worksheet A. In other words, complete one Worksheet I series for line 74 and one for line 94, if appropriate.

4048. WORKSHEET I-1 - ANALYSIS OF RENAL COSTS

This part provides for recording the direct salaries and other direct expenses applicable to the total inpatient and outpatient renal dialysis cost center or outpatient renal dialysis cost center where you maintain a separate and distinct outpatient renal dialysis cost center. If you have more than one renal dialysis department, and/or more than one home dialysis department, submit one Worksheet I series combining the renal dialysis departments and a separate Worksheet I series combining the home dialysis departments. You must also have on file, as supporting documentation, a Worksheet I series for each renal dialysis department and for each home dialysis department along with the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-1, §2720. Do not combine the cost of the renal dialysis with home program dialysis reported separately on Worksheet A, lines 74 and 94.

This worksheet also provides for recording the indirect expenses applicable to the total renal or outpatient renal dialysis department obtained from Worksheet B, Part I, columns 1 through 23, line 74 as adjusted for post stepdown adjustments, if any. When completing a separate Worksheet I for home program dialysis, transfer the direct expenses from Worksheet B, Part I, columns 1 through 23, line 94. Do not combine the cost of the renal department with home program dialysis. These costs are listed separately on Worksheet A, lines 74 and 94, respectively.

Column Descriptions

Column 1--Enter on lines 1 through 8 the amounts included from Worksheet A, column 7 for salaries only. Enter on lines 10 through 16 and 18 through 26 the amounts from Worksheet B, Part I, all columns for lines 74 and 94. The subtotal on Worksheet I-1, line 27 agrees with the sum of Worksheet B, Part I, column 26, line 74 or line 94 if a home dialysis cost center was established and used on Worksheet A.

Column 2--This column lists the statistical bases for allocating costs on Worksheet I-3.

Column 3--Enter paid hours per type of staff listed on lines 1 through 6.

Column 4--Enter full time equivalents by dividing column 3 by 2080 hours.

Line Descriptions

Lines 1 through 6--Enter on these lines the direct patients care salaries after adjustments and reclassification that you reported in column 7 of Worksheet A. Direct patient care salary includes only the salary of staff providing direct patient care services. Also include fee paid to non-employees providing direct patient care services. Time spent furnishing administrative or management services by direct patient care personnel is reported on line 8, non-patient care salary.

Line 7--Include on this line amounts paid to physicians for their administrative services of managing the renal department. These payments are subject to the limitation contained in §2723.3 of CMS Pub. 15-1. Also include payments to physicians for their medical services if the box on line 21 of Worksheet S-5 is marked the initial method. A complete description of the initial method is in CMS Pub. 15-1, §2715. For a renal provider to be paid under the initial method, all renal physicians at the provider must elect the initial method. Under the initial method, renal physicians are paid by the provider for their routine renal medical services and the provider's composite payment rate is increased according to 42 CFR 414.313. No payment to physicians for patient medical services should appear on this line if the monthly capitation payment (MCP) box is marked on Worksheet S-5. Under the MCP, carriers pay physicians directly for their medical services.

Line 8--Enter the amount of salaries paid non-patient care personnel after reclassifications and adjustments that you report in column 7 of Worksheet A.

Lines 10 through 16--Include on the appropriate lines costs directly charged to the renal department after reclassifications and adjustments. Report other direct costs on line 16 that cannot be specifically identified on lines 11 through 15.

Lines 17--Add lines 9 through 16. This total in column 1 should agree with the total on Worksheet A, column 7 for line 74 or line 94, as appropriate.

Lines 18 through 26--Enter the allocated general service costs from Worksheet B, Part I, lines 74 or 94 as listed in the chart below.

NOTE: Line 25 should exclude the costs of EPO and Aranesp administered to ESRD patients in the renal department and home program identified on Worksheet B-2, lines 1, 2, 3 or 4.

Worksheet I-1, Part I, Column 1, Line Number	General Service Cost Centers	Worksheet B, Part I, Lines 71 or 94, Columns
18	Capital-Related Costs-Buildings and Fixtures	1
19	Capital-Related Costs-Moveable Equipment	2
20	Employee Benefits	4
21	Administrative and General	5
22	Maintenance & Repairs, Operation of Plant and Housekeeping	Sum of 6, 7, and 9
23	Medical Education Programs	Sum of 20, 21, 22, 23, and 25 (medical education only)

24	Central Services & Supplies	14
25	Pharmacy	15
26	Other Allocated Costs	Sum of 8, 10, 11, 12, 13, 16, 17, 18, and 19

Line 27--Add lines 18 through 26. This total should agree with the total on Worksheet B, column 26, line 74 or line 94 if a home dialysis cost center was established, less the adjustments for EPO and Aranesp reported on Worksheet B-2, lines 1, 2, 3, or 4 as appropriate.

Lines 28, 29, and 30--These lines provide for the allocation of costs associated with routine dialysis services furnished to renal patients from other ancillary departments. Enter the cost to charge ratio from Worksheet C, Part I, column 9. Payment for routine laboratory services, as defined in the Medicare Benefit Policy Manual (100-02 IOM), chapter 11 (ESRD), §30.2, is paid for under the composite payment rate. No separate payment is made for routine laboratory tests. The costs of these services are allocated to the renal department based on the provider's laboratory cost to charge ratio from Worksheet C, Part I, column 9, line 60. Providers must maintain a log of routine laboratory charges for allocating routine laboratory costs to the renal department. The lab charges reported on Worksheet C do not include the lab charges for ESRD therefore those charges must be grossed up in accordance with PRM-1,§ 2314. The cost to charge ratio must be recalculated and applied against the charges reported in column 3 of this worksheet. Do not gross up ESRD charges. Instead, the cost to charge ratio for lab charges reported on Worksheet C will be used.

Line 31--Enter the sum lines 27 through 30.

4049. WORKSHEET I-2 - ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

The purpose of this schedule is to allocate costs to the different services furnished in the renal department. Line 1 combines the costs reported on Worksheet I-1 for allocating costs to the different services furnished in the renal department.

Line 1--Add the costs from Worksheet I-1, and transfer these amounts to line 1 in the following manner:

Worksheet I-2	Worksheet I-2 Column	Worksheet I-1
Capital & Main Building Costs	1	Sum of lines 11, 18, and 22
Capital, Machine & Repair Costs	2	Sum of lines 12, 13, and 19
Registered Nurses Direct Patient Care Salary	3	Line 1
Other Direct Patient Care Salary	4	Sum of lines 2, 3, 4, 5, and 6
Employee Benefits	5	Sum of lines 10 and 20
Drugs	6	Sum of lines 15 and 25
Medical Supplies	7	Sum of lines 14 and 24
Routine Ancillary Services	8	Sum of lines 28, 29, and 30
Subtotal	9	Not applicable
Overhead	10	Sum of lines 7, 8, 16, 21, and 26

Complete columns 1 through 8 and 10 in conjunction with Worksheet I-3, which contains the statistical bases for allocating costs to the proper lines. For each line item in columns 1 through 8 and 10, multiply the statistic entered in the corresponding line and column of Worksheet I-3 by the unit cost multiplier on line 18.

Lines 2 through 11--These lines identify the type of dialysis treatments that are paid for under the composite payment rate system. The total costs (column 11) for these individual dialysis services are transferred to Worksheet I-4.

Transfer the total on Worksheet I-2, column 11 to Worksheet I-4 per the following instructions.

From Worksheet I-2, Column 11	To Worksheet I-4, Column 2
Line 2	Line 1
Line 3	Line 2
Line 4	Line 3

Line 5	Line 4
Line 6	Line 5
Line 7	Line 6
Line 8	Line 7
Line 9	Line 8
Line 10	Line 9
Line 11	Line 10

If you complete a Worksheet I-2 for the renal department and the home program dialysis department, complete a separate Worksheet I-4.

Lines 12 through 16--These services are not paid for under the composite payment rate system. Therefore, the costs of these services are not transferred to Worksheet I-4. Exclude these costs in the calculation of reimbursement composite payment rate bad debts. (See 42 CFR 413.170(e).)

Line 12.--Report inpatient costs. Inpatient dialysis services are paid under the DRG system for Medicare patients.

Line 13.--Report the costs of support services furnished to Method II home patients. Payment for Method II home patient dialysis services are subject to the rules in 42 CFR 414.330. Under Method II, a renal provider is only allowed to bill for support services and not dialysis equipment or supplies. Payment for support services is limited to the lower of the provider's reasonable cost or the payment limit as defined in the regulation, which is $121.15 per patient per month. This amount includes payment for support services and routine laboratory tests furnished to home patients.

Line 14.--Report the direct costs of EPO net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter EPO amount for informational purposes only. This amount is not included in the total on line 17.

Line 15.--Report the direct costs of Aranesp net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes Aranesp cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter Aranesp amount for informational purposes only. This amount is not included in the total on line 17.

Line 16.--Report the costs of other services furnished and billed in the renal department that are paid for outside the composite payment rate.

Line 17--Add columns and enter totals. Since lines 14 and 15, column 9 are shaded, no costs for EPO and Aranesp are included in the total for line 17, column 9 and column 6, lines 14 and 15 should be excluded from total.

Line 18--Enter the amount of medical educational program costs from Worksheet I-1, line 23. Payment for medical educational program costs allocated to the renal department is not included in the composite payment rate.

Line 19--Add lines 17 and 18. This total agrees with the sum of Worksheet I-1, column 1, line 31.

Column Description

Columns 1 through 8--For each line, multiply the unit cost multiplier on Worksheet I-3, line 18 by the statistical base, and enter the result on the corresponding line and column on Worksheet I-2.