

4108. WORKSHEET S-6 - SKILLED NURSING FACILITY BASED CMHC
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 statistical records for proper determination of costs payable under the Medicare program. The statistics required to be reported on this worksheet pertain to a skilled nursing facility-based CMHC provider.

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

Enter the number of hours in your normal work week in the space provided above line 1.

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

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

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

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

4109. WORKSHEET S-7 – Part I - PPS Statistical Data for SNF.--Use this form to report the Medicare days of the provider by Resource Utilization Group – RUG.

Column Descriptions

Column 1--The M3PI revenue code designations are already entered in this column.

Column 2 - The only data required to be reported are the days associated with each RUG. These days should be reported in column 2. The calculation of the total payment for each RUG is not required. All payment data is reported as a total amount paid under the RUG PPS payment system on Worksheet E, Part I, line 7, and is generated from the PS&R or your records. The total *days* on line 100 must agree with the amount on Worksheet S-3, Part I, column 4, line 1.

4109.1 Part II: Lines 101 through 105 --These lines provide for furnishing certain information concerning the provider. All applicable items must be completed.

Enter in column 1 the amount, and in column 2 the percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. For each line, indicate in column 3 whether the increased RUG payments received reflects increases associated with direct patient care and related expenses by responding “Y” for yes. Indicate “N” for no if there was no increase in spending in any of these areas. If the increased spending is in an area not previously identified in areas one through four, identify on the “Other (Specify)” line(s), the cost center(s) description and the corresponding information as indicated above.

4110. WORKSHEET S-8 - HOSPICE IDENTIFICATION DATA

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

4110.1 Part I - Enrollment Days Based on Level of Care.

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

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

Line 1.--Continuous Home Care Day - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.

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

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

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

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

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

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

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

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

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

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

4110.2 Part II --Census Data

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

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

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

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

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

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

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

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

Average LOS Medicare	54.67 Days
Medicaid Days Patient D (92)	92 Days
Medicaid Patient	1
Average LOS Medicaid	92 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 6, line 8.

Line 9.--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (see CMS Pub. 100.02 Chapter 9, §10). However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and is counted twice.

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

4113. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, C, and D, the line numbers are consistent, and the total line is set at number 100). All of the cost centers listed do not apply to all providers using these forms. An "X" on the cost center line identifies ONLY those cost centers which may be used for the Simplified Method cost report.(See 42 CFR Section 413.321.)

Do not include on this worksheet items not claimed in the cost report but which you wish nevertheless to claim and contest because they conflict with the regulations, manuals, or instructions. Enter amounts on the appropriate settlement worksheet (Worksheet E, Part I, Part A, line 22, Part B, line 41; Worksheet E, Part II, line 35; Worksheet H-4, Part II, line 35; Worksheet J-3, line 20; or Worksheet I-3, line 30).

If the cost elements of a cost center are separately maintained on your books, you must maintain a reconciliation of the costs per the accounting books and records to those on this worksheet. The reconciliation is subject to review by the 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, you may do so by adding additional lines to the cost report. When an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line description. Identify the added line as a numeric (only) subscript of the immediately preceding line. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02. If additional lines are added for general service cost centers, add corresponding columns for cost finding on Worksheets B, B-1, H-1 Parts I & II, H-2-Parts I & II, J-1, and K-5.

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

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. Form CMS-2540-10 provides for preprinted cost center descriptions on Worksheet A. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. Nonstandard cost center descriptions have been identified through analysis of frequently used labels.

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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 four digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. You are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center table # 5, in §4195.

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

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

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

The net total of the entries in column 4 must equal zero on line 100.

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 100.

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 100 must equal Worksheet A-8, column 2, line 100.

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

Line Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lines 16 through 29.—These lines are reserved for future use.

Lines 30 through 33.--These lines are for the inpatient routine service cost centers.

Line 33.--This cost center accumulates the direct costs incurred in maintaining long term care services not specifically required to be included in other cost centers. A long term care unit refers to a unit where the average length of stay for all patients is 25 days or more. The beds in this unit are not certified for titles V, XVIII, or XIX.

Lines 34 through 39.—These lines are reserved for future use.

Lines 40 through 52.--These lines are for the ancillary cost centers.

Line 51.--The support surfaces which are classified as ancillary are those listed under the durable medical equipment regional carrier's (DMERC) level 2 and level 3 support surfaces categories. For example, support surfaces which qualify under DMERC's level 2 support surface criteria are low air loss mattress replacement and overlay systems. An example of support surfaces which qualify under DMERC's level 3 support surface criteria is air fluidized beds.

NOTE: Items listed in the DMERC level 1 support surface criteria do not qualify for this category because they are inexpensive and common enough to be considered routine services in all cases.

Lines 53 through 59.—These lines are reserved for future use.

Lines 60 through 63.--These lines are for outpatient cost centers.

Lines 64 through 69.—These lines are reserved for future use.

Lines 70 through 74.--These lines are for other reimbursable cost centers.

Lines 70.--This line is to accumulate costs which are specific to HHA services.

Line 71.--Enter on this line the ambulance cost where the ambulance is owned and operated by the facility.

Line 72.--Use this line if your SNF operates an intern and resident program not approved by Medicare.

Line 73.--This cost center accumulates the direct costs attributable to a community mental health center (CMHC). Direct costs normally include such cost categories as are listed on the applicable Worksheet J-1, Part I, lines 1 through 21.

Lines 74 through 79.—These lines are reserved for future use.

Lines 80 through 84.--These lines are for special purpose cost centers.

Line 80.--This cost center includes the costs of malpractice insurance premiums and self insurance fund contributions. Also, include the cost if you pay uninsured malpractice losses incurred either through deductible or coinsurance provisions, as a result of an award in excess of reasonable coverage limits, or as a governmental provider. After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.

Line 81.--After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.

Line 82.--Only include utilization review costs of the SNF. Either reclassify or adjust all costs depending on the scope of the review. If the scope of the review covers all patients, reclassify all allowable costs in column 4 to administrative and general expenses (line 4). If the scope of the review covers only Medicare patients or Medicare, title V, and title XIX patients, then (1) in column 4, reclassify to administrative and general expenses all allowable costs other than physician compensation and (2) deduct, in column 6, the compensation paid to the physicians for their personal services on the utilization review committee. After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.

Line 83.--This cost center accumulates the direct costs attributable to a hospice.

Lines 84 through 89.—These lines are reserved for future use.

Lines 90 through 95.--Use these lines to record the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers than those shown, add a subscript consisting of a numeric subscript code to one or more of these lines. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, if the expense (direct and all applicable overhead) attributable to any nonallowable cost area is so insignificant as not to warrant establishment of a nonreimbursable cost center and the sum total of all such expenses is so insignificant as not to warrant the establishment of a composite nonreimbursable cost center, adjust these expenses on Worksheet A-8. (See CMS Pub. 15-I, §2328.)

Line 92.--Establish a nonreimbursable cost center to accumulate the cost incurred by the provider for services related to the physicians' private practice. Examples of such costs include depreciation costs for the space occupied, movable equipment used by the physicians' offices, administrative services, medical records, housekeeping, maintenance and repairs, operation of plant, drugs, medical supplies, and nursing services.

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

4114. WORKSHEET A-6 - RECLASSIFICATIONS

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

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

Examples of reclassification that may be needed are:

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

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

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

4. Interest expense included on Worksheet A, column 3, line 81 and applicable to funds borrowed for administrative and general purposes (e.g., operating expenses) or for the purchase of buildings and fixtures or movable equipment.

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

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

7. Utilization review costs. Administrative costs related to utilization review and the costs of professional personnel other than physicians are allowable costs and are apportioned among all users of the SNF, irrespective of whether utilization review covers the entire patient population. Reclassify these costs from Worksheet A, column 3, line 82 to administration and general costs.

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

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

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

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

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

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

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

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

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

14. Malpractice insurance cost to administrative and general cost.

4115. WORKSHEET A-7 - ANALYSIS OF CAPITAL ASSETS

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 SNF. However, examine the cost finding elections made at the time you submit the cost report to consider the cost finding treatment of HHA, and hospice, distinct parts, 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).

4115.1 Analysis of Changes Capital Asset Balances.--This 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 complex (certified and non-certified components). However, only include in Part I assets that relate to SNF 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 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.

Line Descriptions

Line 8--If you have included in lines 1 through 7 of Part I any of the following, enter those amounts on line 8.

- 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 9--Enter line 6 minus line 8.

4116. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 22.--When depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on line 22 and/or line 23. (See CMS Pub. 15-I, chapter 1.)

Line 24.--Enter any additional adjustments which are required under the Medicare principles of reimbursement. Appropriately label the lines to indicate the nature of the required adjustments.

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

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

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

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

Line 100.--Enter the sum of lines 1 through 24. TRANSFER THE AMOUNTS IN COLUMN 2 TO WORKSHEET A, COLUMN 6.

4117. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

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

Complete this worksheet if you answered yes to question 42 on Worksheet S-2, and there are costs included on Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10. If there are no costs included on Worksheet A which resulted from transactions with related organizations, DO NOT complete Worksheet A-8-1.

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

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

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

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

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

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

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

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

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

4118. 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. (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 incurred by you. 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 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 that are reimbursable on a reasonable cost basis.

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

Column Descriptions

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

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

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

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

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

Column 4.--Enter the amount of total remuneration included in column 3 which is applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B carrier in accordance with 42 CFR 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, which is 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 415.60(b) requires that physician compensation be allocated between physician services to patients, to the provider, and nonallowable services such as research. Physicians' nonallowable services must not be included in columns 4 or 5. The instructions for column 18 ensure that the compensation for nonallowable services which is included in column 3 is correctly eliminated on Worksheet A-8.

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

The final notice on the annual update to RCE limits published in the Federal Register, Vol. 50, No. 34, February 20, 1985, on page 7126 contains Table 1, Estimates of FTE Annual Average Net Compensation Levels for 1984. 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 which are allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040.

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

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

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

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

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

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

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

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

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

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

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

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

Line Descriptions

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

4120. WORKSHEET B, PART I - COST ALLOCATION - GENERAL SERVICE COSTS
AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

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

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

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

To facilitate the allocation process, the general format of Worksheets B, Part I and B-1 are identical. Each general service cost center has the same line number as its respective column number across the top. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers of each ancillary, routine, other reimbursable, and non-reimbursable cost centers are identical on the two worksheets. The cost centers and line numbers are consistent with Worksheet A. Note that lines 80, 81 and 82 from Worksheet A are not needed on Worksheets B and B-1.

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

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

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

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

If the amount of any cost center on Worksheet A, column 7 has a credit balance, this must be shown as a credit balance on Worksheet B, Part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to such cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is to be allocated, such general service cost center must not be allocated. Rather, enter the credit balance in parentheses on line 99 as well as on the first line of the column and on line 100. This enables column 18, line 100, to crossfoot to columns 0 and 3A, line 100. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, Part I, column 18, do not carry forward such credit balance to Worksheet C.

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

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

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

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

Enter on line 102 of Worksheet B-1 the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B, Part I, from the same column and line number used to enter the statistical base on Worksheet B-1 (in the case of Capital Related - Buildings and Fixtures, this amount is on Worksheet B, Part I, column 1, line 1).

Divide the amount entered on line 102 by the total statistics entered in the same column on the first line. Enter the resulting unit cost multiplier on line 103. The unit cost multiplier must be rounded to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B, Part I, in the corresponding column and line. (See §4100.1 for rounding standards.)

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 100) of all of the cost centers receiving the allocation on Worksheet B, Part I, must equal the amount entered on the first line. The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Worksheets B, Part I, and B-1 before proceeding to the next cost center.

If a general service cost center has a credit balance at the point it is allocated on Worksheet B, Part I, such general service cost center must not be allocated. However, the statistic must be displayed departmentally. No unit cost multiplier is calculated for lines 103 and 105 on Worksheet B-1.

Use lines 104 and 105 of Worksheet B-1 in conjunction with the allocation of capital-related cost on Worksheet B, Part II. Complete line 104 for all columns after Worksheets B, Part I, and B-1 have been completed and the amount of direct and indirect capital-related cost has been determined on Worksheet B, Part II. Line 105 for all columns is the unit cost multiplier used in allocating the direct and indirect capital-related cost on Worksheet B, Part II. Compute the unit cost multiplier after the amounts to be entered on line 104 have been determined by dividing the capital-related cost recorded on line 104 by the total statistics entered in the same column on the first line. Round the unit cost multiplier to six decimal places. (See instructions for Worksheet B, Part II, for the complete methodology and exceptions.)

After the costs of the general service cost center have been allocated on Worksheet B, Part I, enter in column 16 the sum of the costs in columns 3A through 15 for lines 30 through 95.

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

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

After the adjustments have been made on Worksheet B, Part I, column 17, adjust the amounts in column 16 by the amounts in column 17 and extend the new balances to column 18 for each line. The total costs entered in columns 18, line 102, must equal the total costs entered in column 0, line 102.

Transfer the totals in column 18, lines 40 through 52 (ancillary service cost centers), lines 60 through 63 (outpatient service cost centers), and line 71, to Worksheet C, column 1, lines 40 through 71 respectively.

Transfer the totals in column 18:
From Worksheet B, Part I, Column 18

To Worksheet D-1, Line 5

Line 30, SNF

For SNF

Line 31, NF
Sum of lines 30 and 31

For Titles V or XIX. For NF

Line 32, ICF/MR

For Title XIX. For ICF/MR

The non-reimbursable cost center totals, lines 90 through 95, are not transferred.

Column Descriptions

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

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

Column 4.--Allocate the administrative and general expenses on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-1, column 4, line 4, is the difference between the amount on Worksheet B, Part I, column 3A and the amount entered on Worksheet B-1, column 4A.

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

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