

4131. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Complete an analysis of payments to providers for services furnished for each component of the health care complex which has a separate provider number. Worksheet E-1 is used by the SNF when the provider has received Medicare interim payments made by the contractor. It must not be completed for purposes of reporting interim payments for titles V or XIX.

The following components use one of the indicated worksheets instead of Worksheet E-1:

- o SNF-based HHAs use Worksheet H-5;
- o SNF-based RHC/FQHCs use Worksheet I-5; and
- o SNF-based CMHC's use Worksheet J-4.

The column headings designate two categories of payments:

Columns 1 and 2 - Inpatient Part A
Columns 3 and 4 - Part B

You should complete lines 1 through 4. Your contractor will complete lines 5 through 9. All amounts reported on this worksheet must be for services, the cost of which is included in this cost report.

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

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to you. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must include amounts withheld from your interim payments due to an offset against overpayments to you, applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) 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.

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 the total from column 2 – for Part A PPS Reimbursement to Worksheet E, Part I, line 18, and from column 4 for Part B, to Worksheet E, Part I, Line 37.

Transfer the total title V or title XIX from column 2 to Worksheet E, Part II, line 33.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 9 ARE FOR CONTRACTOR USE ONLY.

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

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

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

Line 7.--The sum of lines 4, 5.99, and 6, column 2, for inpatient Part A must equal Worksheet E, Part I, Part A, line 17. For Part B, the amount in column 4 must equal Worksheet E, Part B, line 36.

4140. 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.

4140.1 Worksheet G - Balance Sheet--If the lines on the Worksheet G are not sufficient, use lines 5 (Other receivables), 9 (Other current assets), 41 (Other current liabilities), and 47 (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 provider. The Skilled Nursing Facility 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 40 (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 40, 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 SNF 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 SNF 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 SNF 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 SNF 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 SNF operations.

Line 26--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 SNF 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, and 24--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 29--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 30--Deposits on Leases--Report the amount of deposits on leases. This includes security deposits.

Line 31--Due to Owners/Officers--Report the amount loaned to the SNF by owners and/or officers.

Line 32--Other Assets--This is the amount of assets not reported on line 9 (other current assets) or any other line 1 through 31. This could include intangible assets such as goodwill, unamortized loan costs and other organization costs.

Line 33--Total Other Assets--Sum of lines 29 through 32.

Line 34--Total Assets--Sum of lines 11, 28 and 33.

Line 35--Accounts Payable--This amount reflects the amounts due trade creditors and others for supplies and services purchased.

Line 36--Salaries, Wages and Fees Payable--This amount reflects the actual or estimated liabilities of the SNF for salaries and wages/fees payable.

Line 37--Payroll Taxes Payable--This amount reflects the actual or estimated liabilities of the SNF for amounts payable for payroll taxes withheld from salaries and wages, payroll taxes to be paid by the SNF and other payroll deductions, such as hospitalization insurance premiums.

Line 38--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 39--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 40--Accelerated Payments--Accelerated payments are payments not yet due to be repaid to the contractor.

Line 41--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 42--Other Current Liabilities--This line is used to record any current liabilities not reported on lines 35 through 41.

Line 43--Total Current Liabilities--Enter the sum of lines 35 through 41.

Line 44--Mortgage Payable--This amounts reflects the long-term financing obligation used to purchase real estate/property.

Line 45--Notes Payable--These amounts reflect liabilities of the SNF to vendors, banks and other, evidenced by promissory notes due and payable longer than one year.

Line 46--Unsecured Loans--These amounts are not loaned on the basis of collateral.

Line 48--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 44 through 48.

Line 51--Total Liabilities--Enter the sum of lines 43 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 34 equals the amount on line 60.

4140.2 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.

4140.3 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 SNF-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--SNF--Enter revenues generated by the SNF component of the complex. Obtain these amounts from your accounting books and/or records.

Line 2--Nursing Facility--Enter the nursing facility revenue from your accounting books and/or records.

Line 4--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 5--Total General Inpatient Routine Care--Sum of lines 1 through 4.

Line 6--Ancillary Services--Enter in the appropriate column revenue from inpatient ancillary services and outpatient ancillary services from your accounting books and/or records.

Line 7--CMHC--Enter in the appropriate column revenue from outpatient ancillary services from your accounting books and/or records.

Line 8--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 9--Ambulance Services--Enter from your accounting books and/or records the revenue relative to the ambulance service cost reported on Worksheet A, line 71.

Line 10--Outpatient Rehabilitation Providers--Enter in column 2 only, the revenue generated from CMHC, 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 11--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 73.

Line 12--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 13--Total Patient Revenues--Enter the sum of lines 6 through 12.

Column 3--For lines 1 - 13, 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 1--Operating Expenses--This amount is transferred from Worksheet A, line 100, column 3.

Lines 2-7--Add (Specify)--Identify on these lines additional operating expenses not included in line 1.

Line 8--Total Additions--Enter on line 8, column 2, the sum of lines 2 to 7, column 1.

Lines 9-13--Deduct (specify)-- Identify on these lines deductions from operating expenses not accounted for included in line 1.

Line 14--Total Deductions--Enter on line 14, column 2, the sum of lines 9 to 13, column 1.

Line 15--Total Operating Expenses--Enter on line 15, column 2, the result of line 1, column 2 plus line 8, column 2, less line 14, column 2.

4140.4 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 13, 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 15.

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

Lines 6-24--Enter on the appropriate line 6 through 24 all other revenue not reported on line 1. Obtain these amounts from your accounting books and/or records.

Line 25--Other (Specify)--Enter from hospital books. Enter all other revenue not reported on lines 6 through 24. Obtain this from your accounting books and/or records. Subscript this line as necessary.

Line 26--Total Other Income--Enter the sum of lines 6 through 25.

Line 27--Total--Enter the sum of lines 5 and 26.

Line 28--Other Expenses (Specify)--Enter all other expenses not reported on lines 6 through 25.

Line 31--Total Other Expenses--Enter the sum of lines 28 and subscripts.

Line 32--Net Income (or Loss) for the Period--Enter the result of line 27 minus line 31.

4141. 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 contractor. Your contractor 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 contractor 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 contractor 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 24 on line 25.

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 24 on line 25.

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:

- o FICA based on actual expense by cost center;
- o Pension and retirement and health insurance (non union) based on gross salaries of participating individuals by cost centers;
- o 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 24 on line 25.

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 24 on line 25.

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 24 on line 25.

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.

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 25, 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.

Line 15 --Enter the telemedicine costs.

Lines 16-24—These lines identify nonreimbursable services commonly provided by a home health agency. These include home dialysis aide services (line 16), respiratory therapy (line 17), private duty nursing (line 18), clinic (line 19), health promotion activities (line 20), day care program (line 21), home delivered meals program (line 22), and homemaker service (line 23). The cost of all other nonreimbursable services are aggregated on line 24. Use this line throughout all applicable worksheets.

4142 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 25) 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. 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 contractor 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 26, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet H-1, Part I, from the same column, line 25. 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 25 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 25 of the column must match.

Divide the amount entered on Worksheet H-1, Part II, line 26 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 27. 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 25) 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 25 the sum of the expenses on lines 6 through 24. 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.

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 25, add the amounts on each line in columns 4A and 5, and enter the result for each line in this column.

Line 25--Add lines 1 through 24 of columns 0 and 6.

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

<u>From Worksheet H-1</u> <u>Part I, Column 6</u>	<u>To Worksheet H-2,</u> <u>Part I, Column 0</u>
Line 6	Line 2
7	3
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
24	20

4143. WORKSHEET H-2 - ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

4143.1 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 SNF 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 21) from Worksheet A, column 7, line 70. Obtain the cost center allocation (column 0, lines 1 through 20) from Worksheet H-1, lines as indicated. The amounts on line 21, columns 0 through 17 and column 19 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 16 and column 18, line 70. Complete the amounts entered on lines 1 through 19, columns 1 through 16 and column 19.

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 17, excluded the costs of interns and residents, column 18 on this worksheet must also exclude these costs.

Line 22--Enter the unit cost multiplier (column 20, line 1, divided by the sum of column 20, line 21 minus column 20, line 1, rounded to 6 decimal places. Multiply each amount in column 20, lines 2 through 20, by the unit cost multiplier, and enter the result on the corresponding line of column 21.

4143.2 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/contractor 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/contractor approve a change in order to be consistent with their established cost finding practices. (See CMS Pub. 15-1, §2313.)

Lines 1 through 20--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 21--Enter the total of lines 1 through 20 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 70.

Line 22--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, line 70, 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 70).

Line 23--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 22 by the total statistic entered in the same column on line 21. 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 21 Part I) must equal the total cost on line 22, Part II.

Perform the preceding procedures for each general service cost center.

In column 17, Part I, enter the total of columns 3a through 16.

In column 19, Part I, for lines 2 through 20, multiply the amount in column 20 by the unit cost multiplier on line 22, Part I, and enter the result in this column. On line 21, enter the total of the amounts on lines 2 through 20. The total on line 21 equals the amount in column 20 line 1.

In column 21, Part I, enter on lines 2 through 20 the sum of columns 19 and 20. The total on line 21 equals the total in column 21, line 21.

4144. 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.

4144.1 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 ComputationColumn Descriptions

Column 1--Enter the cost for each discipline from Worksheet H-2, Part I, column 21, lines as indicated. Enter the total on line 7.

Column 2--Where the SNF complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the SNF's HHA, complete the amounts entered on lines 2 through 4. 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, title V, or title XIX cost of service, multiply the number of Medicare or Medicaid 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 9, 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.

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 8 and 9, from Worksheet H-2, Part I, column 21, 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 8 and 9, respectively. Enter in column 4, lines 8 and 9, respectively, the total charges for such services in accordance with the instructions in §4142, 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 8--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 OPSS 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 9--This line represents pneumococcal, influenza, and hepatitis B vaccines costs and inject able 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 OPSS. 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 inject able 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.

4144.2 Part II - Apportionment of Cost of HHA Services Furnished by Shared SNF Departments. Use this part only where the SNF complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the SNF's HHA. Subscript lines 1-5, as applicable, if subscripted on Worksheet C.

Column 1--Where applicable, enter in column 1 the cost to charge ratio from Worksheet C, column 3, lines as indicated.

Column 2--Where SNF departments provide services to the HHA, enter on the appropriate lines the charges applicable to the SNF-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.

4145. 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

4145.1 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:

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

The above table reflects the transfer of the cost of pneumococcal and influenza vaccines from Worksheet H-3, Part I, column 10, line 9, 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 9, column 7). In column 3, enter the charges for Medicare covered hepatitis B vaccines and osteoporosis drugs (from worksheet H-3, line 9, 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:

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

4145.2 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, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter on lines 17 through 19 the total DME, oxygen, prosthetics and orthotics payments, respectively, associated with home health PPS services (bill types 32 and 33). For lines 17 through 19 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 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 27--Enter the reimbursable 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 reimbursable 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 line 27.

Line 32--Enter the interim payment amount from Worksheet H-5, line 4. For contractor final settlement, report on line 34 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 4 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.

4146. 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 fiscal intermediary/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 31. Enter in column 4 the amount on Worksheet H-4, Part II, column 2, line 31.

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.

**4148. WORKSHEET I-1 - ANALYSIS OF SNF-BASED RURAL HEALTH CLINIC
FEDERALLY QUALIFIED HEALTH CENTER COSTS**

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

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

Column Descriptions

Columns 1 through 3.--The expenses listed in these columns must be in accordance with your accounting books and records. If the cost elements of a cost center are maintained separately on your books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained by you and is subject to review by your intermediary/contractor

Enter on the appropriate lines in columns 1 through 3 the total expenses incurred during the reporting period. Detail the expenses as Compensation (column 1) and Other (column 2). The sum of columns 1 and 2 must equal column 3.

Column 4.--Enter any reclassifications among the cost center expenses listed in column 3 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. See §4114 for examples of reclassifications that may be needed. Submit with the cost report copies of any workpapers used to compute the reclassifications reported in this column. Show reductions to expenses in parentheses ().

The net total of the entries in column 4 must equal zero on line 32.

Column 5.--Adjust the amounts in column 3 by the amounts in column 4 (increases or decreases), and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 32.

Column 6.--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 §4116.) Submit with the cost report copies of any workpapers used to compute the adjustments reported in this column.

NOTE: The allowable cost of the services furnished by National Health Service Corp (NHSC) personnel may be included in your facility's costs. Obtain this amount from your intermediary/contractor, and include this as an adjustment to the appropriate lines on column 6.

Column 7.--Adjust the amounts in column 5 by the amounts in column 6, (increases or decreases) and extend the net balance to column 7. The total facility costs on line 32 must equal the net expenses for cost allocation on Worksheet A for the RHC (line 61), or FQHC (line 62) cost center.

Line Descriptions

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

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

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

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

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

Lines 15 through 19.--Enter the expenses of health care costs listed on these lines.

Line 20. --Enter the cost of all allowable direct GME costs if the RHC/FQHC incurred all or substantially all of the training costs. Non-allowable costs must be reported on subscribed line 26. If the RHC/FQHC does not provide all or substantially all of the direct GME training costs, all GME costs must be included on line 27 as non-reimbursable. The BBA of 1997, §4625, provided for the payment to nonhospital providers for their direct cost of medical education beginning with services provided on or after October 1, 1997

Line 21.--Enter the sum of the amounts on lines 15 through 19, minus the amount on line 20.

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

Lines 23 through 27.--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 27 --Enter the cost of GME training services which are not allowable for reimbursement under Medicare. If the RHC/FQHC does not provide all or substantially all of the direct costs associated with GME training, all of the RHC/FQHC's GME training costs are deemed non-allowable.

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

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

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

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

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

4149. WORKSHEET I-2 - ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

4149.1 Part I - Visits and Productivity.--Worksheet I-2, Part I, summarizes the number of facility visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 of Part I list the types of practitioners (positions) for whom facility visits must be counted and reported.

Column Descriptions

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

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

Column 3.--Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Enter a level of 4200 visits for each physician (line 1) and a level of 2100 visits for each nonphysical practitioner (lines 2 and 3), unless you received an exception to these levels. If you were granted an exception to the productivity standards, enter the number of productivity visits approved by the intermediary in lines 1 through 3.

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

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

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

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

Line Descriptions

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

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

4149.2 Part II - Determination of Total Allowable Cost Applicable To RHC/FQHC Services.--Worksheet I-2, Part II, determines the amount of the overhead costs incurred by both the parent provider and the facility which apply to RHC/FQHC services.

Line 10.--Enter the cost of health care services from Worksheet I-1, column 7, line 22, minus the amount on line 20. This should not include the total allowable GME costs, on line 20. The allowable GME costs are not subject to the per visit limits.

Line 11.--Enter the total nonreimbursable costs from Worksheet I-1, column 7, line 28.

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

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

Line 14.--Enter the total facility overhead costs incurred from Worksheet I-1, column 7, line 31.

Line 15.--Enter the amount of GME overhead costs. To determine the amount of GME overhead multiply the amount of facility overhead by the ratio of Intern and Resident visits over total visits. This amount will be deducted from the total facility overhead costs on line 14.

Line 16.--Enter the net facility overhead costs. This is determined by subtracting the amount on line 15 from the amount on line 14.

Line 17.--Enter the overhead cost incurred by the parent provider allocated to the RHC/FQHC. This amount is the difference between the total costs allocated to the corresponding RHC/FQHC cost center on Worksheets B, Part I column 18, line 61 or 62, minus column 14, line 61 or 62, minus column 0, line 61 or 62.

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

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

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

4150. WORKSHEET I-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet provides for the reimbursement calculation of Rural Health Clinics and Federal Qualified Health Clinics. Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due you for the reporting period.

4150.1 Part I - Determination of Rate For RHC/FQHC Services.--Part I calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line Descriptions

Line 1.--Enter the total allowable cost from Worksheet I-2, Part II, line 20.

Line 2.--Enter the cost of vaccines and their administration from Worksheet I-4, line 15.

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

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

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

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

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

Lines 8 and 9.—The limits are updated every January 1, Complete columns 1, 2 and if needed 3 of lines 8 and 9, if applicable (add a column 3 for lines 8-14 if the cost reporting overlaps 3 limit update periods) to identify costs and visits affected by different payment limits during a cost reporting period. If only one payment limit is applicable during the cost reporting period, complete column 2 only.

Line 8.--Enter the maximum rate per visit that can be received by you. Obtain this amount from your intermediary/contractor.

Line 9.--Enter the lesser of the amount on line 7 or line 8. For periods with cost reporting periods beginning on or after January 1, complete column 2 only. For cost reporting periods beginning other than January 1, amounts will be entered in columns 1 and 2.

4150.2 Part II - Calculation of Settlement.--Use Part II to determine the total payment based on specific title due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period.

Complete columns 1 and/or 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period. If the provider's cost reporting period begins on or after January 1, then only column 2 is completed. For cost reporting periods beginning other than January 1, both columns 1 and 2 must be completed.

Line Descriptions

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

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

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

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

Line 14.--Enter the limit adjustment. This limit applies only to therapeutic services, not initial diagnostic services. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: for services rendered through December 31, 2009, the limitation is 62.50 percent; for services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; for services from January 1 2012, through December 31, 2012, the limitation is 75 percent; for services from January 1, 2013, through December 31, 2013, the limitation is 81.25 percent; and for services on and after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health service limit percentage. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15. --Enter the total allowable GME pass-through costs. To determine the direct GME cost, divide the program visits performed by Interns and Residents from Worksheet S-5, line 15, column 2, by the total visits from Worksheet I-3, line 6. Multiply the result by the total allowable GME costs from Worksheet I-1, column 7, line 20. Add the applicable overhead costs associated with GME, from Worksheet I-2, line 15. Add the provider facility overhead applicable to GME, from Worksheet B, Part I, column 14, line 61 or 62. Enter the result on this line. (If there are no allowable GME pass-through costs, this line is zero.)

Line 16.--Enter the total program cost. This is equal to the sum of the amounts on line 11, column 1 plus column 2, and line 14, column 1 plus column 2, plus the GME pass through costs on line 15.

Line 17.--Enter the amounts paid or payable by workmen's compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges but are not included in program patient days and charges. In this situation, no primary payer payment is entered on line 17.

Line 18--Enter the amount credited to the RHC program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the intermediary/contacter from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the intermediary/contractor. FQHCs enter zero on this line as deductibles do not apply.

Line 19--Enter the net program cost, excluding vaccines. This is equal to the result of subtracting the amount on line 17 and 18 from the amount on line 16.

Line 20--Enter 80 percent of the amount on line 19.

Line 21--Enter the total reimbursable program cost of vaccines and their administration from Worksheet I-4, line 16..

Line 23--Enter the total reimbursable bad debts, net of recoveries, from your records.

Line 24 -Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 23.

Line 25--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (See CMS Pub 15-1, § 2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 26. --This is the sum of lines 22 plus line 23 plus or minus line 25.

Line 27--Enter the total interim payments made to you for covered services furnished to program beneficiaries during the reporting period (from intermediary records). Transfer amount from Worksheet I-5, line 4.

Line 28—Your contractor will enter the tentative adjustment from Worksheet I-5, line 5.99.

Line 29--Enter the total amount due to/from the program, line 26 minus lines 27 and 28. Transfer this amount to Worksheet S, Part II, columns 1, 3, or 4 as applicable, line 5.

Line 30--Enter the program reimbursement effect of protested items. The reimbursement effect of 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 PRM-15-II §115.2).

4151. WORKSHEET I-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of these vaccines for services rendered on and after August 1, 2000. Additionally, use this worksheet only for vaccines rendered to patients who at the time of receiving the vaccine(s) were not inpatients or outpatients of the parent provider. If a patient simultaneously received vaccine(s) with any Medicare covered services as an inpatient or outpatient, those vaccine costs are reimbursed through the parent provider and cannot be claimed by the RHC and FQHC.

Effective for services rendered on and after September 1, 2009, in accordance with CR 6633, dated August 27, 2009, the administration of influenza A (H1N1) vaccines furnished by RHC's and FQHC's is cost reimbursed. However, no cost will be incurred for the H1N1 vaccine as this is provided free of charge to providers/suppliers.

This worksheet must be completed for services furnished on and after October 1, 2009. The administrative cost of influenza vaccines to Medicare beneficiaries is 100 percent reimbursable by Medicare. This worksheet provides for the computation of these services rendered on and after October 1, 2009.

Line 1.--Enter the health care staff cost from Worksheet I-1, column 7, line 10.

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

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

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

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

Line 6.--Enter the amount on Worksheet I-1, column 7, line 22. This is your total direct cost of the facility.

Line 7.--Enter the amount from Worksheet I-2, line 18.

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

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

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

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

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

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

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

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

Line 16.--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration. This is equal to the sum of the amount in column 1, line 14 and column 2, line 14. Transfer the result to Worksheet I-3, Part II, line 21.

4152. WORKSHEET I-5 - ANALYSIS OF PAYMENTS TO SNF-BASED RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTERS

Complete this worksheet for Medicare interim payments only. Complete a separate worksheet for each rural health clinic and federally qualified health center.

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

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

Line Descriptions

Line 1.--Enter the total program interim payments paid to the component. 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 include amounts withheld from the component's interim payments due to an offset against overpayments to the component 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.

Line 2.--Enter the total program 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.--Transfer the total interim payments to the title XVIII Worksheet I-3, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET I-5. LINES 5 THROUGH 9 ARE FOR CONTRACTOR USE ONLY.

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.

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

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

Line 7.--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet I-3, line 26.

4153.WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO C.M.H.C. COST CENTERS

Use this worksheet only if you operate as part of your complex a certified SNF-based community mental health center (CMHC), If you have more than one SNF-based CMHC, complete a separate worksheet for each provider.

4153.1 Part I - Allocation of General Service Costs to CMHC Cost Centers.-- Worksheet J-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 22) from Worksheet A, column 7, line 73. Obtain the cost center allocation (column 0, lines 1 through 21) from your records.

4153.2 Part II - Allocation of General Service Costs to CMHC Cost Centers -Statistical Basis.--Worksheet J-1, Parts II provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet J-1, Part I.

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

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

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year if received by the intermediary/contractor, in writing, within 90 days prior to the end of the fiscal year. The intermediary/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, is 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.

Lines 1 through 21.--On Worksheet J-1, 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 22.--Enter the total of lines 1 through 21 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 73.

Line 23.--Enter the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B, Part I, line 73, from the same column used to enter the statistical base on Worksheet -J-1, 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 73).

Line 24.--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 23 by the total statistic entered in the same column on line 22. 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 line 24.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 22, Part I) must equal the total cost on line 23, Part II.

Perform the preceding procedures for each general service cost center.

In column 16, Part I, enter the total of columns 3a through 15.

In Part I, compute the unit cost multiplier for allocation of the components' administrative and general costs as follows.

Line 22.--Enter the sum of lines 1 through 21.

Line 23.—Subtract the amount in column 18, line 1 from the amount on line 22.

Line 24.--Divide the amount on line 22 by the amount on line 23 and enter the result rounded to six decimal places.

In column 19, for lines 2 through 21, multiply the amount in column 18 by the unit cost multiplier on line 24, and enter the result in this column. On line 23, enter the total of the amounts on lines 2 through 21. The total on line 23 equals the amount on column 18, line 1.

In column 20, enter on lines 2 through 21 the sum of the amounts in columns 18 and 19. The total in column 20, line 22 must equal the total in column 18, line 22.

4154. WORKSHEET J-2 - COMPUTATION OF COMPONENT COSTS

Use this worksheet if you operate a SNF-based CMHC, Complete a separate worksheet for each provider.

4154.1 Part I - Apportionment of Outpatient Rehabilitation Provider Cost Centers.--

Column 1.--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, column 20. To facilitate the apportionment process, the line number designations are the same on both worksheets.

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

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

Columns 4, 6, and 8--For each cost center, enter the charges from your records for title V, title XVIII, and title XIX patients, respectively. Not all facilities are eligible to participate in all programs.

Columns 5, 7, and 9.--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6 and 8 respectively, by the ratio in column 3.

Line 22.--Enter the totals for columns 1, 2, and 4 through 9.

4154.2 Part II - Apportionment of Cost of Outpatient Rehabilitation Services Furnished by Shared Skilled Nursing Facility Departments.--Use this part only when the SNF complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the skilled nursing facility's outpatient rehabilitation facility.

Column 3.--For each of the cost centers listed, enter the ratio of cost to charges that is shown on Worksheet C, column 3, from the appropriate line for each cost center.

Columns 4, 6, and 8.--For each cost center, enter the charges from your records for title V, title XVIII, and title XIX patients, respectively.

Columns 5, 7, and 9.--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8 respectively by the ratio in column 3.

Line 30.--Enter the totals for columns 4 through 7, 9 and 13.

Line 31.-- Add the amount from Part I, columns 5, 7, and 9 respectively line 22 to and Part II, columns 5, 7, and 9 line 30

4155. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT OF REHABILITATION SERVICES

Line 1.--Enter the cost of rehabilitation services from Worksheet J-2, Part II, line 31 from columns 5, 7, or 9

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

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

Line 6.--Enter in column 2, 80 percent of line 5 for Title XVIII Make no entry for title V or title XIX.

Line 7.--Enter the actual coinsurance billed to program patients (from your records).

Line 9.--Enter reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records).

Line 10.-- Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 9.

Line 11-- Enter the sum of line 8 and 9

Line 12.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132ff.) Enter the amount of any excess depreciation taken in parentheses ().

NOTE: Section 1861 (v) (1) (O) sets a limit on the valuation of a depreciable asset that may be recognized in establishing an appropriate allowance for depreciation, and for interest on capital indebtedness after a change of ownership that occurs on or after December 1, 1997.

Line 13.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136ff.)

Line 14.--Enter the amount of other adjustments from your records.

Line 15.--Enter the amount on line 11 minus the amount on line 12, 13, plus or minus line 14.

Line 16.--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4.

Line 17.--Enter the balance due provider/program and transfer this amount to Worksheet S, Part II, columns as appropriate, line 6.

Line 18.--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items 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.) Attach a worksheet showing the details and computations for this line.

4156. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED COMPONENT FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. Complete a separate worksheet for each outpatient rehabilitation provider.

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

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

Line Descriptions

Line 1.--Enter the total program interim payments paid to the component. 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 include amounts withheld from the component's interim payments due to an offset against overpayments to the component 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.

Line 2.--Enter the total program 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.--Transfer the total interim payments to the title XVIII Worksheet J-3, line 17.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 9 ARE FOR CONTRACTOR USE ONLY.

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.

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

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

Line 7.--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet J-3, line 17.

4157. WORKSHEET K – ANALYSIS OF SNF BASED HOSPICE COST

In accordance with 42 CFR 413.20, the methods of determining costs payable under Title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. This worksheet provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets K, K-4, Parts I & II, the line numbers are consistent, and the total line is set at 39). Not all of the cost centers listed apply to all providers using these forms.

Column 1.--Obtain salaries to be reported from Worksheet K-1, column 9, line 3-38.

Column 2.--Obtain employee benefits to be reported from Worksheet K-2 column 9 lines 3-38.

Column 3.--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center, enter them on line 21.

Column 4.--Obtain the contracted services to be reported from Worksheet K-3, column 9 lines 3-38.

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

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

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

Column 8.--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 39.

Column 9.--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §3519.)

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

Transfer the amount in column 10, line 1 through 39 to the corresponding lines on Worksheet K-4, Part I, column 0.

Line Description

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

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

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

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

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

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

Line 6 - Administrative and General.--Use this line to record expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs.

Line 7 - Inpatient - General Care.--This cost center includes costs applicable to patients who receive this level of care because their condition is such that they can no longer be maintained at home. Generally, they require pain control or management of acute and severe clinical problems which cannot be managed in other settings. The costs incurred on this line are those direct costs of furnishing routine and ancillary services associated with inpatient general care for which other provisions are not made on this worksheet.

Costs incurred by a hospice in furnishing direct patient care services to patients receiving general inpatient care either directly from the hospice or under a contractual arrangement in an inpatient facility is to be included in the visiting service costs section.

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

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

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

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

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

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

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

Line 11 - Nursing Care--Continuous Home Care.--Enter the continuous home care portion of costs for nursing services provided by a registered nurse, licensed practical nurse, or licensed vocational nurse as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 12 - Physical Therapy.--Physical therapy is the provision of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 13 - Occupational Therapy.--Occupational therapy is the application of purposeful goal-oriented activity in the evaluation, diagnostic, for the persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, and to maintain health. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 14 - Speech/Language Pathology.--These are physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 15 - Medical Social Services.--This cost center includes only direct expenses incurred in providing medical social services. Medical social services consist of counseling and assessment activities which contribute meaningfully to the treatment of a patient's condition. These services must be provided by a qualified social worker under the direction of a physician.

Lines 16, 17, and 18 - Counseling.--Counseling services must be available to both the terminally ill individual and family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. This includes dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Costs associated with such counseling are accumulated in the appropriate counseling cost center. Costs associated with bereavement counseling are recorded on line 35.

Line 19- Home Health Aide and Homemaker.--Enter the cost of a home health aide and homemaker services. Home health aide services are provided under the general supervision of a registered professional nurse and may be provided by only individuals who have successfully completed a home health aide training and competency evaluation program or competency evaluation program as required in 42 CFR 484.36.

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

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

Line 20 - Home Health Aide and Homemaker-Continuous Home Care.--Enter the continuous care portion of cost for home health aide and/or homemaker services provided as specified in the plan of care and under the supervision of a registered nurse.

Line 21 - Other.--Enter on this line any other visiting cost which cannot be appropriately identified in the services already listed.

Line 22 - Drugs, Biological and Infusion Therapy.--Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. The amount entered on this line includes costs incurred for drugs or biologicals provided to the patients while at home. If a pharmacist dispenses prescriptions and provides other services to patients while the patient is both at home and in an inpatient unit, a reasonable allocation of the pharmacist cost must be made and reported respectively on line 22 (Drugs and Biologicals) and line 7 (Inpatient General Care) or line 8 (Inpatient Respite Care) of Worksheet K.

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

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

Line 23 - Analgesics.- Enter the cost of analgesics.

Line 24 - Sedatives/Hypnotics. - Enter the cost of sedatives/hypnotics.

Line 25 - Other Specify. - Specify the type and enter the cost of any other drugs which cannot be appropriately identified in the drug cost center already listed.

Line 26 - Durable Medical Equipment/Oxygen.--Durable medical equipment as defined in 42 CFR 410.38 as well as other self-help and personal comfort items related to the palliation or management

of the patient's terminal illness are covered. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

Line 27 - Patient Transportation.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 28 - Imaging Services.--Enter the cost of imaging services including MRU.

Line 29 - Labs and Diagnostics.--Enter the cost of laboratory and diagnostic tests.

Line 30 - Medical Supplies.--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients.

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

Line 31 - Outpatient Services.--Use this line for any outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department.

Lines 32-33 - Radiation Therapy and Chemotherapy.--Radiation, chemotherapy, and other modalities may be used for palliative purposes if you determine that these services are needed for palliation. This determination is based on the patient's condition and your care giving philosophy.

Line 34 - Other (Specify).--Enter any additional costs involved in providing visiting services which have not been provided for in the previous lines.

Lines 35-38 - Non Reimbursable Costs.--Enter in the appropriate lines the applicable costs. Bereavement program costs consists of counseling services provided to the individual's family after the individual's death. In accordance with §1814 (I)(1) (A) of the Social Security Act, bereavement counseling is a required hospice service, but it is not reimbursable.

Line 39 - Total.--Line 39 column 10, must agree with Worksheet A, line 83, column 7.

4158. WORKSHEET K-1 – HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Enter all salaries and wages for the hospice on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs visiting services which account for 55 percent of that person's time, then enter 45 percent of the administrator's salary on line 6 (A&G) and 55 percent of the administrator's salary enter on line 10 (Nursing Care).

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

Definitions

Salary.--This is gross salary paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-1, Chapter 21.)

Administrator (Column 1).--

Possible Titles: President, Chief Executive Officer.

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

Director (Column 2).--

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

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

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

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

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

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

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

Physical therapy	-	line 12
Occupational therapy	-	line 13
Speech pathology	-	line 14

Therapy and speech-language pathology may be provided to control symptoms or to enable the individual to maintain activities of daily living and basic functional skill.

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

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

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

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

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

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

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

4159. WORKSHEET K-2 – HOSPICE COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

Enter all payroll-related employee benefits for the hospice on this worksheet. See CMS Pub. 15-I, Chapter 20, for a definition of fringe benefits. Use the same basis as that used for reporting salaries and wages on Worksheet K-1. Therefore, using the same example as given for Worksheet K-1, enter 45 percent of the administrator's payroll-related fringe benefits on line 6 (A&G) and enter 55 percent of the administrator's payroll-related fringe benefits on line 10 (Nursing Care). Payroll-related employee benefits must be reported in the cost center in which the applicable employee's compensation is reported.

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

FICA - actual expense by cost center;

Pension, retirement, and health insurance (nonunion) (gross salaries of participating individuals by cost center);

Union health and welfare (gross salaries of participating union members by cost center); or

All other payroll-related benefits (gross salaries by cost center). Include non payroll-related employee benefits in the A&G cost center, e.g., cost for personal education, recreation activities, and day care.

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

4160. WORKSHEET K-3 – HOSPICE COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES

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

Enter on this worksheet all contracted and/or purchased services for the hospice. Enter the contracted/purchased cost on the appropriate cost center line within the column heading which best describes the type of services purchased. Costs associated with contracting for general inpatient or respite care would be recorded on this worksheet. For example, where physical therapy services are purchased, enter the contract cost of the therapist in column 6, line 12. If a contracted/purchased service covers more than one cost center, then the amount applicable to each cost center is included on each affected cost center line. Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 4, corresponding lines. To facilitate transferring amounts from Worksheet K-3 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets.

4161. WORKSHEET K-4, PART I - COST ALLOCATION – HOSPICE GENERAL SERVICE COST AND PART II - COST ALLOCATION - HOSPICE STATISTICAL BASIS

Worksheet K-4 provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, reimbursable cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet K, column 10. To facilitate transferring amounts from Worksheet K to Worksheet K-4, Part I, the same cost centers with corresponding line numbers (lines 1 through 34) are listed on both worksheets.

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

To facilitate the allocation process, the general format of Parts I & II are identical. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each general, reimbursable, nonreimbursable, and special purpose cost center are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheets K, K-1, K-2, and K-3. If the provider has subscribed any lines on these K worksheets, the provider must subscribe the same lines on Worksheet K-4, Part I.

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

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

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

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) which states, in part, that "the cost of the nonrevenue-producing cost center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first." This is clarified in CMS Pub. 15-I, §2306.1 which further clarifies the order of allocation for step down purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year cost if received by the intermediary/contractor in writing within 90 days prior to the end of that fiscal year. The intermediary/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 or, if the allocation is accurate, it must be changed due to simplification of maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach must be used. (See CMS Pub. 15-I, §2313.)

If the amount of any cost center on Worksheet K, column 10, has a credit balance, show this amount as a credit balance on Worksheet K-4, Part I column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated, do not allocate the general service cost center. Rather, enter the credit balance on the first line of the column and on line 34. This enables column 6, line 34, to cross foot to columns 0 and 5A, line 34. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet K-4, Part I, column 6, do not carry forward a credit balance to any worksheet.

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

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

For all cost centers (below the cost center being allocated) to which the service rendered is being allocated, enter that portion of the total statistical base applicable to each.

The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total statistics entered on the first line.

Enter on Worksheet K-4, Part II line 49, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet K-4, Part I from the same column and line number of the same column. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet K-4, Part I, column 1, line 1.

Divide the amount entered on line 49 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 50. Round the unit cost multiplier to at least the nearest six decimal places. Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet K-4, Part I in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 49) of all of the cost centers receiving the allocation on Worksheet K-4, Part I, must equal the amount entered on the first line of the cost center being allocated.

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

After all the costs of the general service cost centers have been allocated on Worksheet K-4, Part I, enter in column 7 the sum of the expenses on lines 7 through 38. The total expenses entered in column 7, line 39, must equal the total expenses entered in column 0, line 39.

Column Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

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

Worksheet K-4, Part II, Column 6.--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet K-4, Part II, column 6, line 6, is the difference between the amounts entered on Worksheet K-4, column 5A and Worksheet K-4, Part II, column 6A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

4162. WORKSHEET K-5 - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

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

4162.1 Part I - Allocation of General Service Costs to Hospice Cost Centers.--Worksheet K-5, Part I, provides for the allocation of the expenses of each general service cost center of the SNF to those cost centers which receive the services. Worksheet K-5, Part II provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-5, Part I.

Obtain the total direct expenses (column 0 line 39) from Worksheet A, column 7, line 83. Obtain the cost center allocation (column 0, lines 1 through 38) from Worksheet K-4, lines as indicated. The amounts on line 38, columns 0 through 16 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 16, line 83. Calculate the amounts entered on lines 1 through 38, columns 1 through 16.

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 17, excluded the costs of interns and residents, column 17 on this worksheet must also exclude these costs.

Line 50.--Enter the unit cost multiplier (column 16, line 1), divided by the sum of column 16, line 39 minus column 16, line 1, rounded to 6 decimal places. Multiply each amount in column 16, lines 2 through 38, by the unit cost multiplier, and enter the result on the corresponding line of column 17.

4162.2 Part II - Allocation of General Service Costs to Hospice Cost Centers - Statistical Basis.--To facilitate the allocation p

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

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

Lines 1 through 38.--On Worksheet K-5, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 39.--Enter the total of lines 1 through 38 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 83.

Line 50.--Enter the unit cost multiplier which is obtained by dividing the cost entered in Part I, line 39 by the total statistic entered in the same column in Part II, line 39. Round the unit cost multiplier to six decimal places.

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

Perform the preceding procedures for each general service cost center.

In column 18, Part I, enter the total of columns 4A through 15.

In column 17, Part I, for lines 2 through 38, multiply the amount in column 17 by the unit cost multiplier on line 50, Part I, and enter the result in this column. On line 39, enter the total of the amounts on lines 2 through 38. The total on line 39 equals the amount in column 16, line 1.

In column 18, Part I, enter on lines 2 through 38 the sum of columns 16 and 17. The total on line 39 equals the total in column 18, line 39.

4162.3 Part III- Apportionment Hospice Shared Services.--This worksheet provides for the shared therapy, drugs, or medical supplies from the SNF to the hospice.

Column Description

Columns 1 & 2.-- Enter in column 2, the cost for each discipline from Worksheet K-5, Part I, col. 18, lines as indicated in column 1.

Columns 3 & 4.--Where applicable, enter in column 4 the cost to charge ratio from Worksheet C, I column 3, lines as indicated in column 3.

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

Column 6.--Multiply the amount in column 5 by the ratios in column 4 and enter the result in column 6.

4163. WORKSHEET K-6 - CALCULATION OF PER DIEM COST

Worksheet K-6 calculates the average cost per days in providing care for a hospice patient. It is only an average and should not be misconstrued as the absolute.

Line 1.--Total cost from Worksheet K-5, Part I, line 39, less line 38, column 18, plus Worksheet K-5, Part III, column 6, line 9. This line reflects the true cost including shared cost and excluding any non hospice related costs.

Line 2.--Total unduplicated days from Worksheet S-8, line 5, col. 6.

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

Line 4.--Unduplicated Medicare days from Worksheet S-8, line 5, column 1.

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

Line 6.--Unduplicated Medicaid days from Worksheet S-8, line 5, column 2.

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

Line 8.--Unduplicated SNF days from Worksheet S-8, line 5, column 3.

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

Line 10.--Unduplicated NF days from Worksheet S-8, line 5, column 4.

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

Line 12.--Unduplicated other days from Worksheet S-8, line 5, column 5.

Line 13.--Average other cost. Multiply the average cost from line 3 by the number of unduplicated other days on line 5 to arrive at the average other cost.