

CHAPTER 43  
HOSPICE FACILITY COST REPORT  
FORM CMS-1984-14

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## 4300. GENERAL

The Paperwork Reduction Act of 1995 establishes the requirement that the private sector be told why information is collected and how it will be used by the government. In accordance with 42 CFR 418.310, hospices must provide reports and keep records as the Secretary determines necessary to administer the program. Also, 42 CFR 413.20 requires providers participating in the Medicare program to submit information for health care services rendered to Medicare beneficiaries through annual cost reports. The data submitted on the cost reports supports management of Federal programs. The information reported on Form CMS-1984-14, must conform to the requirements and principles set forth in CMS Pub. 15, as well as those set forth in the Medicare Benefit Policy Manual, CMS Pub. 100-02, chapter 9, and the Medicare Claims Processing Manual, CMS Pub. 100-04, chapter 11. These instructions are effective for cost reporting periods beginning on or after October 1, 2014.

Providers receiving Medicare reimbursement must provide adequate cost data based on financial and statistical records that can be verified by qualified auditors. The cost data must be based on the accrual basis of accounting. Under the accrual basis of accounting, revenue is recorded in the period earned regardless of when it is collected, and expenditures for expense and asset items are recorded in the period incurred regardless of when paid. See 42 CFR 413.24(b)(2). However, where governmental institutions operate on a cash basis of accounting, cost data developed on such basis of accounting is acceptable subject to appropriate treatment of capital expenditures.

An electronic cost report (ECR) and supporting documentation must be submitted to the fiscal intermediary (FI)/Medicare administrative contractor (MAC), hereafter referred to as contractor. Providers meeting the conditions set forth in the Provider Reimbursement Manual Part 2, CMS Pub. 15-2, chapter 1, §110 are permitted to file less than a full cost report.

Form CMS-1984-14 must be used by all freestanding hospices for cost reporting periods beginning on or after October 1, 2014. Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. The only provision for an extension of the cost report due date is identified in 42 CFR 413.24(f)(2)(ii).

**NOTE:** This form is to be used by freestanding hospices only. Hospices that are considered provider-based for cost reporting purposes must use the following: hospital based hospices must use Form CMS-2552, skilled nursing facility (SNF) based hospices must use Form CMS-2540, and home health agency based hospices must use Form CMS-1728.

The public reporting and recordkeeping burden for this cost report is estimated to average 188 hours per response. This includes time for reviewing instructions, gathering data, maintaining records, and completing the forms. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to:

Centers for Medicare and Medicaid Services  
PRA Reports Clearance Officer  
7500 Security Boulevard  
Mail Stop C4-26-05  
Baltimore, Md. 21244-1850

**4301. ROUNDING STANDARDS FOR FRACTIONAL COMPUTATIONS**

Throughout the Medicare cost report, where computations result in fractions, use the following rounding standards:

1. Round to 2 decimal places:
  - percentages
  - averages, standard work week, and payment rates
  - full time equivalent employees
  - per diem
  - hourly rates
2. Round to 6 decimal places:
  - ratios (e.g., unit cost multipliers)

When costs computed using a fraction or decimal result in the sum of the parts not equal to the whole, adjust the greatest computed amount so the sum of the computed amounts equals the whole. Should the computed amounts include multiple occurrences of the same greatest amount, adjust the first occurrence of the greatest amount.

**4302. DEFINITIONS**

A freestanding hospice, refers to a hospice that is not part of any other type of participating provider meeting the requirements of §1861(dd) of the Social Security Act. Refer to the Provider Reimbursement Manual Part 1 (CMS Pub. 15-1), CMS Pub. 100-02, chapter 9, and CMS Pub. 100-04, chapter 11 for further definitions of terms.

When referring to patients in the Form CMS-1984 and the cost reporting instructions, the term "Medicare" refers to Medicare patients currently under a valid Medicare hospice election. Medicare patients not covered under a valid Medicare hospice election are classified as Other.

### 4303. ACRONYMS AND ABBREVIATIONS

Acronyms and abbreviations used throughout the Medicare cost report and instructions are summarized below.

A&G	-	Administrative and General
ALOS	-	Average Length of Stay
CAP REL	-	Capital-Related
CBSA	-	Core Based Statistical Area
CCN	-	CMS Certification Number (formerly known as provider number)
CFR	-	Code of Federal Regulations
CHC	-	Continuous Home Care
CMS Pub.	-	Centers for Medicare & Medicaid Services Publication
CNA	-	Certified Nursing Assistant
COL	-	Column
ECR	-	Electronic Cost Report
GIP	-	General Inpatient Care
HCRIS	-	Healthcare Cost Report Information System
IRC	-	Inpatient Respite Care
LOC	-	Level of Care
LPN	-	Licensed Practical Nurse
LVN	-	Licensed Vocational Nurse
MAC	-	Medicare Administrative Contractor
NF	-	Nursing Facility
NPR	-	Notice of Program Reimbursement
OTC	-	Over-the-counter
PS&R Report	-	Provider Statistical and Reimbursement Report
RHC	-	Routine Home Care
RN	-	Registered Nurse
SNF	-	Skilled Nursing Facility
WKST	-	Worksheet

<u>Step No.</u>	<u>Worksheet</u>	<u>Instructions</u>
1	S	Read §4306. Complete entire worksheet.
2	S-1	Read §4307. Complete entire worksheet.
3	A-1, A-2, A-3, A-4	Read §4311. Complete columns 1 through 3.
4	A	Read §4310. Complete columns 1 through 3.
5	A-6	Read §4316. Complete, if applicable.
6	A-8	Read §4318. Complete all lines.
7	A-8-1	Read §4319. Complete, if applicable.
8	A-1, A-2, A-3, A-4	Read §4311. Complete columns 4 through 7.
9	A	Read §4310. Complete columns 4 through 7.
10	B and B-1	Read §4320. Complete both worksheets entirely.
11	C	Read §4330. Complete entire worksheet.
12	F	Read §4350 through §4350.1. Complete entire worksheet.
13	F-1	Read §4350.2 Complete entire worksheet.
14	F-2, Parts I & II	Read §4350.3 Complete entire worksheet.

Submit the cost report worksheets in the order indicated below when using Form CMS-1984-14. Include only applicable, completed worksheets. Do not include blank worksheets.

<u>Worksheet</u>	<u>Part</u>
S	I & II
S-1	
A-1 through A-4	
A	
A-6	
A-8	
A-8-1	
B	
B-1	
C	
F	
F-1	
F-2	

#### 4306. WORKSHEET S - HOSPICE COST AND DATA REPORT

4306.1 Part I - Cost Report Status.--This section is completed by the provider or contractor as indicated on the worksheet.

Provider use only.--The provider completes lines 1 through 4.

Lines 1 and 2.--Indicate the type of cost report submission by checking line 1, column 1 if an electronic submission or line 2 if a manual submission. Line 2 is only completed by providers filing low utilization cost reports in accordance with CMS Pub. 15-2, chapter 1, §110 or providers demonstrating financial hardship in accordance with §133. For electronic submission, enter the date and time corresponding to the creation of the ECR file on line 1, columns 2 and 3. The date and time are archived in the ECR as an identifier for the file. This file is your original submission and must not be modified.

Line 3.--If this is an amended cost report, enter on line 3 the number of times the cost report has been amended.

Line 4.--Enter an "F" if this is full cost report or an "L" for a low Medicare utilization cost report. Providers must obtain contractor approval prior to submitting a low Medicare utilization cost report. (See CMS Pub. 15-2, chapter 1, §110.)

Contractor use only.--The contractor completes lines 5 through 12.

Line 5.--Enter the Healthcare Cost Report Information System (HCRIS) cost report status code that corresponds to the filing status of the cost report. Valid codes are: 1=As submitted or 5=Amended. Codes 2 through 4 are reserved for future use.

Line 6.--Enter the date (mm/dd/yyyy) the accepted cost report was received.

Line 7.--Enter the contractor number.

Lines 8 and 9.--If this is the very first cost report for this provider CMS certification number (CCN), enter "Y" for yes on line 8. If this is the final (terminating) cost report for this provider CCN, enter "Y" for yes on line 9. If the cost report is neither a first nor a final cost report for this provider CCN, do not complete these lines.

Line 10.--Reserved.

Line 11.--Enter the software vendor code of the cost report software used by the contractor. Enter "3" for KPMG or "4" for HFS.

Line 12.--Reserved.

4306.2 Part II - Certification.--This certification is read, completed, and signed by an officer or administrator of the provider after the cost report has been completed in its entirety.

#### 4307. WORKSHEET S-1 - HOSPICE IDENTIFICATION DATA

4307.1 Part I - Identification Data.--The information required on this worksheet is needed to properly identify the provider.

Lines 1 through 4.--Enter the name, address, city, state, ZIP code, and county of the hospice.

Line 5.--Enter the provider CCN.

Line 6.--Enter the date the hospice began operation. Enter the date of State licensure if the hospice is located in a State that requires a State hospice license for operation.

Line 7.--Enter the date(s) the hospice was certified for Medicare (title XVIII) and, if applicable, Medicaid (title XIX).

Line 8.--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), providers are required to submit periodic reports of operations, which generally cover a consecutive 12-month period. (See CMS Pub. 15-2, chapter 1, §§102.1 through 102.3 for situations when a provider may file a cost report for a period other than a 12-month period.)

Line 9.--Indicate whether the provider is legally required to carry malpractice insurance. Enter "Y" for yes or "N" for no.

Line 10.--If line 9 is yes, indicate whether the malpractice insurance is a claims-made or occurrence policy. Enter 1 if the policy is claims-made. Enter 2 if the policy is occurrence.

Line 11.--Enter the amounts of malpractice premiums paid in column 1, the total amount of paid losses in column 2, and the total amount of self insurance in column 3.

Malpractice insurance premiums are money paid by the provider to a commercial insurer to protect the provider against potential negligence claims made by their patients/clients. Malpractice paid losses is money paid by the healthcare provider to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the provider where the healthcare provider acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often providers will manage their own funds or purchase a policy referred to as captive insurance, which provides insurance coverage they need but could not obtain economically through the mainstream insurance market.

Line 12.--Indicate whether malpractice premiums paid, paid losses, or self insurance are reported in a cost center other than the A&G cost center. Enter "Y" for yes or "N" for no. If yes, submit supporting schedule listing cost centers and amounts.

Line 13.--Indicate whether this cost report includes home office costs. (See CMS Pub. 15-1, chapter 21, §2150ff.) Enter "Y" for yes or "N" for no in column 1. If yes, enter the chain home office number in column 2, complete lines 14 through 18, and complete Worksheet A-8-1.

Lines 14 through 18.--If line 13 is yes, enter the name and address of the home office on lines 14 through 16, the home office contractor name on line 17, and the home office contractor number on line 18.

Line 19.--Indicate the type of control under which the hospice operates. Select from the following choices:

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

Line 20.--Enter the number of CBSAs in which Medicare covered services were provided during the cost reporting period.

Line 21.--List the code for each CBSA in which Medicare covered hospices services were provided during the cost reporting period. Enter the first CBSA on line 21 and subscript line 21 as necessary to report additional CBSAs.

4307.2 Part II - Statistical Data.--This section collects days and census count data.

Lines 30 through 33.--Enter the enrollment days applicable to each level of care (LOC) in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1.

Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received one of four levels of care -- continuous home care (CHC), routine home care (RHC), inpatient respite care (IRC), or general inpatient care (GIP). When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Report an IRC day on line 32 only when the hospice provided or arranged to provide the inpatient respite care.

Enter the total unduplicated days by LOC (sum of columns 1 through 3) in column 4.

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

Continuous Home Care Day--A CHC day is a day on which the hospice patient is not in an inpatient facility, and receives continuous care during a period of crisis in order to maintain the individual at home. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. For each day a beneficiary received 8 or more hours of predominantly nursing care, count the day as one CHC day. Do not count days by dividing the total hours by 24.

Routine Home Care Day--An RHC day is a day on which the hospice patient is at home and not receiving CHC.

Inpatient Respite Care Day--An IRC day is a day on which the hospice patient receives care in an approved inpatient facility to provide respite for the individual's family or other persons caring for the individual at home.

General Inpatient Care Day--A GIP day is a day on which the hospice patient receives care in a Medicare certified hospice facility, hospital or SNF for pain control or acute or chronic symptom management that cannot be managed in other settings.

Line 34--Enter the total unduplicated days (sum of lines 30 through 33) in each column as applicable.

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4307.3 Part III - Contracted Statistical Data--This section collects days and census count data for inpatient services at a contracted facility. The days reported in Part III are a subset of the days reported in Part II.

Lines 40 and 41.--Enter the contracted inpatient service enrollment days applicable to each LOC in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received IRC or GIP care at a contracted facility. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Enter the total unduplicated days by LOC (sum of columns 1 through 3) in column 4.

#### 4308. WORKSHEET S-2 - HOSPICE REIMBURSEMENT QUESTIONNAIRE

This worksheet collects organizational, financial and statistical information previously reported on Form CMS-339. Where instructions for this worksheet direct the provider to submit documentation/information, mail or otherwise transmit the requested documentation to the contractor with submission of the ECR. The contractor has the right under §§1815(a) and 1883(e) of the Act to request any missing documentation required to complete the desk review.

NOTE: The responses on all lines are “yes” or “no” unless otherwise indicated. When the instructions require documentation, indicate on the documentation the Worksheet S-2 line number the documentation supports.

Line 1.--Indicate whether the hospice has changed ownership immediately prior to the beginning of the cost reporting period. Enter “Y” for yes or “N” for no in column 1. If yes, enter the date the change of ownership occurred in column 2. Also, submit documentation identifying the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2.--Indicate whether the hospice has terminated participation in the Medicare program. Enter “Y” for yes or “N” for no in column 1. If yes, enter the date of termination in column 2, and “V” for voluntary or “I” for involuntary in column 3.

Line 3.--Indicate whether the hospice is involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter “Y” for yes or “N” for no. If yes, submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report. (See CMS Pub. 15-1, chapter 10 and 42 CFR §413.17.)

Line 4.--Indicate in column 1 whether the financial statements were prepared by a certified public accountant; enter “Y” for yes or “N” for no. If column 1 is yes, indicate the type of financial statements in column 2 by entering “A” for audited, “C” for compiled, or “R” for reviewed. Submit a complete copy of the financial statements (i.e., the independent public accountant’s opinion, the statements themselves, and the footnotes) with the cost report. If the

financial statements are not available for submission with the cost report, enter in column 3 the date the financial statements will be available.

If column 1 is no, submit a copy of the internally prepared financial statements, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement that occurred during the cost reporting period. The changed accounting or administrative procedures manuals may be submitted in lieu of written statements.

Line 5.--Indicate whether the total expenses and total revenues reported on the cost report differ from those on the financial statements. Enter "Y" for yes or "N" for no in column 1. If yes, submit a schedule reconciling the financial statements with the cost report.

Line 6.--Indicate whether the cost report was prepared using only the Provider Statistical & Reimbursement (PS&R) report by entering "Y" for yes or "N" for no in column 1. If yes, enter the paid-through date of the PS&R report in column 2. Submit a crosswalk matching revenue codes and charges found on the PS&R report to the cost center groupings on the cost report.

Line 7.--Indicate whether the cost report was prepared using the PS&R report for totals and provider records for allocation by entering "Y" for yes or "N" for no in column 1. If yes, enter the paid-through date of the PS&R report used to prepare this cost report in column 2. Submit a detailed crosswalk matching revenue codes, departments and charges on the PS&R report to the cost center groupings on the cost report. This crosswalk must show dollars by cost center and identify which revenue codes were allocated to each cost center. The total revenue on the cost report must match the total charges on the PS&R report (as appropriately adjusted for unpaid claims, etc.) to use this method. Workpapers must accompany this crosswalk to support the accuracy of the provider records. If the contractor does not find the documentation sufficient, the PS&R report will be used in its entirety.

Line 8.--If either line 6 or 7, column 1 is yes, indicate whether adjustments were made to the PS&R report data for additional claims that have been billed but not included on the PS&R report. Enter "Y" for yes or "N" for no. If yes, include a schedule supporting any claims not included on the PS&R report. On the schedule, include totals consistent with the breakdowns on the PS&R report, and list claims that are unprocessed or unpaid as of the paid-through date of the PS&R report.

Line 9.--If either line 6 or 7, column 1 is yes, indicate whether adjustments were made to the PS&R report data for corrections of other PS&R report information. Enter "Y" for yes or "N" for no. If yes, submit a detailed explanation and supporting documentation reconciling the PS&R report to the cost report.

Line 10.--If either line 6 or 7, column 1 is yes, indicate whether other adjustments were made to the PS&R report data. Enter "Y" for yes or "N" for no. If yes, enter a description of the adjustments in the space provided and submit documentation reconciling the PS&R report to the cost report.

Line 11.--Indicate whether the cost report was prepared using only provider records. Enter "Y" for yes or "N" for no. If yes, submit detailed documentation of the system used to support the data reported on the cost report. If detailed documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum documentation requirements are:

- Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a manner consistent with the PS&R report.
- A reconciliation of remittance totals to the provider's internal records.
- The name of the system used and system maintainer (vendor or provider). If the provider maintained the system, include date of last software update.

NOTE: Additional documentation may be supplied such as narratives, internal flow charts, or outside vendor informational material to further describe and validate the reliability of the system.

Line 12.--Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.

Line 13.--Enter the employer or company name of the cost report preparer.

Line 14.--Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.

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4310. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A provides for recording the trial balance of expense accounts from the hospice 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 that facilitates the

combination of the various groups of cost centers for purposes of cost finding. Cost centers listed may not apply to every provider using these forms. Complete only those lines that are applicable.

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

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

Cost center coding is a method for standardizing cost center labels used by health care providers on the Medicare cost report. Form CMS 1984-14 provides for preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. The standard cost center labels are automatically coded by CMS approved cost reporting software. The CMS approved cost reporting software also accommodates cost centers that are frequently used by health care providers but not included as standard cost centers, hereafter referred to as the nonstandard cost centers. Table 5 provides a description of cost center coding and the table of cost center codes (see §4395).

This coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each provider label in the ECR provide standardized meaning for data analysis. Providers are required to compare any added or changed label to the descriptions offered on the standard and nonstandard cost center tables.

#### COLUMN DESCRIPTIONS

Column 1.--Salaries are the gross salaries paid to employees before taxes and other items are withheld. Salaries include deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-1, chapter 21.) Enter salaries from the hospice accounting books and records and/or trial balance. Salaries for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported in column 1 of Worksheets A-1, A-2, A-3 and A-4.

Column 2.--Enter all costs other than salaries from the hospice accounting books and records and/or trial balance. Other costs for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported in column 2 of Worksheets A-1, A-2, A-3 and A-4.

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Column 3.--For each cost center, add the amounts in columns 1 and 2 and enter the total in column 3.

Column 4.--For each cost center, enter the net amount of reclassifications from Worksheet A-6. The net total of the entries in column 4 must equal zero on line 100.

Column 5.--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4. The total on column 5, line 100 must equal the total on column 3, line 100.

Column 6.--For each cost center, enter the net of any increase and decrease amounts from Worksheet A-8. The total on Worksheet A, column 6, line 100 must equal Worksheet A-8, column 2, line 50.

Column 7.--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. Transfer the amounts in column 7 for cost centers marked with an asterisk (\*) to Worksheet B as follows:

From Worksheet A, Column 7, Line Number and Cost Center Description	To Worksheet B, Column 0:
1 Cap Rel Costs-Bldg & Fixt	Line 1
2 Cap Rel Costs-Mvble Equip	Line 2
3 Employee Benefits	Line 3
4 Administrative & General	Line 4
5 Plant Operation and Maintenance	Line 5
6 Laundry & Linen	Line 6
7 Housekeeping	Line 7
8 Dietary	Line 8
9 Nursing Administration	Line 9
10 Routine Medical Supplies	Line 10
11 Medical Records	Line 11
12 Staff Transportation	Line 12
13 Volunteer Service Coordination	Line 13
14 Pharmacy	Line 14
15 Physician Administrative Services	Line 15
16 Other General Service	Line 16
60 Bereavement Program	Line 60
61 Volunteer Program	Line 61
62 Fundraising	Line 62
63 Hospice/Palliative Medicine Fellows	Line 63
64 Palliative Care Program	Line 64
65 Other Physician Services	Line 65
66 Residential Care	Line 66
67 Advertising	Line 67
68 Telehealth/Telemonitoring	Line 68
69 Thrift Store	Line 69
70 Nursing Facility Room and Board	Line 70
71 Other Nonreimbursable	Line 71

LINE DESCRIPTIONS

The Worksheet A cost centers are segregated into general service, direct patient care service, and nonreimbursable categories to facilitate the transfer of costs to the various worksheets. For example, the general service cost centers appear on Worksheets B and B-1 using the same line

numbers as Worksheet A. The direct patient care service cost centers appear on Worksheets A-1, A-2, A-3, and A-4 using the same line numbers as Worksheet A.

## GENERAL SERVICE COST CENTERS

General service cost centers include expenses incurred in **operating** the facility as a whole that are not directly **associated** with furnishing patient care such as, but not limited to mortgage, **rent**, plant operations, administrative **salaries**, utilities, **telephone**, and computer hardware and software costs. General service cost centers furnish services to other general service cost centers and to reimbursable and nonreimbursable cost centers.

Lines 1 and 2 - Capital Related Costs-Buildings & Fixtures and Capital Related Costs-Moveable Equipment.--These cost centers include the capital-related costs for buildings and fixtures and the capital-related costs for movable equipment including 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 lease payments for repairs and/or maintenance; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Line 3 - Employee Benefits.--This cost center includes the costs of the employee benefits department. In addition, this cost center includes the fringe benefits paid to, or on behalf of, an employee when a provider's accounting system is not designed to accumulate the benefits on a departmentalized or cost center basis. (See CMS Pub. 15-1, chapter 21, §2144).

Line 4 - Administrative and General.--The administrative and general (A&G) cost center includes a wide variety of provider administrative costs that benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs. Marketing and advertising costs that are not related to patient care, fundraising costs, and other nonreimbursable costs are not included here, but are reported in the appropriate nonreimbursable cost center.

If the option to subscript A&G costs into more than one cost center is elected (in accordance with CMS Pub. 15-1, chapter 23, §2313), eliminate line 4. Begin numbering the subscripted A&G cost centers with line 4.01 and continue in sequential order.

Line 5 - Plant Operation and Maintenance.--This cost center includes 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 costs 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 costs of maintaining the safety and well-being of personnel, visitors and the provider's facilities are also included in this cost center.

Line 6 - Laundry and Linen Service.--This cost center includes the cost of routine laundry and linen services whether performed in-house or by outside contractors.

Line 7 - Housekeeping.--This cost center includes the cost of routine housekeeping activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 8 - Dietary.--This cost center includes the cost of preparing meals for patients. Do not include the cost of dietary counseling in this cost center; report dietary counseling on line 35.

Line 9 - Nursing Administration.--This cost center includes the cost of overall management and direction of the nursing services. Do not include the cost of direct nursing services reported on lines 27 through 29. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. However, if the hospice accounting system fails to specifically identify all direct nursing services to the applicable direct patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 10 - Routine Medical Supplies.--This cost center includes the cost of supplies used in the normal course of caring for patients, such as gloves, masks, swabs, or glycerin sticks, that generally are not traceable to individual patients. Do not include the costs of non-routine medical supplies that can be traced to individual patients; report non-routine medical supplies on line 42.

Line 11 - Medical Records.--This cost center includes cost of the medical records department where patient medical records are maintained. The general library and the medical library are not included in this cost center but are included in the A & G cost center.

Line 12 - Staff Transportation.--This cost center includes the cost of owning or renting vehicles, public transportation expenses, parking, tolls, or payments to employees for driving their private vehicles to see patients or for other hospice business. Staff transportation costs do not include patient transportation costs; report patient transportation costs on line 39.

Line 13 - Volunteer Service Coordination.--This cost center includes the cost of the overall coordination of service volunteers including their recruitment and training costs of volunteers.

Line 14 - Pharmacy.--This cost center includes the costs of drugs (both prescription and OTC), pharmacy supplies, personnel, and services. Do not report the cost of palliative chemotherapy drugs on this line; report the cost of palliative chemotherapy on line 45.

Line 15 - Physician Administrative Services.--This cost center includes the costs for physicians' administrative and general supervisory activities that are included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies. These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group. Nurse practitioners may not serve as or replace the medical director or physician member of the interdisciplinary group.

Line 17 - Patient/Residential Care Services.--Do not use this line on this worksheet. This cost center is used on Worksheet B to accumulate in-facility costs not separately identified as IRC, GIP, or residential care services that are not part of a separate and distinct residential care unit (e.g., depreciation related to in-facility areas that provide IRC, GIP or residential care). The amounts allocated to this cost center on Worksheet B are allocated to IRC, GIP and residential care services that are not part of a separate and distinct residential care unit, based on in-facility days. This cost center does not include any costs related to contracted inpatient services.

When a residential care unit is separate and distinct and only used for resident care services, costs are reported directly on line 66.

Lines 18 through 24.--Reserved for future use.

#### DIRECT PATIENT CARE SERVICE COST CENTERS

Direct patient care service costs are reported by LOC on Worksheets A-1, A-2, A-3 and A-4. For each cost center on Worksheet A, enter the sum of the amounts from Worksheets A-1, A-2, A-3, and A-4 for salaries, other costs, reclassifications, and adjustments in columns 1, 2, 4, and 6, respectively.

Line 25- Inpatient Care - Contracted.--This cost center includes the contractual costs paid to another facility for use by the hospice for hospice inpatient care (IRC or GIP) in accordance with 42 CFR 418.108(c). This cost center does not include the cost of any direct patient care services or nonreimbursable services provided by hospice staff in the contracted setting. Costs of any services provided by hospice staff in the contracted setting are included in the appropriate direct patient care service or nonreimbursable cost center. Contracted costs in this cost center are excluded from the allocation of A&G costs.

Line 26 - Physician Services.--This cost center includes the costs incurred by the hospice for physicians, or nurse practitioners providing physician services, for direct patient care services and general supervisory services, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group. (See 42 CFR 418.304.) Reclassify the cost for the portion of time physicians spent on general supervisory services or other hospice administrative activities to A&G (line 4). This cost center

must not include costs associated with palliative care or other nonreimbursable physician services. Those nonreimbursable physician services must be reported in the appropriate nonreimbursable cost center.

Line 27 - Nurse Practitioner.--This cost center includes the costs of nursing care provided by nurse practitioners. Do not include costs for nurse practitioners providing physician services on this line; report the costs for nurse practitioners providing physician services on line 26.

Line 28 - Registered Nurse.--This cost center includes the costs of nursing care provided by registered nurses.

Line 29 - LPN/LVN.--This cost center includes the costs of nursing care provided by licensed practical nurses (LPN) or licensed vocational nurses (LVN). Do not include costs for certified nursing assistant (CNA) services on this line; report the costs for CNA services on line 34.

Line 30 - Physical Therapy.--This cost center includes the costs 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. Physical therapy 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 31 - Occupational Therapy.--This cost center includes the costs of purposeful goal-oriented activities in the evaluation, diagnosis, and/or treatment of persons whose function 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. Occupational therapy 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 32 - Speech/Language Pathology.--This cost center includes the costs of 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. 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 33 - Medical Social Services.--This cost center includes the cost of the medical social services defined in CMS Pub. 100-02, chapter 9, §40.1.2. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 34 - Spiritual Counseling.--This cost centers includes the cost of spiritual counseling services. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 35 - Dietary Counseling.--This cost center includes the costs of dietary counseling services.

Line 36 - Counseling - Other.--This cost center include the cost of counseling services not already identified as spiritual, dietary or bereavement counseling. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 37 - Hospice Aide and Homemaker Services.--This cost center includes the costs of:

- Hospice aide services such as personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient; and,
- Homemaker services such as assistance in the maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Include the cost of CNAs that meet the criteria for an aide in this cost center.

Line 38 - Durable Medical Equipment/Oxygen.--This cost center includes the costs of durable medical equipment (DME) and oxygen, as defined in 42 CFR 410.38 and 42 CFR 418.202(f), furnished to individual RHC or CHC patients. Report DME costs by the LOC the patient was receiving at the time the DME/oxygen was delivered. If the LOC of a patient changed after delivery of the DME/Oxygen, the hospice may report the costs proportionally between RHC and CHC based on patient days.

Line 39 - Patient Transportation.--This cost center includes the costs of ambulance transports of hospice patients, related to the terminal prognosis and occurring after the effective date of the hospice election, that are the responsibility of the hospice. (See CMS Pub. 100-02, chapter 9, §40.1.9.) When a patient is transferred to a LOC, report the transportation cost to that LOC. For example, a patient in a GIP LOC is transferred to RHC LOC and transported to their home, the transportation cost associated with the transfer must be included in the RHC LOC.

Line 40 - Imaging Services.--This cost center includes the costs of imaging services.

Line 41 - Labs and Diagnostics.--This cost center includes the costs of laboratory and diagnostic tests.

Line 42 - Medical Supplies - Non-routine.--This cost center includes the costs of medical supplies furnished to individual patients for which a separate charge would be applicable. These supplies are specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician. Do not include the cost of routine medical supplies used in the normal course of caring for patients, (such as gloves, masks, swabs, or glycerin sticks) on this line; report routine medical supplies on line 10. When a provider does not track the use of

non-routine medical supplies by LOC, the provider may report the costs proportionally between LOCs based on patient days.

Line 43 - Outpatient Services.--This cost center includes the costs of outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department visit when related to the terminal condition.

Lines 44 and 45 - Palliative Radiation Therapy and Palliative Chemotherapy.--These cost centers include costs of radiation, chemotherapy and other modalities used for palliative purposes based on the patient's condition and the hospice's caregiving philosophy.

Lines 47 through 49.--Reserved for future use.

Lines 50 through 53.--Reserved for use on Worksheets B and B-1.

Lines 54 through 59.--Reserved for future use.

#### NONREIMBURSABLE COST CENTERS

Nonreimbursable cost centers include costs of nonreimbursable services and programs. Report the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers other than those shown, subscript one or more of these lines with a numeric code. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, when the expense (direct and all applicable overhead) attributable to any non-allowable cost area is so insignificant as to not warrant establishment of a nonreimbursable cost center, remove the expense on Worksheet A-8. (See CMS Pub. 15-1, chapter 23, §2328.)

Line 60 - Bereavement Program.--This cost center includes the cost of bereavement services, defined as emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with grief, loss, and adjustment (42 CFR 418.3). Bereavement counseling is a required hospice service, but it is not reimbursable (see §1814(I)(1)(A) of the Act).

Line 61 - Volunteer Program.--This cost centers includes costs of volunteer programs. (See CMS Pub. 15-1, chapter 7.)

Line 62 - Fundraising.--This cost centers includes costs of fundraising. (See CMS Pub. 15-1, chapter 21, §2136.)

Line 63 - Hospice/Palliative Medicine Fellows.--This cost center includes costs of hospice and palliative medicine fellows.

Line 64 - Palliative Care Program.--This cost center includes costs of palliative care provided to non-hospice patients. This includes physician services.

Line 65 - Other Physician Services.--This cost center includes costs of other physician services that are provided outside of a palliative care program to non-hospice patients.

Line 66 - Residential Care.--This cost center includes the costs of residential care for patients living in the hospice, but who are not receiving inpatient hospice services. Patients living in the hospice are considered residents, where the hospice is their home. These patients are liable for their room and board charges; however, the outpatient hospice care services provided must be recorded in the direct patient care cost centers on the appropriate RHC and/or CHC LOC worksheet.

Lines 67 - Advertising.--This cost center includes costs of nonallowable community education, business development, marketing and advertising (see CMS Pub. 15-1, chapter 21, §2136).

Lines 68 - Telehealth/Telemonitoring.--This cost center includes costs of telehealth/telemonitoring services. The costs are included as a nonreimbursable since a hospice is not an approved originating site (see 42 CFR 410.78(b)(3)).

Lines 69 - Thrift Store.--This cost center includes costs of thrift stores.

Line 70 - Nursing Facility Room and Board.--This cost center includes costs incurred by a hospice for dually eligible beneficiaries residing in a nursing facility (NF) when room and board is paid by the State to the hospice. The full amount paid to the NF by the hospice must be included on this line and offset by the State payment via an adjustment on Worksheet A-8. The residual cost is the net cost incurred.

For example, a dually eligible beneficiary is residing in a NF and has elected the Medicare hospice benefit. The NF charges \$100 per day for room and board. The State pays the hospice \$95 for the NF room and board. The hospice has a written agreement with the NF that requires full room and board payment of \$100 per day. The hospice receives \$95 per day, but pays the NF \$100 per day, thereby incurring a net cost of \$5 per day.

4311. WORKSHEETS A-1, A-2, A-3 AND A-4 - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A-1 - Continuous Home Care  
Worksheet A-2 - Routine Home Care

Worksheet A-3 - Inpatient Respite Care  
Worksheet A-4 - General Inpatient Care

Worksheets A-1, A-2, A-3 and A-4 provide for recording the direct patient care costs by LOC, including reclassifications and adjustments. The general format of these worksheets is identical to Worksheet A in order to facilitate the transfer of direct patient care costs to Worksheet A. For each cost center, the sums of the amounts reported in columns 1, 2, 4, and 6 of these worksheets are transferred to the corresponding columns on Worksheet A.

Column 1.--Enter salaries from the hospice accounting books and records and/or trial balance.

Column 2.--Enter all costs other than salaries from the hospice accounting books and records and/or trial balance.

Column 3.--For each cost center, add the amounts in columns 1 and 2 and enter the total in column 3.

Column 4.--For each cost center, enter the net Worksheet A-6 increase and decrease amounts that can be identified by LOC. The total of the entries in column 4 may not equal zero on line 100.

Column 5.--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4.

Column 6.--For each cost center, enter the net Worksheet A-8 increase and decrease amounts that can be identified by LOC.

Column 7.--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. Transfer the amounts in column 7, line 100 to Worksheet B, column 0 as follows:

<u>From column 7, line 100 of:</u>	<u>To</u>	<u>Worksheet</u>	<u>B,</u>	<u>column</u>	<u>0:</u>
Worksheet A-1					Line 50
Worksheet A-2					Line 51
Worksheet A-3					Line 52
Worksheet A-4					Line 53

4316. WORKSHEET A-6 - RECLASSIFICATIONS AND ADJUSTMENTS TO EXPENSES

This worksheet provides for the reclassification of costs to effect proper cost allocation under cost finding. For example:

- Reclassification of employee benefits expenses (e.g., personnel department, employee health service, hospitalization insurance, workers compensation, employee group insurance, social security taxes, unemployment taxes, annuity premiums, past service benefits, and pensions) included in the A & G cost center.
- Reclassification from Worksheet A-4 (GIP) to Worksheet A-3 (IRC) of IRC RN expenses included in the registered nurse cost center on Worksheet A-4.

Column 1.--Identify each reclassification adjustment by assigning an alpha character (e.g., A, B, C) in column 1. Do not use numeric designations.

Columns 2, 3 and 4.--For each increase reclassification, enter the amount in column 4, the Worksheet A cost center line number reference in column 3, and the corresponding cost center description in column 2.

Columns 5, 6 and 7.--For each decrease reclassification, enter the amount in column 7, the Worksheet A cost center line number reference in column 6, and the corresponding cost center description in column 5.

Column 8.--Enter the LOC worksheet indicator using 1, 2, 3 or 4 when a reclassification affects a direct patient care service cost center (lines 25 through 46). If a reclassification affects more than one LOC, report each entry as a separate line to properly identify each LOC worksheet. The indicators are defined as follows:

<u>LOC Worksheet</u>	<u>LOC</u>	<u>Worksheet</u>	<u>Indicator</u>
Worksheet A-1			1
Worksheet A-2			2
Worksheet A-3			3
Worksheet A-4			4

For line 100, the sum of all increases in column 4 must equal the sum of all decreases in column 7. Submit (with the cost report) copies of workpapers used to compute the reclassifications.

4318. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

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

amounts are not allowable. This worksheet provides for the adjustments in support of those listed on Worksheet A, column 6. These adjustments, required under Medicare principles of reimbursement, are made on the basis of cost or, only if the cost (including direct cost and all applicable overhead) cannot be determined, amount received (revenue). If the total direct and indirect cost can be determined, enter the cost. Adjustments to expenses based on cost cannot be based on revenue in subsequent cost reporting periods. Submit documentation used to compute a cost adjustment with the cost report. Adjustments entered on this worksheet are to:

- reflect actual expenses incurred,
- record the recovery of expenses through sales, charges, or fees,
- adjust expenses in accordance with the Medicare principles of reimbursement, and
- adjust expenses for those items provided for separately in the cost apportionment process.

When an adjustment to an expense affects more than one cost center or more than one LOC, record the adjustment to each cost center or LOC on a separate line.

Column 1.--Enter the basis for each adjustment using "A" for cost or "B" for revenue.

Columns 2, 3 and 4.--For each adjustment, enter the amount in column 2, enter the Worksheet A cost center line number reference in column 4, and enter the corresponding cost center description in column 3.

Column 5.--For each adjustment, enter the LOC worksheet indicator (defined in §4316) using 1, 2, 3 or 4 when an adjustment affects a direct patient care service cost center (lines 25 through 46).

Line 1.--Enter the investment income applied against interest expense. (See CMS Pub. 15-1, chapter 2, §202.2.)

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

Line 3.--Enter the amount from Worksheet A-8-1, column 6, line 10.

Line 4.--Enter the amount received from the sale of meals to employees and guests.

Line 5.--Enter the amounts received from imposition of interest, finance, or penalty charges on overdue receivables. This income must be used to offset allowable A&G costs. (See CMS Pub. 15-1, chapter 21, §2110.2.)

Line 6.--Enter the amount of bad debts included on the trial balance.

Line 7.--Include items patients purchased from the hospice, the cost of which is included in any of the cost centers on Worksheet A such as laundry and linen service.

Lines 8 and 9.--When depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per the hospice's books, enter the difference on line 8 and/or line 9. (See CMS Pub. 15-1, chapter 1.)

Line 10.--Enter the Medicaid room and board payments, for dual-eligible beneficiaries, that are redirected by the State from the nursing home to the hospice.

Line 11 through 49.--Enter any additional adjustments required under the Medicare principles of reimbursement. A description must be entered in the description column to indicate the nature of the adjustment.

Line 50.--Enter the sum of lines 1 through 49.

NOTE: Transfer amounts entered in column 2, lines 1 through 49 to the appropriate lines on Worksheet A, column 6.

#### 4319. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

In accordance with 42 CFR 413.17 (except as provided in 42 CFR 413.17(d)), costs applicable to services, facilities, and supplies furnished to the hospice by organizations related to the hospice by common ownership or control are includable in the hospice's allowable cost at the cost to the related organization. However, such cost must not exceed the amount a prudent and cost conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.

4319.1 Part I - Costs Incurred and Adjustments Required as a Result of Transactions with Related Organizations or Claimed Home Office Costs.--This part of the worksheet provides for the computation of adjustments needed to properly report costs of services, facilities, and supplies furnished to the hospice by related organizations or costs associated with the home office.

Columns 1 and 2.--Enter in column 1 the Worksheet A cost center line number to be adjusted. Enter the corresponding cost center description in column 2.

Column 3.--Enter the description of the related organization or home office expense.

Column 4.--Enter the allowable costs from the books and/or records of the related organization or home office. Allowable costs are the actual costs incurred by the related organization or home office for services, facilities, and/or supplies and exclude any markup, profit or amounts that otherwise exceed the acquisition cost of such items.

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Column 5.--Enter the amount included on Worksheet A for services, facilities, and/or supplies acquired from related organizations or home office.

Column 6.--Enter the result of column 4 minus column 5.

Column 7.--Enter the LOC worksheet indicator (defined in §4316) using 1, 2, 3 or 4 when an adjustment affects a direct patient care service cost center (lines 25 through 46).

4319.2 Part II - Interrelationship to Related Organizations and/or Home Office.--This part of the worksheet identifies the interrelationship between the hospice and individuals, partnerships, corporations, or other organizations having either a related interest to, a common ownership with, or control over the hospice as defined in CMS Pub. 15-1, chapter 10. Complete columns 1 through 6 as applicable for each interrelationship.

Column 1.--Enter the symbol that represents the interrelationship between the hospice and the related organization or home office. Select from the following choices:

<u>Symbol</u>	<u>Relationship</u>
A	Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider
B	Corporation, partnership or other organization has financial interest in provider
C	Provider has financial interest in corporation, partnership, or other organization
D	Director, officer, administrator or key person of provider or organization
E	Individual is director, officer, administrator or key person of provider and related organization
F	Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider
G	Other (financial or non-financial) -- specify

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

Column 3.--If the individual reported in column 2, or the organization reported in column 4, has a financial interest in the hospice, enter the percentage of ownership.

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

Column 5.--If the hospice, or an individual reported in column 2, has a financial interest in the organization reported in column 4, enter the percentage of ownership.

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

4320. WORKSHEET B - COST ALLOCATION - GENERAL SERVICE COSTS AND  
WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

In accordance with 42 CFR 413.24, cost data must be based on an approved method of cost finding and on the accrual basis of accounting except where governmental institutions operate on a cash basis of accounting. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

Worksheets B and B-1 facilitate the step-down method of cost finding. This method recognizes that general services of the hospice are utilized by other general service, direct patient care service, and nonreimbursable cost centers. Worksheet B provides for the equitable allocation of general service costs based on statistical data reported on Worksheet B-1. To facilitate the allocation process, the general format of Worksheets B and B-1 is identical. The column and line numbers for each general service cost center are identical on the two worksheets. The direct patient care service cost centers (lines 25 through 46 of Worksheet A) are reported by LOC on lines 50 through 53 of Worksheets B and B-1. The line numbers for nonreimbursable cost centers are identical on Worksheets A, B and B-1.

When certain general services costs are related to in-facility days and are not separately identifiable by LOC or service, Worksheets B and B-1 provide for the accumulation of these costs on line 17. The amounts accumulated in this cost center are allocated based on the in-facility days for IRC, GIP, and residential care services that are not part of a separate and distinct residential care unit. This cost center does not include any costs related to contracted inpatient services.

The statistical basis shown at the top of each column on Worksheet B-1 is the recommended basis of allocation. The total statistic for cost centers using the same basis (e.g., square feet) may differ with the closing of preceding cost centers. A hospice can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is submitted in accordance with CMS Pub. 15-1, chapter 23, §2313.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) so that the cost centers rendering the most services to and receiving the least services from other cost centers are closed first (see CMS Pub. 15-1, chapter 23, §2306.1). If a more accurate result is obtained by allocating costs in a sequence that differs from the recommended sequence, the hospice must request approval in accordance with CMS Pub. 15-1, chapter 23, §2313.

If the amount of any cost center on Worksheet A, column 7, has a negative balance, show this amount as a negative balance on Worksheet B, column 0. Allocate the costs from the overhead cost centers to applicable cost centers, including those with a negative balance. Close a general service cost center with a negative balance by entering the negative balance in parentheses on the first line and on line 99 of the column, and do not allocate. This enables Worksheet B, column 18, line 100 to cross foot to Worksheet B, column 0, line 100. After receiving costs from overhead cost centers, LOC cost centers with negative balances on Worksheet B, column 18, are not transferred to Worksheet C.

On Worksheet B-1, enter on the first line of each column the total statistics applicable to the cost center being allocated (e.g., in column 1, Capital-Related Costs - Buildings and Fixtures, enter on line 1 the total square feet of buildings on which depreciation was taken). Use accumulated cost for allocating A&G expenses.

Such statistical base, including accumulated cost for allocating A&G expenses, 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 the hospice's books/records; or
- The contractor determines that the hospice is able to and does gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if the hospice had furnished such services directly to all patients. (See CMS Pub. 15-1, chapter 23, §2314.)

For each cost center being allocated, enter that portion of the total statistical base applicable to each cost center receiving services. For each column, the sum of the statistics entered for cost centers receiving services must equal the total statistical base entered on the first line.

For each column on Worksheet B-1, enter on line 100 the total expenses of the cost center to be allocated. Obtain the total expenses from the first line of the corresponding column on Worksheet B, which includes the direct expenses from Worksheet B column 0 plus allocated costs from previously closed cost centers. Divide the amount entered on Worksheet B-1, line 100 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier (rounded to six decimal places) on line 101.

Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving services and enter the result in the corresponding column and line on Worksheet B. For each column, the sum of the costs allocated (line 100) must equal the total cost on the first line.

After all the costs of the general service costs have been allocated on Worksheet B, enter in column 18 the sum of the costs in columns 3A through column 17 for lines 50 through 71. The total costs entered in column 18, line 100 must equal the total costs entered in column 0, line 100.

#### COLUMN DESCRIPTIONS

Column 0.--For each cost center except the direct patient care cost centers (lines 25 through 46), enter the total direct costs from Worksheet A, column 7. For the direct patient care cost centers, enter the total direct costs as follows:

<u>From column 7, line 100 of:</u>	<u>To Worksheet B, column 0:</u>
Worksheet A-1	Line 50
Worksheet A-2	Line 51
Worksheet A-3	Line 52
Worksheet A-4	Line 53

Column 3A.--For each cost center, enter the sum of columns 0 through 3. The sum for each cost center is the accumulated cost and, unless an adjustment is required, is the Worksheet B-1, column 4 statistic for allocating A&G costs.

If an adjustment to the accumulated cost statistic on Worksheet B-1, column 4 is required to properly allocate A&G costs, enter the adjustment amount on Worksheet B-1, column 4A for the applicable cost center. For example, when the hospice contracts for services and the contract

identifies A&G costs, the contracted cost may be used to reduce the accumulated cost statistic of the applicable cost center.

For each cost center, the accumulated cost statistic on Worksheet B-1, column 4 is the difference between the amount on Worksheet B, column 3A and the adjustment amount on Worksheet B-1, column 4A. Accumulated cost for A&G is not included in the total statistic for the A&G cost center; therefore, transfer the amount on Worksheet B, column 3A, line 4 to Worksheet B-1, column 4A, line 4.

The total accumulated cost statistic for Worksheet B-1, column 4, line 4 is the difference between the total on Worksheet B, column 3A, line 100 and the amounts in column 4A of Worksheet B-1.

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.

Column 18.--Transfer the amounts on lines 50 through 53 as follows:

<u>From Worksheet B, column 18:</u>	<u>To Worksheet C, column 3:</u>
Line 50	Line 1
Line 51	Line 6
Line 52	Line 11
Line 53	Line 16

#### 4330. WORKSHEET C - CALCULATION OF PER DIEM COST

Worksheet C calculates the average cost per diem by level of care and in total.

Line 1.--Enter in column 3 the total CHC cost from Worksheet B, column 18, line 50.

Line 2.--Enter in column 3 the total CHC days from Worksheet S-1, column 4, line 30.

Line 3.--Enter in column 3 the average CHC cost per diem by dividing column 3, line 1 by column 3, line 2.

Line 4.--Enter in column 1 the Title XVIII - Medicare CHC days from Worksheet S-1, column 1, line 30. Enter in column 2 the Title XIX - Medicaid CHC days from Worksheet S-1, column 2, line 30.

Line 5.--Enter in column 1 the Title XVIII - Medicare program cost calculated by multiplying column 3, line 3 by column 1, line 4. Enter in column 2 the Title XIX - Medicaid program cost calculated by multiplying column 3, line 3 by column 2, line 4.

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Line 6.--Enter in column 3 the total RHC cost from Worksheet B, column 18, line 51.

Line 7.--Enter in column 3 the total RHC days from Worksheet S-1, column 4, line 31.

Line 8.--Enter in column 3 the average RHC cost per diem by dividing column 3, line 6 by column 3, line 7.

Line 9.--Enter in column 1 the Title XVIII - Medicare RHC days from Worksheet S-1, column 1, line 31. Enter in column 2 the Title XIX - Medicaid RHC days from Worksheet S-1, column 2, line 31.

Line 10.--Enter in column 1 the Title XVIII - Medicare program cost calculated by multiplying column 3, line 8 by column 1, line 9. Enter in column 2 the Title XIX - Medicaid program cost calculated by multiplying column 3, line 8 by column 2, line 9.

Line 11.--Enter in column 3 the total IRC cost from Worksheet B column 18, line 52.

Line 12.--Enter in column 3 the total IRC days from Worksheet S-1, column 4, line 32.

Line 13.--Enter in column 3 the average IRC cost per diem by dividing column 3, line 11 by column 3, line 12.

Line 14.--Enter in column 1 the Title XVIII - Medicare IRC days from Worksheet S-1, column 1, line 32. Enter in column 3 the Title XIX - Medicaid IRC days from Worksheet S-1, column 2, line 32.

Line 15.--Enter in column 1 the Title XVIII - Medicare program cost calculated by multiplying column 3, line 13 by column 1, line 14. Enter in column 2 the Title XIX - Medicaid program cost calculated by multiplying column 3, line 13 by column 2, line 14.

Line 16.--Enter in column 3 the total GIP cost from Worksheet B, column 18, line 53.

Line 17.--Enter in column 3 the total GIP days from Worksheet S-1, column 4, line 33.

Line 18.--Enter in column 3 the average GIP cost per diem by column 3, line 16 by column 3, line 17.

Line 19.--Enter in column 1 the Title XVIII - Medicare GIP days from Worksheet S-1, column 1, line 33. Enter in column 3 the Title XIX - Medicaid GIP days from Worksheet S-1, column 2, line 33.

Line 20.--Enter in column 1 the Title XVIII - Medicare program cost calculated by multiplying column 3, line 18 by column 1, line 19. Enter in column 2 the Title XIX - Medicaid program cost calculated by multiplying column 3, line 18 by column 2, line 19.

Line 21.--Enter in column 3 the sum of lines 1, 6, 11 and 16.

Line 22.--Enter in column 3 total days from Worksheet S-1, column 4, line 34.

Line 23.--Enter the average cost per diem by dividing column 3, line 21 by column 3, line 22.

#### 4350. FINANCIAL STATEMENT WORKSHEETS

Prepare these worksheets from the hospice accounting books and records. Where applicable, the worksheets must be consistent with financial statements prepared by certified public accountants.

##### 4350.1 WORKSHEET F - BALANCE SHEET

Report the sum of account balances and adjustments consistent with the hospice financial statements.

Line 1 - Cash on hand and in banks.--Enter 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, impress cash funds, saving accounts, certificates of deposit, treasury bills and treasury notes and other cash accounts.

Line 2 - Temporary investments.--Enter current securities evidenced by certificates of ownership or indebtedness. Typical accounts would be marketable securities and other current investments.

Line 3 - Notes receivable.--Enter current unpaid amounts evidenced by certificates of indebtedness.

Line 4 - Accounts receivable.--Enter unpaid inpatient and outpatient billings. Include direct billings to patients for deductibles, co-insurance and other patient chargeable items not included elsewhere.

Line 5 - Other receivable.--Enter other unpaid amounts due to the hospice.

Line 6 - Less: Allowance for uncollectable notes and accounts.--Enter the estimated amount of the hospice accounts receivable which are expected to not be paid.

Line 7 - Inventory.--Enter the costs of unused hospice 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 hospice. The 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 that are properly chargeable to a future accounting period.

Line 9 - Other current assets.--Enter the balances of other current assets.

Line 10 - Total Current Assets.--Enter the sum of lines 1 through 9.

Line 11 - Land.--Enter the cost of land as defined in CMS Pub. 15-1, chapter 1, §104.6.

Lines 12 and 13 - Land improvements.--Enter on line 12 the costs of land improvements as defined in CMS Pub. 15-1, chapter 1, §104.7. Enter accumulated depreciation on line 13.

Lines 14 and 15 - Buildings.--Enter on line 14 the costs of the hospice buildings as defined in CMS Pub. 15-1, chapter 1, §104.2. Enter accumulated depreciation on line 15.

Lines 16 and 17 - Leasehold improvements.--Enter on line 16 the costs of leasehold improvements as defined in CMS Pub. 15-1, chapter 1, §104.8. Enter accumulated depreciation on line 17.

Lines 18 and 19 - Fixed equipment.--Enter on line 18 the costs of building equipment as defined in CMS Pub. 15-1, chapter 1, §104.3. Enter accumulated depreciation on line 19.

Lines 20 and 21 - Automobiles and trucks.--Enter on line 20 the costs of automobiles and trucks used in hospice operations. Enter accumulated depreciation on line 21.

Lines 22 and 23 - Major movable equipment.--Enter on line 22 the costs of equipment as defined in CMS Pub. 15-1, chapter 1, §104.4. Enter accumulated depreciation on line 23.

Lines 24 and 25 - Minor equipment-depreciable.--Enter on line 24 the costs of minor equipment as defined in CMS Pub. 15-1, chapter 1, §104.5. Enter accumulated depreciation on line 25.

Line 26 - Total fixed assets.--Enter the sum of lines 11 through 25.

Line 27 - Investments.--Enter the cost of investments purchased with hospice funds and the fair market value (at date of donation) of securities donated to the hospice.

Line 28 - Deposits on leases.--Enter the amount of deposits on leases including security deposits.

Line 29 - Due from owners/officers.--Enter the amount loaned to the hospice by owners and/or officers.

Line 30 - Other assets.--Enter the amounts for assets not reported on lines 1 through 9, lines 11 through 25, or lines 27 through 29 (e.g., intangible assets such as goodwill, unamortized loan costs and other organization costs).

Line 31 - Total other assets.--Sum of lines 27 through 30.

Line 32 - Total assets.--Sum of lines 10, 26 and 31.

Line 33 - Accounts payable.--Enter amounts due trade creditors and others for supplies and services purchased.

Line 34 - Salaries, wages and fees payable.--Enter the actual or estimated liabilities of salaries and wages/fees payable.

Line 35 - Payroll taxes payable.-- Enter the actual or estimated liabilities of amounts payable for payroll taxes withheld from salaries and wages, payroll taxes to be paid and other payroll deductions, such as hospitalization insurance premiums.

Line 36 - Notes and loans payable (short-term).--Enter amounts payable on notes and loans as evidenced by certificates of indebtedness due in the next 12 months.

Line 37 - Deferred income.--Enter the amount of deferred income received or accrued 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 38 - Accelerated payments.--Enter the amounts payable for accelerated payments in accordance with CMS Pub 15-1 §2412.

Line 39 - Other current liabilities.--Enter current liabilities not reported on lines 33 through 38.

Line 40 - Total current liabilities.--Enter the sum of lines 33 through 39.

Line 41 - Mortgage payable.--Enter the long-term financing obligation as evidenced by certificates of indebtedness used to purchase real estate/property.

Line 42 - Notes payable.--Enter amounts payable on notes and loans as evidenced by certificates of indebtedness due after the next 12 months.

Line 43 - Unsecured loans.--Enter amounts payable for unsecured liabilities due after the next 12 months.

Line 44 - Other long-term liabilities.--Enter the amounts payable to owners and/or officers for loans to the hospice.

Line 45 - Other long-term liabilities.--Enter long-term liabilities not reported on lines 41 through 44.

Line 46 - Total long-term liabilities.--Enter the sum of lines 41 through 45.

Line 47 - Total liabilities.--Enter the sum of lines 40 and 46.

Line 48 - Fund balance.--Enter the end of period fund balance.

Line 49 - Total liabilities and fund balance.--Enter the sum of lines 47 and 48.

#### 4350.2 WORKSHEET F-1 - STATEMENT OF CHANGES IN FUND BALANCES

Hospices maintaining fund-type accounting records complete the applicable columns. Nonproprietary hospices not maintaining fund-type accounting records complete the general fund column.

#### 4350.3 WORKSHEET F-2 - STATEMENT OF REVENUES AND OPERATING EXPENSES

Part I - Revenues.--Enter gross revenue amounts for each payor source.

Part II - Operating Expenses.--Enter gross operating expenses for the cost reporting period.