

CHAPTER 41

SKILLED NURSING FACILITY AND SKILLED NURSING  
FACILITY HEALTH CARE COMPLEX COST REPORT  
FORM CMS-2540-10

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## 4100. GENERAL

The Paperwork Reduction Act (PRA) of 1995 requires that the private sector be informed as to why information is collected and what the information is used for by the government. In accordance with §§1815(a) and 1861(v)(1)(A) of the Act, providers of service participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. *In addition*, 42 CFR 413.20 *and 413.24* require *adequate cost data and* cost reports from providers on an annual basis. In accordance with these provisions, Form CMS-2540-10 must be completed by all skilled nursing facilities (SNFs) and SNF health care complexes. The information reported must conform to the requirements and principles set forth in the Provider Reimbursement Manual (CMS Pub. 15-1). The instructions contained in this chapter are effective for cost reporting periods beginning on or after December 1, 2010.

*The electronic cost report (ECR) file is considered the official means of cost report submissions.* In addition to Medicare reimbursement, these forms also provide for the computation of reimbursable costs applicable to titles V and XIX. Complete the worksheets and portions of worksheets applicable to titles V and XIX only when reimbursement is being claimed from these respective programs and only to the extent these forms are required by the State program.

Public reporting burden for this collection of information is estimated to average 65 hours per response, and record keeping burden is estimated to average 137 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. 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

4100.1 Rounding Standards for Fractional Computations.--Throughout the Medicare cost report, required computations result in the use of fractions. The following rounding standards must be employed for such computation.

1. Round to 2 decimal places:
  - a. Percentages
  - b. Averages, standard work week, payment rates, and cost limits
  - c. Full time equivalent employees
  - d. Per diem, hourly rates
2. Round to 6 decimal places:
  - a. Ratios (e.g., unit cost multipliers, cost/charge ratios)

If a residual exists as a result of computing costs using a fraction, adjust the residual in the largest amount resulting from the computation. For example, in cost finding, a unit cost multiplier is applied to the statistics in determining costs. After rounding each computation, the sum of the allocation may be more or less than the total cost allocated. This residual is adjusted to the largest amount resulting from the allocation so that the sum of the allocated amounts equals the amount allocated.

4100.2 Acronyms and Abbreviations.--Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

A&G	-	Administrative and General
AHSEA	-	Adjusted Hourly Salary Equivalency Amount
ASC	-	Ambulatory Surgical Center
BBA	-	Balanced Budget Act of 1997 (PL105-33)
CAP-REL	-	Capital-Related
CBSA	-	Core-Based Statistical Area
CCN	-	CMS Certified Number
CCU	-	Coronary Care Unit
CFR	-	Code of Federal Regulations
CMHC	-	Community Mental Health Center
CMS	-	Centers for Medicare and Medicaid Services
CMS Pub.	-	Centers for Medicare and Medicaid Services' Publication
<i>CNA</i>	-	<i>Certified Nursing Assistant</i>
COL	-	Column
CORF	-	Comprehensive Outpatient Rehabilitation Facility
CRNA	-	Certified Registered Nurse Anesthetist
DMERC	-	Durable Medical Equipment Regional Carrier
DRA	-	Deficit Reduction Act of 2005
EKG	-	Electrocardiogram
FQHC	-	Federally Qualified Health Center
FR	-	Federal Register
<i>GME</i>	-	<i>Graduate Medical Education</i>
<i>HCHC</i>	-	<i>Hospice Continuous Home Care</i>
<i>HGIP</i>	-	<i>Hospice General Inpatient Care</i>
<i>HIRC</i>	-	<i>Hospice Inpatient Respite Care</i>
<i>HRHC</i>	-	<i>Hospice Routine Home Care</i>
HHA	-	Home Health Agency
HMO	-	Health Maintenance Organization
HSPC	-	Hospice
ICF/ <i>IID</i>	-	Intermediate Care Facility for <i>Individuals with Intellectual Disabilities</i>

ICU	-	Intensive Care Unit
INPT	-	Inpatient
IOM	-	Internet Only Manual
LCC	-	Lesser of Reasonable Cost or Customary Charges
<i>LOC</i>	-	<i>Level of Care</i>
LUPA	-	Low Utilization Payment Adjustment
MED-ED	-	Medical Education
MSA	-	Metropolitan Statistical Area
NHCMQ	-	Nursing Home Case Mix and Quality Demonstration
NF	-	Nursing Facility
NPI	-	National Provider Identifier
OBRA	-	Omnibus Budget Reconciliation Act
OLTC	-	Other Long Term Care
OOT	-	Outpatient Occupational Therapy
OPT	-	Outpatient Physical Therapy
OSP	-	Outpatient Speech Pathology
PBP	-	Provider-Based Physician
PEP	-	Partial Episode Payment
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PRO	-	Professional Review Organization
PS&R	-	Provider Statistical and Reimbursement System
PT	-	Physical Therapy
RCE	-	Reasonable Compensation Equivalent
RHC	-	Rural Health Clinic
RPCH	-	Rural Primary Care Hospitals
RT	-	Respiratory Therapy
RUG	-	Resource Utilization Group
SNF	-	Skilled Nursing Facility
WKST	-	Worksheet

## 4101 RECOMMENDED SEQUENCE FOR COMPLETING A SNF COST REPORT

4101.1 Recommended Sequence for Completing a SNF or SNF Health Care Complex - Full Cost Report.Part I - Departmental Cost Adjustments and Cost Allocation

<u>Step No.</u>	<u>Worksheet</u>	
1	S-2, <i>Parts I &amp; II</i>	Read §4104. Complete entire worksheet.
2	<i>S-3, Parts I - V</i>	Read §4105. Complete all worksheets.
3	S-7	Read §4109. Complete entire worksheet.
4	A	Read §4113. Complete columns 1 through 3, lines 1 through 100.
5	A-6	Read §4114. Complete, if applicable.
6	A	Read §4113. Complete columns 4 and 5, lines 1 through 100.
7	A-7	Read §4115. Complete entire worksheet.
8	A-8-1	Read §4117. Complete entire worksheet.
9		
10	A-8	Read §4116. Complete entire worksheet.
11	A	Read §4113. Complete columns 6 and 7, lines 1 through 100.
12	B (Parts I & II), B-1, and B-2	Read §4120 and §4121. Complete all worksheets entirely.

Part II - Departmental Cost Distribution and Cost Apportionment

<u>Step No.</u>	<u>Worksheet</u>	
1	C	Read §4123. Complete entire worksheet.
2	D	Read §4124. Complete entire worksheet. A <u>separate</u> copy of this worksheet must be completed for each applicable health care program for the SNF and the nursing facility (NF).
3	D-1	Read §4125. A separate worksheet must be completed for each applicable health care program for the SNF and the NF.



Part III - Calculation of Reimbursement Settlement

Step Worksheet  
No.

- |   |               |  |
|---|---------------|--|
| 1 | E, Part I     | Read §4130. Complete through line 17 for Part A services and lines 18 through 33 for Part B services.  |
| 2 | E-1           | Complete lines 1-4. See Section 4131.  |
| 3 | G through G-3 | Read §4140. This step is completed by all providers maintaining fund type accounting records. Non-proprietary providers which do not maintain fund type records complete the General Fund column only. |

Calculation of Reimbursement Settlement of Subproviders

- |    |                 |   |
|----|-----------------|---|
| 1  | S-4             | Read §4106. Complete this worksheet when applicable.  |
| 2  | H               | Read §4141. Complete this worksheet where applicable.   |
| 3  | H-1             | Read §4142. Complete this worksheet where applicable.   |
| 4  | H-2             | Read §4143. Complete this worksheet where applicable.   |
| 5  | H-3             | Read §4144. Complete this worksheet where applicable.   |
| 6  | H-4             | Read §4145. Complete this worksheet when applicable.  |
| 7  | H-5             | Read §4146. Complete this worksheet when applicable.  |
| 8  | S-5             | Read §4107. Complete this worksheet when applicable.  |
| 9  | I-1 through I-4 | Read §§4148-4151. Complete these worksheets when applicable.  |
| 10 | I-5             | Read §4152. Complete this worksheet when applicable.  |
| 11 | <i>S-6</i>      | <i>Read §4108. Complete this worksheet when applicable.</i>   |
| 12 | J-1 through J-4 | Read §4153-4156. Complete these worksheets when applicable. A separate copy of this worksheet must be completed for each component. |
| 13 | S-8             | Read §4110. Complete this worksheet <i>when applicable</i> .  |
| 14 | K through K-1   | Read §4157-4158. Complete this worksheet when applicable.   |

Step WorksheetNo.

- |    |                      |  |
|----|----------------------|--|
| 15 | K-2                  | Read §4159. Complete this worksheet when applicable.                 |
| 16 | K-3                  | Read §4160. Complete this worksheet when applicable.                 |
| 17 | K-4                  | Read §4161. Complete this worksheet when applicable.                 |
| 18 | K-5                  | Read §4162. Complete this worksheet when applicable.                 |
| 19 | K-6                  | Read §4163. Complete this worksheet when applicable.                 |
| 20 | <i>O through O-8</i> | <i>Read §4164-4164.5. Complete these worksheets when applicable.</i> |

## 4102. SEQUENCE OF ASSEMBLY

All providers using Form CMS-2540-10 must adhere to the sequence of worksheets set forth below in filing their annual cost report. If worksheets are not completed because they are not applicable, do not include blank worksheets in the assembly of the cost report.

<u>Worksheet</u>	<u>Part</u>	<u>Full Cost Report</u>
S	I, II & III	X
S-2	I & II	X
S-3	I, II, III, <i>IV &amp; V</i>	X
S-4		X
S-5		X
S-6		X
S-7		X
S-8		X
A		X
A-6		X
A-7		X
A-8		X
A-8-1		X
A-8-2		X
B	I	X
B	II	X
B-1		X

<u>Worksheet</u>	<u>Part</u>	<u>Full Cost Report</u>
B-2		X
C		X
D		X
D-1		X
E	I	X
E	II	X
E-1		X
G		X
G-1		X
G-2		X
G-3		X
H Through H-5		X
I Through I-5		X
J-I Through J-4		X
K Through K-6		X <sup>(1)</sup>
<i>O Through O-8</i>		<i>X<sup>(2)</sup></i>

*(1) For cost reporting periods beginning before October 1, 2015.*

*(2) For cost reporting periods beginning on or after October 1, 2015.*

4103. WORKSHEET S - SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Check the appropriate box to indicate whether you are filing electronically or manually. For electronic filing, indicate on the appropriate line the date and time corresponding to the creation of the electronic file. This date and time remains as an identifier for the file by the contractor and is archived accordingly. *For a manual filing, the provider must have contractor approval for submission of a low utilization cost report in accordance with CMS Pub. 15-2, chapter 1, §110 or the provider must have demonstrated financial hardship in accordance with 42 CFR 413.24(f)(4)(v).*

4103.1 Part I – Cost Report Status.--This section is to be completed by the provider and contractor as indicated on the worksheet.

Lines 1 through 3--The provider must check the appropriate box to indicate on line 1 or 2, column 1, whether this cost report is being filed electronically or manually. For electronic filing, indicate on line 1, column 2 the date and on column 3 the time corresponding to the creation of the electronic file. This date and time remains as an identifier *on your original submission to the* contractor and is archived accordingly. If this is an amended cost report, enter on line 3, column 1 the number of times the cost report has been amended.

*Lines 4 through 11--Completed by the contractor.*

Line 4, column 1--Enter the Healthcare Cost Report Information System (HCRIS) cost report status code that corresponds to the filing status of the cost report: 1=As submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 5, column 1--Enter the date (mm/dd/yyyy) an accepted cost report was received from the provider.

Line 6, column 1-- Enter the 5 position *contractor number*.

Lines 7 and 8, column 1--If this is an initial cost report, enter “Y” for yes in the box on line 7. If this is a final cost report, enter “Y” for yes in the box on line 8. If neither, leave both lines 7 and 8 blank. An initial report is the very first cost report for a particular provider CMS certification number (CCN). A final cost report is a terminating cost report for a particular provider CCN.

Line 9, column 1--Enters the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code (*line 4, column 1*) is 2, 3 or 4.

Line 10, column 1--If this is a reopened cost report (response to line 4, column 1 is “4”), enter the number of times the cost report has been reopened.

Line 11, column 1--Enter the software vendor code for the software used by the contractor to process this cost report. Use the format “X99”, where X is the alpha character representing a specific cost report transmittal and 99 is the two digit software vendor code.

4103.2 Part II - Certification.--This certification is read, prepared, and signed after the cost report has been completed in its entirety.

4103.3 Part III - Settlement Summary.--Enter the balance due to or due from the applicable program for each applicable component of the program. Transfer settlement amounts as follows:

<u>Skilled Nursing Facility Component</u>	<u>Title V</u>	<u>From</u>		<u>Title XIX</u>
		<u>Title XVIII Part A</u>	<u>Title XVIII Part B</u>	
Skilled Nursing Facility Line 1	Wkst. E, Part II, Line 33	Wkst. E, Part I, Line 15	Wkst. E, Part I, Line 29	Wkst. E, Part II, Line 33
Nursing Facility Line 2	Wkst. E, Part II, Line 33	N/A	N/A	Wkst. E, Part II, Line 33
ICF/IID Line 3	N/A	N/A	N/A	Wkst. E, Part II, Line 33
SNF-Based Home Health Agency Line 4	Wkst. H-4, Part II, Sum of Cols. 1&2, Line 34	Wkst. H-4, Part II, Col. 1 Line 34	Wkst. H-4, Part II, Col. 2 Line 34	Wkst. H-4, Part II, Sum of Cols. 1&2, Line 34
SNF-Based RHC Line 5	Wkst. I-3, Line 28	N/A	Wkst. I-3, Line 28	Wkst. I-3, Line 28
SNF-Based* FQHC Line 6	Wkst. I-3, Line 28	N/A	Wkst. I-3, Line 28	Wkst. I-3, Line 28
SNF-Based CMHC Line 7	Wkst. J-3, Col. 1, Line 20	N/A	Wkst. J-3, Col. 1, Line 20	Wkst J-3, Col. 1, Line 20

\*Wkst I -3 is to be used by SNF-Based FQHCs through cost reporting periods beginning prior to October 1, 2014.

4104. WORKSHEET S-2 - PART I SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA

The information required on this worksheet is needed to properly identify the provider.

Lines 1 and 2.--Enter the address of the skilled nursing facility.

Line 3.--Indicate your county in column 1. Enter in column 2 the Core Based Statistical Area (CBSA) code. Enter in column 3, a "U" or "R" designating urban or rural.

Lines 4 through 12.--On the appropriate lines and columns indicated, enter the names, provider identification numbers, and certification dates of the SNF and its various components, if any. For each health care program, indicate the payment system applicable to the SNF and its various components by entering "P" (prospective payment system), "O" (indicating cost reimbursement), or "N" (for not applicable) respectively.

Line 4.--This is an institution that meets the requirements set forth in 42 CFR section 483.5 that has been issued a separate *CCN* indicating that it meets the requirements of §1819 of the Social Security Act. SNF cost reports, reimbursed under title XVIII must use the Prospective Payment System.

Line 5.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR 483.5 that has been issued a separate identification number indicating that it meets the requirements of §1919 of the Social Security Act.

Line 6.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR 440.155 that has been issued a separate identification number indicating that it meets the requirements of §1905 of the Social Security Act.

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Line 7.--This is a SNF-based HHA that has been issued a CCN and which meets the requirements of §§1861(o) and 1891 of the Act. If you have more than one SNF-based HHA, subscript this line and report the required information for each HHA.

Lines 8.--This is a SNF-based RHC that meets the requirements of §1861(aa) of the Act.

*Lines 9.--This is a SNF-based FQHC that meets the requirements of §1861(aa) of the Act. If this is a SNF-based FQHC filing a consolidated cost report only the primary FQHC is reported here. Effective for cost reporting periods beginning on and after October 1, 2014 do not complete this line. SNF-based FQHCs must complete a free standing FQHC cost report Form CMS-224-14.*

Line 10.--This is a SNF-based community mental health center that has been issued a separate identification number. See § 1861(ff) of the Social Security Act.

Line 11.--This is any other SNF-based facility not listed above. The beds in this unit are not certified for titles V, XVIII, or XIX.

Line 12.--This is a SNF-based Hospice that meets the requirements of §1861(dd) of the Social Security Act.

Line 13.--For any component type not identified on lines 4 through 12, enter the required information in the appropriate column. Subscript this line accordingly to accommodate multiple SNF-based CORFs (lines 13.00-13.09), OPTs (lines 13.10-13.19), OOTs (lines 13.20-13.29) and OSPs (lines 13.30-13.39).

Line 14.--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of operations which generally cover a consecutive 12-month period of operations. (See §§102.1 - 102.3 for situations when you may file a short period cost report.)

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).

When you voluntarily or involuntarily cease to participate in the health insurance program or experience a change of ownership, a cost report is due no later than 5 months following the effective date or termination of your agreement or change of ownership.

Line 15.--Enter in column 1, a number from the list below which indicates the type of ownership or auspices under which the SNF is conducted.

- |                                  |                                      |
|----------------------------------|--------------------------------------|
| 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        |                                      |

\* Where an "other" item is selected, please specify in column 2.

Lines 16 through 18.--These lines provide for furnishing certain information concerning the provider. All applicable items must be completed.

Line 19.--If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for No.

Line 19.01.--If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for No.

Lines 20 through 23.--These lines provide for furnishing certain information concerning depreciation. All applicable items must be completed. (See CMS Pub. 15-1, Chapter 1, regarding depreciation).

Lines 20, 21, and 22.--Indicate, on the appropriate lines, the amount of depreciation claimed under each method of depreciation used by the SNF during the cost reporting period.

Line 23.--The total depreciation shown on this line may not equal the amount shown on lines 1 and/or 2 on the Trial Balance of Expenses Worksheet, but represents the amount of depreciation included in costs on Worksheet A, column 7.

Lines 25 through 28.--Indicate a "Yes" or "No" answer to each question on these lines.

Lines 29 through 36.--Indicate for each component the type of service that qualifies for the exception.

Line 37.--Indicate whether the provider is licensed in a State that certifies the provider as an SNF as described on line 4 above, regardless of the level of care given for Titles V and XIX patients.

Line 38.--Malpractice insurance, sometimes referred to as professional liability insurance, is insurance purchased by physicians and SNF's to cover the cost of being sued for malpractice.

Line 39.--A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a "claims-made" contract. The Occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. If the policy is claims-made, enter 1. If the policy is occurrence, enter 2.

Line 40.-- Removed and reserved.

Line 41.--List the total amount of malpractice premiums paid, (column 1) the total amount of paid losses, (column 2), and the total amount of self insurance, (column 3) allocated in this fiscal year.

Line 42.--Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.

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, that provides providers with excess protection that may be unavailable or cost-prohibitive at the primary level.

Line 43.--Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10? Enter "Y" for yes, or "N" for no, in column 1

Line 44.--If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.

Line 45, columns 1, 2 and 3.--Enter the name of the home office in column 1, and enter the name of the contractor of the home office in column 2. Enter the contractor number in column 3.

Line 46, columns 1 and 2.--Enter the street address in column 1, or the post office box number in column 2.

Line 47, columns 1, 2 and 3.--Enter the city, State and zip code in columns 1, 2, and 3.

4104.1 Part II – Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Reimbursement Questionnaire.-- The information required on Part II of this worksheet (formerly Form CMS-339) must be completed by all providers submitting cost reports to the Medicare contractor under Title XVIII of the Social Security Act (hereafter referred to as “The Act”). Its purpose is to assist you in preparing an acceptable cost report, to minimize the need for direct contact between you and your contractor, and to expedite review and settlement of the cost report. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost report and to gather information necessary to support certain financial and statistical entries on the cost report. The questionnaire is a tool used in arriving at a prompt and equitable settlement of your cost report.

Where the instructions for this worksheet direct you to submit documentation/information, mail or otherwise transmit to the contractor immediately, after 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.

To the degree that the information in the questionnaire constitutes commercial or financial information which is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act. If there is any question about releasing information, the contractor should consult with the CMS Regional Office.

**NOTE:** The responses on all lines are Yes or No unless otherwise indicated. If in accordance with the following instructions, you are requested to submit documentation, indicate the line number for each set of documents you submit.

### Line Descriptions

Lines 1 through 18 are required to be completed by all Skilled Nursing Facilities.

Line 1.--Indicate whether the provider has changed ownership. Enter “Y” for yes or “N” for no in column 1. If column 1 is “Y”, enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

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

Line 3.--Indicate whether the provider 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 in column 1. If column 1 is “Y”, submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

**NOTE** A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See CMS Pub. 15-1, Chapter 10 and 42 CFR 413.17)

Line 4.--Indicate whether the financial statements were prepared by a Certified Public Accountant. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "A" for audited, "C" for compiled, or "R" for reviewed in column 2. 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 the date they will be available in column 3.

If you do not engage public accountants to prepare your financial statements, submit a copy of the financial statements you prepared, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual 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 filed financial statements. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit reconciliation with the cost report.

Line 6.--Indicate whether costs were claimed for Nursing School. Enter "Y" for yes, or "N" for no in column 1. If you answer "Y" in column 1, enter "Y" for yes or "N" for no in column 2 to indicate whether the provider is the legal operator of the program.

Line 7.--Indicate whether costs were claimed for Allied Health Programs. Enter "Y" for yes, or "N" for no in column 1. If you answer "Y" in column 1, submit a list of the program(s) with the cost report and annotate for each, whether the provider is the legal operator of the program.

**NOTE:** For purposes of lines 6 and 7, the provider is the legal operator of a nursing school and/or allied health program if it meets the criteria in 42 CFR 413.85(f)(1) or (f)(2).

Line 8.--Indicate whether approvals and/or renewals were obtained during the cost reporting period for Nursing School and/or Allied Health programs. Enter "Y" for yes, or "N" for no in column 1. If you answer "Y" in column 1, submit a list of the program(s), and copies of the approvals and/or renewals with the cost report.

Line 9.--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries. (See 42 CFR 413.89ff and CMS Pub. 15-1, §§306-324 for the criteria for an allowable bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a completed Exhibit 1 or internal schedules duplicating the documentation requested on Exhibit 1 to support the bad debts claimed. If you are claiming bad debts for inpatient and Part B SNF services, complete a separate Exhibit 1 or internal schedule for each category. Also, complete a separate Exhibit 1, as applicable, for bad debts of each sub provider.

Exhibit 1 displayed at the end of this section requires the following documentation:

Columns 1, 2, 3 - Patient Names, Health Insurance Claim (HIC) Number, Dates of Service (From - To).--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, health insurance claim number and dates of service that correlate to the filed bad debt. (See CMS Pub. 15-1, §314 and 42 CFR 413.89)

Column 4--Indigency/Welfare Recipient--If the patient included in column 1 has been deemed indigent, place a check in this column. If the patient in column 1 has a valid Medicaid number, also include this number in this column. See the criteria in CMS Pub. 15-1, §§312 and 322 and 42 CFR 413.89 for guidance on the billing requirements for indigent and welfare recipients.

Columns 5 & 6--Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased--This information should be obtained from the provider's files and should correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2 and 3 of this exhibit. The dates in column 6 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by an outside entity, ceased and there is no likelihood of recovery of the unpaid account. (See CFR 413.89(f), and CMS Pub. 15-1, §§308, 310, and 314)

Column 7--Remittance Advice Dates--Enter in this column the remittance advice dates that correlate with the beneficiary name, HIC No., and dates of service shown in columns 1, 2, and 3 of this exhibit.

Columns 8 & 9--Deductibles & Coinsurance--Record in these columns the beneficiary's unpaid deductible and coinsurance amounts that relate to covered services.

Column 10--Total Medicare Bad Debts--Enter on each line of this column, the sum of the amounts in columns 8 and 9. Calculate the total bad debts by summing up the amounts on all lines of Column 10. This "total" must agree with the bad debts claimed on the cost report. Attach additional supporting schedules, if necessary, for bad debt recoveries.

**NOTE: The information in Exhibit 1 is not captured in the ECR file. Therefore, this exhibit must be completed and submitted either manually (hard copy), or in electronic media format (e.g. diskette, or CD).**

Line 10--Indicate whether your bad debt collection policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a copy of the policy with the cost report.

Line 11--Indicate whether patient deductibles and/or coinsurance are waived. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, ensure that they are not included on the bad debt listings (i.e., Exhibit 1 or your internal schedules) submitted with the cost report.

Line 12--Indicate whether total available beds have changed from the prior cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, provide a copy of the approval from the Regional Office for a change in bed size required under CMS Pub. 15-1, §2337.2.

**NOTE:** For purposes of line 12, available beds are provider beds that are permanently maintained for lodging inpatients. They must be available for use and be housed in patient rooms or wards (i.e., do not include beds in corridors or temporary beds). (See 42 CFR 412.105(b) and CMS Pub. 15-1, §2200.2.C.)

Line 13--Indicate whether the cost report was prepared using the Provider Statistical & Reimbursement Report (PS&R) only. Use columns 1 and 2 for Part A and columns 3 and 4 for Part B. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y" enter the paid through date of the PS&R in columns 2 and/or 4. Also, submit a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 14--Indicate whether the cost report was prepared using the PS&R for totals and provider records for allocation. Use columns 1 and 2 for Part A and columns 3 and 4 for Part B. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y" enter the paid through date of the PS&R in columns 2 and/or 4. Also, submit a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must include which revenue codes were allocated to each cost center. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records.

Line 15--If you entered "Y" on either line 13 or 14, columns 1 and/or 3, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", include a schedule which supports any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R, and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 16--If you entered "Y" on either line 13 or 14, columns 1 and/or 3, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", submit a detailed explanation and documentation which provides an audit trail from the PS&R to the cost report.

Line 17--If you entered "Y" on either line 13 or 14, columns 1 and/or 3, indicate whether other adjustments were made to the PS&R data. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", include a description of the other adjustments and documentation which provides an audit trail from the PS&R to the cost report.

Line 18--Indicate whether the cost report was prepared using provider records only. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements are:

- Copies of input tables, calculations, or charts supporting data elements for PPS operating rate components and other PRICER information covering the cost reporting period.
- Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&R.
- Reconciliation of remittance totals to the provider's internal records.
- Include the name of the system used and indicate how the system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.

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

EXHIBIT 1

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER \_\_\_\_\_

PREPARED

BY

NUMBER \_\_\_\_\_

DATE

PREPARED

FYE \_\_\_\_\_

SNF INPATIENT \_\_\_\_\_ SNF Part B \_\_\_\_\_  
Subprovider \_\_\_\_\_

(1) Patient Name	(2) HIC. NO.	(3) DATES SERVICE		(4) INDIGENCY & WEL. RECIP. (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFI- CIARY	(6) DATE COLLEC- TION EFFORTS CEASED	(7) REMIT- TANCE ADVICE DATES	(8)* DEDUCT	(9)* CO- INS	(10) TOTA L
		FROM	TO	YES	MEDICAID NUMBER						

\* THESE AMOUNTS MUST NOT BE CLAIMED UNLESS THE PROVIDER BILLS FOR THESE SERVICES WITH THE INTENTION OF PAYMENT.  
SEE INSTRUCTIONS FOR COLUMN 4 - INDIGENCY/WELFARE RECIPIENT, FOR POSSIBLE EXCEPTION

4105. WORKSHEET S-3 **PART I** - SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

In accordance with 42 CFR 413.20(a), and 42 CFR 413.24(a), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to the SNF, the NF, the ICF/**IID**, and SNF-based HHAs, CMHCs, OLTCs and hospices. The data to be maintained, depending on the services provided by the component, include the number of beds, the number of bed days available, the number of inpatient days/visits, the number of discharges, the average length of stay, the number of admissions, and full time equivalents (FTEs).

Column Descriptions

Column 1.--Enter on the appropriate line the beds available for use by patients at the end of the cost reporting period.

Column 2.--Enter the total bed days available. Bed days are computed by multiplying the number of beds available throughout the period by the number of days in the reporting period. If there is an increase or decrease in the number of beds available during the period, multiply the number of beds available for each part of the cost reporting period by the number of days for which that number of beds was available.

**NOTE:** An institution or institutional complex may only change the bed size of its SNF and/or its NF up to two times per cost reporting period. The two changes must occur as follows; once on the first day of the beginning of its cost reporting period; and again on the first day of a single cost reporting quarter within that same cost reporting period, in order to effect one of the combinations set forth in §2337.2.

Columns 3 through 6.--Enter the number of inpatient days/visits for all classes of patients for each component by program.

Column 7.--Enter the total number of inpatient days for each component. The total in column 7 must equal the sum of columns 3 through 6.

Columns 8 through 11.--Enter the number of discharges, including deaths, for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.)

Column 12.--Enter the total number of discharges (including deaths) for all classes of patients for each component.

Columns 13 through 16.--The average length of stay is calculated as follows:

- |                                    |   |
|------------------------------------|---|
| a. Column 13, lines 1, 2 & 7       | Column 3 divided by column 8                        |
| b. Column 14, lines 1 & 7          | Column 4 divided by column 9                        |
| c. Column 15, lines 1, 2, 3, & 7   | Column 5 divided by column 10                       |
| d. Column 16, lines 1, 2, 3, 5 & 7 | Column 7 divided by column 12                       |
| e. Column 16, line 8               | Column 7 (line 8 minus line 4) divided by column 12 |

**EXCEPTION:** Where the skilled nursing facility is located in a State that licenses the provider as an SNF regardless of the level of care given for Titles V and XIX patients combine the statistics on lines 1 and 2.

Columns 17 through 21.--Enter the number of admissions (from your records) for each component by program.



Columns 22 and 23.--The average number of employees (full-time equivalent) for the period may be determined either on a quarterly or semiannual basis. When quarterly data are used, add the total number of hours worked by all employees on the first week of a payroll for the beginning of each quarter and divide the sum by 160 (four times the number of hours in the standard work week). When semiannual data are used, add the total number of hours worked by all employees on the first week of a payroll period for the first and seventh months of the period, and divide the sum by 80 (two times the number of hours in the standard work week). Enter the average number of paid employees in column 22 and the average number of non-paid worker's in column 23 for each component, as applicable.

4105.1 *Part II - SNF Wage Index Information – Direct Salaries.*--This part provides for the collection of skilled nursing facility and nursing facility data to develop a SNF wage index in accordance with the Social Security Act Amendments of 1994 (P.L. 103-432). In order to collect the data necessary to develop a SNF wage index, CMS has developed an SNF wage index form, as part of the cost report, to be completed by all SNFs.

**NOTE:** Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Line 1.--Enter the wages and salaries paid to employees from Worksheet A, column 1, line 100.

Line 2.--Enter physician salaries paid to employees which are included on Worksheet A, column 1, line 100.

Line 3.--Enter the total physician and physician assistant salaries and wage related costs that are related to patient care and are included on line 1. Under Medicare, these services are billed separately under Part B.

Line 4.--If you are a member of a chain or other related organization, as defined in CMS Pub. 15-1, §2150, enter the allowable wages and salaries and wage related costs for home office personnel from your records that are included in line 1.

Line 5.--Enter the sum of lines 2 through 4.

Line 6.--Subtract line 5 from line 1 and enter the result.

Line 7.--Enter the total of Worksheet A, column 1, line 33. This amount represents other long term care.

Line 8.--Enter the total of Worksheet A, column 1, line 70. If this line is subscripted to accommodate more than one HHA, also enter the total of the subscripted lines.

Line 9.--Enter the amount from Worksheet A, column 1, line 73.

Line 10.--Enter the amount from Worksheet A, column 1, line 83.

Line 11.--Enter the amount from Worksheet A, column 1, lines 14, 72, 74, 84, and lines 90 through 95.

Line 12.--Enter the sum of lines 7 through 11.

Line 13.--Line 6 minus line 12 and enter the result.

Line 14.--Enter the amount paid (include only those costs attributable to services rendered in the SNF and/or NF), rounded to the nearest dollar, for contracted direct patient care services, i.e., nursing, therapeutic, rehabilitative, or diagnostic services furnished under contract rather than by employees and management contract services as defined below. For example, you have a contract with a nursing service to supply nurses for the general routine service area on weekends. Report only those personnel costs associated with these contracts. Eliminate all supplies and other miscellaneous items. Do not apply the guidelines for contracted therapy services under §1861(v) (5) of the Act and 42 CFR 413.106. Contracted labor for purposes of this worksheet does **NOT** include the following services: consultant contracts, billing services, legal and accounting services, Part A CRNA services, clinical psychologists and clinical social worker services, housekeeping services, planning contracts, independent financial audits, or any other service not directly related to patient care.

Include the amount paid (rounded to the nearest dollar) for contract management services, as defined below, furnished under contract rather than by employees. Report only those personnel costs associated with the contract. Eliminate all supplies, travel expenses, and other miscellaneous items. Contract management is limited to the personnel costs for those individuals who are working at the facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract labor does **NOT** include the following services: other management or administrative services, consultative services, unmet physician guarantees, physician services, clinical personnel, security personnel, housekeeping services, planning contracts, independent financial audits, or any other services not related to the overall management and operation of the facility.

In addition, if you have no contracted labor as defined above or management contract services; enter a zero in column 1. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 1.

Line 15.--Enter from your records the amount paid under contract for physician services for Part A only related directly to the SNF and/or NF. This includes Part A physician services from the home office allocation and/or from related organizations.

Line 16.--Enter the salaries and wage related costs (as defined on lines 17 and 18 below) paid to personnel who are affiliated with a home office and/or related organization, who provide services to the SNF and/or NF, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office salaries excluded on line 4. This figure is based on recognized methods of allocating an individual's home office salary to the SNF and/or NF. If no home office/related organization exists or if you cannot accurately determine the hours associated with the home office/related organization salaries that are allocated to the SNF and/or NF, then enter a zero in column 1. All costs for any related organization must be shown as the cost to the related organization.

**NOTE:** All wage-related costs, including amounts related to excluded areas and physician services should be included on lines 17 and 18.

Line 17.--Enter the total core wage related costs as described in Part IV. Only the total cost of the wage related costs that are considered fringe benefits may be directly charged to each cost center provided the costs are reported in column 2 and not column 1 of Worksheet A. For purposes of determining the wage related costs for the wage index, a facility must use generally accepted accounting principles (GAAP). Continue to use Medicare payment principles on all other areas to determine allowable fringe benefits.

Line 18.--Enter the total of all wage related costs that are considered an exception to the core list. A detailed list of each additional wage related core must be shown in Part IV. In order for a wage related cost to be considered an exception, it must meet the following tests:

- a. The costs are not listed on Part IV,
- b. The cost is reasonable and prudent,
- c. The individual wage related cost exceeds 1 percent of total salaries after the direct excluded salaries are removed,
- d. The wage related cost is a fringe benefit and has not been furnished for the convenience of the provider, and
- e. The wage related costs that are fringe benefits, where required, have been reported as wages to Internal Revenue Service, (e.g., the unrecovered cost of employee meals, education costs, auto allowances).

Wage related cost exceptions are not to include those wage related costs that are required to be reported to the Internal Revenue Service, since they are considered as salary or wages, i.e., loan forgiveness, sick pay accruals. Include these costs in total salaries reported on line 1 of this worksheet. The total wage related costs listed on this line must agree with the total of all other wage related costs listed in Part IV.

Line 19.--Enter the total (core and other) wage-related costs applicable to the excluded areas reported on line 12.

Line 20.-- Enter the total wage-related costs applicable to Part A Physicians. Do not include wage-related costs for excluded areas reported on line 19.

Line 21.-- Enter the total wage-related costs applicable to Part B Physicians. Do not include wage-related costs for excluded areas reported on line 19.

Line 22.--Enter the total adjusted wage related costs, line 17 plus line 18, minus lines 19 through 21.

Column 2.--Enter on each line, as appropriate, the **salary** portion of any reclassification made on Worksheet A-6.

Column 3.--Enter the result of column 1 plus or minus column 2.

Column 4.--Enter on each line the number of **paid** hours corresponding to the amount reported in column 3.

**NOTE:** The hours must reflect any change reported in column 2. On call hours are not included in the total paid hours. Overtime hours are calculated as one hour when an employee is paid time and a half.

Column 5.--Enter on line 1 through line 16 the average hourly wage resulting from dividing column 3 by column 4.

4105.2 Part III - *SNF Wage Index Information* - Overhead Cost - Direct Salaries.--This part provides for the collection of SNF and/or NF wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. This form is completed by all SNFs and/or NFs.

**NOTE:** Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Column 1.--Enter the direct wages and salaries paid on lines 1 through 13, from Worksheet A, column 1, respectively.

Column 2.--Enter on the line, as appropriate, the salary portion of any reclassification made on Worksheet A-6.

Column 3.--Enter the result of column 1 plus or minus column 2.

Column 4.--Enter on each line the number of paid hours corresponding to the amount reported in column 3.

Column 5.--Enter on each line the average hourly wage resulting from dividing column 3 by column 4.

4105.3 Part IV - *SNF Wage Related Costs.*--The SNF must provide the contractor with a complete list of all core wage related costs included in Part II, lines 17 and 19 through 21. This worksheet provides for the identification of such costs.

The provider must determine whether each wage related cost “other than core”, reported on line 25, exceeds one (1) percent of the total adjusted salaries net of excluded salaries and meets all of the following criteria:

- The costs are not listed on lines 1 through 23, “Wage Related Costs Core”
- If any of the additional wage related cost applies to the excluded areas of the SNF, the cost associated with the excluded areas has been removed prior to applying the 1 percent threshold test.
- The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS.
- The individual wage related cost is not included in salaries reported on Worksheet S-3, Part II, column 3, line 17.
- The wage related cost is not being furnished for the convenience of the employer.

For wage related costs not covered by Medicare reasonable cost principles, a SNF shall use GAAP in reporting wage related costs. In addition, some costs such as payroll taxes, which are reported as a wage related cost(s) on Worksheet S-3, Part IV, are not considered fringe benefits for Medicare cost finding.

Enter on each line as applicable the corresponding amount from you accounting books and/or records.

4105.4 *Part V - SNF Reporting of Direct Care Expenditures*--Section 6104(1) of Public Law 111-148 amended section 1888(f) of the Social Security Act ("Reporting of Direct Care Expenditures"), to require Skilled Nursing Facilities (SNF) to separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

Effective for cost reporting periods beginning on or after January 1, 2012, this part provides for the collection of SNF and/or Nursing Facilities (NF) direct care expenditures. Complete this form for employees who are full-time and part-time, directly hired, and acquired under contract. Do not include employees in areas excluded from SNF PPS via Worksheet S-3, Part II, Lines 7 through 11. This exclusion applies to directly-hired and contracted employees who provided either direct or indirect patient care services in SNF PPS excluded areas. Do not include employees whose services are excluded from the SNF PPS, such as physician Part B, and nursing and allied health. This form is completed by the SNFs and/or the NFs.

Column 1--Enter the total of paid wages and salaries for the specified category of SNF/NF employees including overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses on lines 1 through 3 and 5 through 13. Do not include fringe benefits or wage-related costs as defined in §4105.1.

Enter the amount paid (include only those costs attributable to services rendered in the SNF/NF), rounded to the nearest dollar, for contracted direct patient care services on lines 14 through 16 and 18 through 26.

Column 2--Enter the appropriate portion of fringe benefits corresponding to paid wages and salaries reported in column 1, lines 1 through 3, and 5 through 13.

Column 3--Enter the result of column 1 plus column 2.

Column 4--Enter on each line the number of paid hours corresponding to the amount reported in column 3.

Column 5--Enter on each line the average hourly wage resulting from dividing column 3 by column 4.

Line 4--Enter the sum of the amounts of lines 1 through 3.

Line 17--Enter the sum of the amounts of lines 14 through 16.

For Medicare cost reporting purposes, nursing personnel working in the following cost centers must be included in the appropriate nursing subcategory. These cost centers reflect where the majority of nursing employees are assigned in SNFs and are selected to ensure consistent reporting among SNFs. The wages and hours for nursing personnel working in other areas of the SNF or nurses who are performing solely administrative functions, should not be included.

#### **COST CENTER DESCRIPTIONS**

##### **Lines for 2540-10**

09  
30  
31  
47

##### **Cost Centers**

Nursing Administration  
Skilled Nursing Facility  
Nursing Facility  
Electrocardiology

**NOTE:** Subscripted cost centers that would normally fall into one of these cost centers should be included.

## Definitions

### **Paid Salaries, Paid Hours and Wage Related Costs:**

- **Paid Salaries** – Include the total of paid wages and salaries for the specified category of SNF employees including overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses.
- **Paid Hours** – Include the total paid hours for the specified category of SNF employees. Paid hours include regular hours, overtime hours, paid holiday, vacation, sick, and other paid-time-off hours, and hours associated with severance pay. Do not include non-paid lunch periods and on-call hours in the total paid hours. Overtime hours must be calculated as one hour when an employee is paid time and a half. No hours are required for bonus pay. The hours reported for salaried employees who are paid a fixed rate must be recorded based on 40 hours per week or the number of hours in the SNF's standard workweek.
- **Wage Related Costs** –Include wage related costs applicable to the specific category of SNF employees as reported in §4105.1, lines 17, 18 and 21.

### Nursing Occupations

- **Registered Nurses (RNs)** - Assess patient health problems and needs, develop and implement nursing care plans, and maintain medical records. Administer nursing care to ill, injured, convalescent, or disabled patients. May advise patients on health maintenance and disease prevention or provide case management. Licensing or registration required.
- **Licensed Practical Nurses (LPNs)** - Care for ill, injured, convalescent, or disabled persons. LPNs monitor patients' health, administer basic nursing care, including changing bandages and inserting catheters, discuss health care with patients and listen to their concerns, report patients' status to RNs and physicians and maintain medical records. LPNs may work under the supervision of a registered nurse. More experienced LPNs may supervise nursing assistants and aides. Licensing is required after the completion of a State-approved practical nursing program.
- **Certified Nursing Assistants/Aides** - Provide basic patient care under direction of nursing staff. Perform duties, such as taking vital signs, feeding, bathing, dressing, grooming, moving patients, or changing linens.

### Other Medical Staff

Non-nursing employees (directly hired and under contract) that provide direct patient care. Do not include employees in excluded areas or that function solely in administrative or leadership roles that do not provide any direct patient care themselves. This category must not include occupations such as physician Part B services and the services of Advance Practice Nurses (APNs) such as nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists that are billable under a Part B fee schedule.

## 4106 WORKSHEET S-4 - SNF-BASED HOME HEALTH AGENCY STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under titles V, XVIII, and XIX. The statistics required on this worksheet pertain to a SNF-based home health agency. The data maintained is dependent upon the services provided by the agency, number of program home health aide hours, total agency home health aide hours, program unduplicated census count, and total unduplicated census count. In addition, FTE data are required by employed staff, contracted staff, and total. Complete a separate Worksheet S-4 for each SNF-based home health agency.

Line 1--Enter the county of residence.

Line 2--Enter the number of hours applicable to home health aide services.

Line 3--Enter the unduplicated count of all individual patients and title XVIII patients receiving home visits or other care provided by employees of the agency or under contracted services during the reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count (column 5, line 3) may not equal the sum of columns 1 through 4, line 3. For purposes of calculating the unduplicated census, if a beneficiary has received healthcare in more than one CBSA, you must prorate the count of that beneficiary so as not to exceed a total of (1). A provider is to also query the beneficiary to determine if he or she has received healthcare from another provider during the year, e.g., Maine versus Florida for beneficiaries with seasonal residence.

Lines 4 through 20--Lines 4 through 20 provide statistical data related to the human resources of the HHA. The human resources statistics are required for each of the job categories specified in lines 5 through line 20.

Line 4--Enter the number of hours in your normal work week.

Report in column 1 the full time equivalent (FTE) employees on the HHA's payroll. These are staff for which an IRS Form W-2 is used.

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

Compute staff FTEs for column 1 as follows. Add all hours for which employees were paid and divide by 2080 hours. Round to two decimal places, e.g., .4452 is rounded to .45. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked and divide by 2080 hours.

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

Line 21--Enter the number of CBSAs that you serviced during this cost reporting period.

Line 22--Identify each CBSA where the reported HHA visits are performed by entering the 5 digit CBSA code and Non-CBSA (rural) code as applicable. Subscript the lines to accommodate the number of CBSAs that you provide services. Rural CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the state of Maryland the rural CBSA code is 99921.

PPS Activity Data--Applicable for Medicare Services

In accordance with 42 CFR 484.200(a) and §1895 of the Social Security Act, home health agencies transitioned from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

The statistics required on this worksheet pertain to home health services furnished on or after October 1, 2000. The data to be maintained, depending on the services provided by the agency, includes the number of aggregate program visits furnished in each episode of care payment category for each covered discipline, the corresponding aggregate program charges imposed in each episode of care payment category for each covered discipline, total visits and total charges for each episode of care payment category, total number of episodes and total number of outlier episodes for each episode of care payment category, and total medical supply charges for each episode of care payment category.

HHA Visits--See CMS Pub. 15-2, Chapter 32, §3205, for the definition of an HHA visit

Episode of Care--Under home health PPS the 60 day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. Beneficiaries are covered for an unlimited number of non-overlapping episodes. The duration of a full length episode will be 60 days. An episode begins with the start of care date and must end by the 60<sup>th</sup> day from the start of care.

Less than a full Episode of Care--When 4 or fewer visits are provided by the HHA in a 60 day episode period, the result is a low utilization payment adjustment (LUPA). In this instance the HHA will be reimbursed based on a standardized per visit payment.

An episode may end before the 60<sup>th</sup> day in the case of a beneficiary elected transfer, or a discharge and readmission to the same HHA (including for an intervening inpatient stay). This type of situation results in a partial episode payment (PEP) adjustment.

Use lines 23 through 34 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 35 and 37 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 35 identifies the total number of episodes completed for each episode payment category. Line 39 identifies the total number of outlier episodes completed for each episode payment category. Outlier episodes do not apply to: 1) Full Episodes without Outliers and 2) LUPA Episodes. Line 40 identifies the total medical supply charges incurred for each episode payment category. Column 5 displays the sum total of data for columns 1 through 4. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report.

When an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all statistical data (i.e., cost, charges, counts, etc...) associated with that episode of care will appear on the PS&R of the fiscal year in which the episode of care is concluded. Similarly, all data required in the cost report for a given fiscal year must only be associated with services rendered during episodes of care that conclude during the fiscal year. Title XVIII visits reported on this worksheet must equal the sum of the title XVIII visits reported on Worksheet H-3, sum of columns 6 and 7 line 7.

Columns 1 through 4--Enter data pertaining to title XVIII patients only. Enter, as applicable, in the appropriate columns 1 through 4, lines 23 through 34, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episodes of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only Episodes) will not include any visit counts and corresponding charges that appear in column 5



Line 35.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the sum of total visits from lines 23, 25, 27, 29, 31 and 33.

Line 36.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the charges for services paid under PPS and not identified on any previous lines.

Line 37.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the sum of total visit charges from lines 24, 26, 28, 30, 32, 34 and 36.

Line 38.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the total number of episodes (standard/non-outlier) of care rendered and concluded in the provider's fiscal year.

Line 39.--Enter in columns 2 and 4 for each episode of care payment category identified, respectively, the total number of outlier episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

**NOTE:** Lines 38 and 39 are mutually exclusive.

Line 40.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the total non-routine medical supply charges for services rendered and concluded in the provider's fiscal year.

Column 5.--Enter on lines 23 through 40, respectively, the sum total of amounts from columns 1 through 4.

4107 WORKSHEET S-5 - *SNF*-BASED *RHC/FQHC* STATISTICAL DATA

In accordance with 42 CFR 413.20 and 42 CFR 413.24 you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to *SNF*-based rural health clinics (RHCs) and federally qualified health centers (FQHCs). If you have more than one of these clinics/*centers*, complete a separate worksheet for each *clinic/center*. *Effective for cost reporting periods beginning or after October 1, 2014, SNF-based FQHCs no longer complete Worksheet S-5 or Worksheets I-1 through I-5 rather they must complete a free standing FQHC cost report Form CMS-224-14.*

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

Line 3.--For FQHC only, enter your appropriate designation (U=urban or R=rural). See CMS Pub. 100-04, chapter 9, §20.6.2, for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor. RHCs do not complete this line.

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

Line 10.--If the facility operates as other than an RHC or FQHC, answer yes to this question and indicate the number of other operations in column 2. List other types of operations and hours on subscripts of line 11.

Line 11.--Enter the starting and ending hours for each applicable day(s) in the columns for the clinic services provided. If the *RHC/FQHC* provides other than RHC or FQHC services (e.g. laboratory or physician services), subscript line 11 and enter the type of operation on each of the subscripted lines. Enter in each column the starting and ending hours for the applicable day(s) that the facility is available to provide other than RHC/FQHC services.

**NOTE:** Line 11 must still be completed even if the facility answers NO to the question on line 10.

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

Line 13.--Is this a consolidated cost report? Enter in column 1 "yes" or "no" for consolidated report. If column 1 = yes, then enter in column 2 the number of reports

Line 14.--If line 13 is yes, enter the *RHC/FQHC*'s name and CCN number filing the consolidated cost report. (See CMS Pub. 100-04, chapter 9, §30.8)

**4108. WORKSHEET S-6 - SNF-BASED COMMUNITY MENTAL HEALTH CENTERS AND OTHER OUTPATIENT REHABILITATION *FACILITIES STATISTICAL DATA***

In accordance with 42 CFR 413.20 and 42 CFR 413.24 you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics required to be reported on this worksheet pertain to SNF-based community mental health centers (CMHCs), comprehensive outpatient rehabilitation facilities (CORFs), or outpatient rehabilitation facilities (ORFs) which generally furnish outpatient physical therapy (OPT), outpatient occupational therapy (OOT), or outpatient speech pathology (OSP). If you have more than one of these SNF-based components complete a separate worksheet for each component.

Additionally, only CMHCs are required to complete the corresponding Worksheet J series. However, all CMHCs, CORFs, ORFs, OPTs, OOTs, and OSPs must complete the Worksheet A accordingly for the purpose of overhead allocation.

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

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

Report in column 1 the full time equivalent (FTE) employees on the SNF-based component's payroll. These are staff for which an IRS Form W-2 is issued.

Report in column 2 the FTE contracted and consultant staff of the SNF-based component.

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

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

4109. WORKSHEET S-7 PROSPECTIVE PAYMENT FOR *SNF* STATISTICAL DATA

In accordance with 42 CFR 413.20 and 42 CFR 413.24 you are required to maintain statistical records for proper determination of costs payable under the Medicare program. Public Law 105-33 (Balanced Budget Act of 1997) requires that all SNFs be reimbursed under PPS for cost reporting periods beginning on and after July 1, 1998. Use this form to report the Medicare days of the provider by Resource Utilization Group (RUG).

Column Descriptions

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

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

Lines 101 through 106.--These lines provide for furnishing certain information concerning the provider. All applicable items must be completed.

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

4110 WORKSHEET S-8 - *SNF-BASED* HOSPICE IDENTIFICATION DATA

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

4110.1 Part I - Enrollment Days *for Cost Reporting Periods beginning before October 1, 2015.*

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

*Line 5*--Enter the total of columns 1 through 6 for lines 1 through 4.

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

**Hospice Continuous Home Care (HCHC) Day** - A *HCHC* day is a day *that* 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 HCHC day. Note: Do not count days by dividing the total hours by 24.*

**Hospice Routine Home Care (HRHC) Day** - A *HRHC* day is a day *that* the hospice patient is at home and not receiving HCHC.

**Hospice Inpatient Respite Care (HIRC) Day** - An *HIRC* day is a day *that* the hospice patient receives care in an *approved* inpatient facility, *to provide respite individual's family or other persons caring for the individual at home*.

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

Column Descriptions

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

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

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

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

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

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

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

4110.2 Part II --Census Data *for Cost Reporting Periods beginning before October 1, 2015.*--

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

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

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

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

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

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

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

Medicare Days (90 & 45 & 29) Patient (A, B & C)	164 days
Medicare Patients	/3
Average LOS Medicare	54.67 Days
Medicaid Days Patient D (92) Medicaid Patient	92 Days 1
Average LOS Medicaid	92 Days
Other (Insurance) Days (87 & 27) Other Payments (D & E)	114 Days 2
Average LOS (Other)	57 Days
All Patients (90+45+29+92+87+27) Total number of patients	370 Days 6
Average LOS for all patients	61.67 Days

Enter the hospice's average length of stay, without regard to payer source, in column 6, line 8.

Line 9.--Enter the unduplicated census count of the SNF-based hospice for all patients initially admitted and filing an election statement with the hospice within a cost reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (see CMS Pub. *100-02, chapter 9, §10*). A beneficiary, who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the cost reporting period is considered a new admission with each new election and is counted twice.

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

4110.3 Part III – Enrollment Days for Cost Reporting Periods beginning on or after October 1, 2015.--This section collects unduplicated days data.

Lines 10 through 13.--Enter the 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 one of four levels of care -- HCHC, HRHC, HIRC, or HGIP. 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 HIRC day on line 12 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.

Line 14.--Enter the total unduplicated days (sum of lines 30 through 33) in each column as applicable



4110.4 Part IV - Contracted Statistical Data for Cost Reporting Periods beginning on or after October 1, 2015.--This section collects unduplicated days data for inpatient services at a contracted facility. The days reported in Part IV are a subset of the days reported in Part III.

Lines 15 and 16.--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 HIRC or HGIP 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.

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

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, C, and D, the line numbers are consistent, and the total line is set at number 100).

Do not include on this worksheet items not claimed in the cost report but you wish to claim and contest because they conflict with the regulations, manuals, or instructions. Enter amounts on the appropriate settlement worksheet (Worksheet E, Part I, Part A, line 16, Part B, line 30; Worksheet H-4, Part II, line 35; Worksheet J-3, line 21; or Worksheet I-3, line 29).

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

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If you need to use additional or different cost center descriptions, you may do so by adding additional lines to the cost report. When an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line description. Identify the added line as a numeric (only) subscript of the immediately preceding line. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02. If additional lines are added for general service cost centers, add corresponding columns for cost finding on Worksheets B, B-1, H-1 Parts I & II, H-2-Parts I & II, J-1, and K-5.

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

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

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The five digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. You are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §4195, table 5.

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

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

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

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

Column 5.--Adjust the amounts entered in column 3 by the amounts in column 4 (increase or decrease) and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 100.

Column 6.--Enter on the appropriate lines in column 6 of Worksheet A the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The total on Worksheet A, column 6, line 100 must equal Worksheet A-8, column 2, line 100.

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

### Line Descriptions

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

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

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

Many providers incur costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control. 42 CFR 413.17 and CMS Pub. 15-1, Chapter 10, require that the reimbursable cost of the provider include the costs for these items at the cost to the supplying organization (unless the exception provided in 42 CFR 413.17(d) and CMS Pub. 15-1, §1010 is applicable).

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

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

However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplying related organization, your allowable cost may not exceed the market price. Unless the services, facilities, or supplies are otherwise considered capital-related cost, no part of the market price is considered capital-related cost. Also, if the exception in 42 CFR 413.17(d) and CMS Pub.15-1, §1010 applies, no part of the cost to you of the services, facilities, or supplies is considered capital-related cost unless the services, facilities, or supplies are otherwise considered capital-related.

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

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

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

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

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

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

Line 14.--Use this line to record the cost of nursing and allied health activities as described in 42 CFR 413.85(d).

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

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

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

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

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

Line 51.--The support surfaces which are classified as ancillary are those listed under the durable medical equipment regional DME MAC Group 2 and Group 3 support surfaces categories. For example, support surfaces which qualify under Group 2 include powered air flotation beds, powered pressure reducing air mattresses and non-powered advanced pressure reducing mattresses. An example of a support surface which qualifies under Group 3 is an air fluidized bed.

**NOTE:** Items listed in the DME MAC's Group 1 support surface criteria do not qualify for this category because they are inexpensive and common enough to be considered routine supplies in all cases.

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

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

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

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

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

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

Line 72.--This cost center accumulates the direct costs for SNF-based outpatient rehabilitation providers (CORFs, OPTs, OOTs or OSPs). If you have multiple components, subscript this line accordingly. Use lines 72.00-72.09 for CORFs, 72.10-72.19 for OPTs, 72.20-72.29 for OOTs and 72.30-72.39 for OSPs.

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

Lines 75 through 79.-- These lines are reserved for future use.

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

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

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

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

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

Lines 85 through 88.--These lines are reserved for future use.

Lines 90 through 95.--Use these lines to record the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers than those shown, add a subscript consisting of a numeric subscript code to one or more of these lines. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, if the expense (direct and all applicable overhead) attributable to any nonallowable cost area is so insignificant as not to warrant establishment of a nonreimbursable cost center and the sum total of all such expenses is so insignificant as not to warrant the establishment of a composite nonreimbursable cost center, adjust these expenses on Worksheet A-8. (See CMS Pub. 15-1, §2328)

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

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

**4114. WORKSHEET A-6 - RECLASSIFICATIONS**

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

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

Examples of reclassifications that may be needed are:

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

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

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

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

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

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

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

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

Make the appropriate adjustment for physician compensation on Worksheet A-8. For further explanations concerning utilization review in SNFs, see CMS Pub. 15-1, §2126.2.

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

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

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

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

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

However, when you purchase therapy services that include performing administrative functions such as completion of medical records, training, etc. as discussed in CMS Pub 15-1, §1412.5, the bundled charge for therapies provided under arrangements includes the provision of these services. Therefore for cost reporting purposes, these related services are NOT reclassified to A&G.

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

14. Malpractice insurance cost to administrative and general cost.



## 4115. WORKSHEET A-7 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

This part enables the Medicare program to analyze the changes that occurred in your capital asset balances during the current reporting period. This worksheet is completed only once for the entire SNF complex.

The analysis of changes in capital asset balances during the cost reporting period must be completed by all SNFs and SNF health care complexes. Do not reduce the amount entered by any accumulated depreciation reserves.

Columns 1 and 6.--Enter the balance recorded in your books of accounts at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6).

Columns 2 through 4.--Enter the cost of capital assets acquired by purchase (including assets transferred from another provider, noncertified health care unit, or nonhealth care unit) in column 2 and the fair market value at date acquired of donated assets in column 3. Enter the sum of columns 2 and 3 in column 4.

Column 5.--Enter the cost or other approved basis of all capital assets sold, traded, or transferred to another provider, a noncertified health care unit, or nonhealth care unit or retired or disposed of in any other manner during your cost reporting period.

The sum of columns 1 and 4 minus column 5 equals column 6.

Column 7.--Enter the initial acquisition cost of fully depreciated assets for each category. An asset that is fully depreciated and continues to be used in the facility must be recorded in this column. There will be no depreciation expense recorded after the asset is fully depreciated.

## 4116. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

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

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

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

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

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

Line 5.--For patient telephones, either make an adjustment on this line or establish a nonreimbursable cost center. When line 5 is used, base the adjustment on cost. Revenue cannot be used. (See CMS Pub. 15-1, §2328.)

Line 8.--Enter the adjustment amount from Worksheet A-8-2, column 18. Amounts paid to SNF-based physicians for general SNF services rendered are not included in these adjustments. (See CMS Pub. 15-1, §§2108 - 2108.11.)

Line 9.--Enter allowable home office costs which have been allocated to the SNF and which are not already included in your cost report. Use additional lines to the extent that various SNF cost centers are affected. (See CMS Pub. 15-1, §§2150 - 2153.)

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

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

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

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

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

Line 20.--Enter the cash received from imposition of interest, finance, or penalty charges on overdue receivables. This income must offset the allowable administrative and general costs. (See CMS Pub. 15-1, §2110.2.)

Line 21.--Enter the interest expense imposed by the contractor on Medicare overpayments to you. Also, enter the interest expense on borrowing made to repay Medicare overpayments to you. (See CMS Pub 15-1, Chapter 2.)

Line 22.-- If the utilization review covers only Medicare patients, the costs of the physician services are removed from the utilization review costs and are shown as a direct reimbursement item of Worksheet E, Part I, line 10.

If the utilization review extends to beneficiaries under titles V or XIX, then providing that there is sufficient documentation of physician activities, the costs of physician review services for the utilization review are a direct reimbursement item for each title under which reimbursement is claimed.

If the utilization review extends to more than the Medicare patients, but the records of the physician activities are not satisfactory for allocation purposes, then apportion the utilization review physician services cost among all the patients using the SNF. Accomplish this apportionment by including the cost of the physician services in administrative and general costs.

The reference on this form in column 4 has been changed to line 82.

Line 23 and 24.--When depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on line 23 and/or line 24. (See CMS Pub. 15-1, Chapter 1.)

Line 25.--Enter any additional adjustments which are required under the Medicare principles of reimbursement. Appropriately label the lines to indicate the nature of the required adjustments.

**NOTE:** An example of an adjustment entered on these lines is the grossing up of costs in accordance with provisions of CMS Pub. 15-1, §2314, and is explained below.

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

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

Line 100.--Enter the sum of lines 1 through 99. TRANSFER THE AMOUNTS IN COLUMN 2 TO WORKSHEET A, COLUMN 6.

**4117. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS**

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includible in the allowable cost of the provider at the cost to the related organization (except for the exceptions outlined in 42 CFR 413.17(d).) This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the SNF by organizations related to the provider. In addition, certain information concerning the related organizations with which the provider has transacted business must be shown. (See CMS Pub. 15-1, Chapter 10.)

Complete this worksheet if you answered yes to question 18 or 43 on Worksheet S-2, Part I, and there are costs included on Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-1, Chapter 10. If there are no costs included on Worksheet A which resulted from transactions with related organizations, DO NOT complete Worksheet A-8-1.

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

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

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

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

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

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

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

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

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

## 4118. WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 415.55, 42 CFR 415.60, 42 CFR 415.70, and 42 CFR 415.102(d) you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population. 42 CFR 415.70 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost incurred by you. 42 CFR 415.60 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services such as research. Only provider services are reimbursable to you through the cost report. This worksheet also provides for computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 415.70. The methodology used in this worksheet applies the RCE limit to the total physician compensation attributable to provider services that are reimbursable on a reasonable cost basis.

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

Column Descriptions

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

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

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

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

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

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

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

**NOTE:** 42 CFR 415.60(b) requires that physician compensation be allocated between physician services to patients, to the provider, and nonallowable services such as research. Physicians' nonallowable services must not be included in columns 4 or 5. The instructions for column 18 ensure that the compensation for nonallowable services included in column 3 is eliminated on Worksheet A-8.

Column 6.--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the Federal Register before any allowable adjustments. (See CMS Pub. 15-1, §2182)

Column 7.--Enter for each line of data the physician's hours which are allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040.

The hours entered are the actual hours for which the physician is compensated by you for furnishing services of a general benefit to your patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered. Time records or other documentation that supports this allocation must be available for verification by your contractor upon request. (See CMS Pub. 15-1, §2182.3E.)

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

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

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

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

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

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

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

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

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

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

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

#### Line Descriptions

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

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

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

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

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

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

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

A change in order of allocation and/or allocation statistics is appropriate for the current cost reporting period if received by the contractor, in writing, within 90 days prior to the end of the cost reporting period. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, should be changed due to simplification of maintaining the statistics. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If the request is denied, the provider must use the previously approved methodology. (See CMS Pub. 15-1, §2313)

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



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

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

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

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

- Both Medicare and non-Medicare costs of arranged for services are recorded in your records; or
- The contractor determines that you are able to and do gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if you had furnished such services directly to all patients. (See CMS Pub. 15-1, §2314.)

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

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

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

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

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

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

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

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

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

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

After the adjustments have been made on Worksheet B, Part I, column 17, adjust the amounts in column 16 by the amounts in column 17 and extend the new balances to column 18 for each line. The total costs entered in columns 18, line 100, must equal the total costs entered in column 0, line 100.

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

Transfer the totals in column 18:

From Worksheet B, Part I, Column 18

To Worksheet D-1, Line 5

Line 30, SNF

For SNF

Line 31, NF

For Titles V or XIX. For NF

Sum of lines 30 and 31

Line 32, ICF/*IID*

For Title XIX. For ICF/*IID*

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

### Column Descriptions

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

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

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

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

**4121. WORKSHEET B, PART II - ALLOCATION OF CAPITAL-RELATED COSTS**

This worksheet provides for the determination of direct and indirect capital-related costs allocated to inpatient general routine services, special care, and ancillary services as well as to other cost centers. This worksheet is needed to provide CMS with data on capital-related costs for program purposes.

Use this worksheet in conjunction with Worksheets B, Part I, and B-1. The format and allocation process employed are identical to that used on Worksheets B, Part I, and B-1.

Column 0.--If capital-related costs have been directly assigned to specific cost centers on Worksheet A, column 2, enter those amounts directly assigned from your records. If you include costs incurred by a related organization in your cost report, the portion of these costs that are capital-related costs are considered directly assigned capital-related costs of the applicable cost center. For example, a provider that is part of a chain organization includes some costs incurred by the home office of the chain organization in its administrative and general cost center. The amount so included representing capital-related cost is included in this column.

Columns 1 and 2.--The amounts entered in column 1, lines 3 through 95, are obtained from Worksheet B, Part I, column 1, lines 3 through 95. The amounts entered in column 2, lines 3 through 95, are obtained from Worksheet B, Part I, column 2, lines 3 through 95.

Enter on Worksheet B-1, line 104, for each cost center (column) the capital-related costs to be allocated. Report these costs on the first line of each column on Worksheet B, Part II. Complete a unit cost multiplier for each column by dividing the amount on line 104 of Worksheet B-1 by the statistic reported on the first line of the same column. Enter the unit cost multiplier on line 105 and round to six decimal places, e.g., .102589241 is rounded to .102589. The allocation process on Worksheet B, Part II, is identical to that used on Worksheets B, Part I, and B-1.

Multiply the unit cost multiplier by the portion of the total statistic applicable to each cost center. Enter the result of each computation on Worksheet B, Part II, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers, the total cost on Worksheet B, Part II, line 100, of all the cost centers receiving the allocation must equal the amount being allocated on the first line of the column. These procedures must be performed for each general service cost center. Each cost center must be completed on Worksheets B-1 and B, Part II, before proceeding to the next cost center.

**4122. WORKSHEET B-2 - POST STEP DOWN ADJUSTMENTS**

This worksheet provides an explanation of the post Step down adjustment reported in column 17 of Worksheet B, Parts I and II.

Column 1.--Enter a brief description of the post Step down adjustment.

Column 2.--The post Step down adjustment may be made on Worksheet B, Parts I and II. Enter the appropriate part to which the post Step down adjustment applies.

Column 3.--Enter the Worksheet B line number to which the adjustment applies.

Column 4.--Enter the amount of the adjustment. Transfer these amounts to the applicable lines on Worksheet B, Parts I or II, column 17.

4123. WORKSHEET C - RATIO OF COST TO CHARGES FOR ANCILLARY AND  
OUTPATIENT COST CENTERS

Column 1.--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 18. Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 18. However, report the charges applicable to such cost centers with a credit balance in column 2 of the applicable line on Worksheet C.

Column 2.--Enter on each cost center line the total gross patient charges including charity care for that cost center. Include in the applicable cost centers items reimbursed on a fee schedule do not include Medicare charges applicable to items that are excluded from SNF PPS and paid on a fee schedule in the Medicare charges reported on Worksheet D. However, include your standard customary charges for these items in total charges on Worksheet C.

Column 3.--Divide the cost for each cost center in column 1 by the total charges for the cost center in column 2 to determine the ratio of total cost to total charges. Enter the resultant department ratios in this column. Round ratios to 6 decimal places, e.g., .102589241 is rounded to .102589.

**4124. WORKSHEET D - APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST**

A separate copy of this worksheet must be completed for each situation applicable under titles V, XVIII, and XIX.

**4124.1 Part I - Calculation of Ancillary and Outpatient Cost.**--This worksheet provides for the apportionment of cost applicable to inpatient and outpatient services reimbursable under titles V, XVIII, and XIX for SNFs, NFs, ICF/*IID* and Other in accordance with 42 CFR 413.53(b).

**NOTE:** For titles V and XIX, use columns 1, 2, and 4.

Column 1.--Enter the ratio of cost to charges developed for each cost center from Worksheet C, column 3.

Columns 2 and 3.--Enter from your records or the PS&R, the program SNF charges for each cost center.

For title XVIII, Part B, transfer the charges (less any professional component charges included therein) from column 3, line 100, plus Part II, line 2 to Worksheet E, Part I, line 20.

Provide a reconciliation showing how the elimination of any professional component charges was accomplished.

Columns 4 & 5.--Multiply the indicated program charges in column 2 by the ratio in column 1 to determine the program expenses. Transfer column 4, sum of lines 40 through 52, to Worksheet E, Part I, line 1. Title XVIII outpatient, Part B expenses will be transferred from column 5, line 100, to Worksheet E, Part I, line 17.

Line 48.--Enter only the program charges for medical supplies charged to patients that are not paid on a fee schedule.

4124.2 Part II - Apportionment Vaccine Cost. This part provides for the apportionment of the costs applicable to the administration and cost of the following vaccines: Pneumococcal, Hepatitis B, Influenza, and Osteoporosis.

Line 1.--Enter the cost to charges ratio from Worksheet C, column 3, line 49.

Line 2.--Enter the program charges from the PS&R or from provider records.

Line 3.--Multiply line 1 by line 2 and enter the result. Transfer this amount to Worksheet E, Part I, line 18.

4124.3 Part III - Calculation of Pass Through Costs for Nursing & Allied Health.--This part calculates the ancillary costs associated with Nursing & Allied costs applicable for pass through for Title XVIII.

Column 1.--Enter on each ancillary line the total ancillary costs from Worksheet B, Part I, column 18

Column 2.--Enter the Nursing & Allied costs allocated to ancillary cost centers on Worksheet B, Part I, column 14.

Column 3.--Calculate the ratio of Nursing & Allied Health costs to total costs for each ancillary cost center. Divide the amounts in column 2 by the amounts in column 1.

Column 4.--Enter the title XVIII Part A cost from Part I, column 4 above.

Column 5.--Determine the title XVIII pass through amount for Nursing & Allied costs by multiplying the ratios in column 3 times the cost in column 4. Transfer the total amount on line 100, column 5 to Worksheet E, Part I, line 2.

## 4125. WORKSHEET D-1 - COMPUTATION OF INPATIENT ROUTINE COSTS

This worksheet provides for the computation of SNF inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries) and 42 CFR 413.30 (limitations on reimbursable costs). This worksheet applies to all Title V, Title XVIII, and Title XIX inpatient routine costs.

A separate copy of this worksheet must be completed for the SNF, NF, and ICF/*IID*. Also, a separate copy of this worksheet must be completed for each health care program under which inpatient operating costs are computed. Report separately the required statistics for the SNF, NF, and ICF/*IID*.

4125.1 Part I - Calculation of Inpatient Routine Costs.

At the top of each page, indicate by checking the appropriate box the health care program and provider component for which the page is prepared.

Line Descriptions

Line 1.--Enter the following data depending on the health care program and provider component for which the page is completed:

<u>Description</u>	<u>Inpatient Days From</u>
SNF	Worksheet S-3, Part I, column 7, line 1, including private room days for title XVIII
NF	Worksheet S-3, Part I, column 7, line 2 for titles V and XIX
ICF/ <i>IID</i>	Worksheet S-3, Part I, column 7, line 3 for title XIX

**EXCEPTION:** When the SNF is located in a State that licenses the provider as an SNF regardless of the level of care given for titles V and XIX patients, enter the days from Worksheet S-3, column 7, sum of lines 1 and 2.

Line 2.--Enter the total private room days. (From provider's records.)

Line 3.--Enter the following data depending on the health care program and provider component for which the page is completed:

<u>Description</u>	<u>Inpatient Days From</u>
SNF	Worksheet S-3, Part I, column 4, line 1, for title XVIII
NF	Worksheet S-3, Part I, column 3, line 2 for title V and Worksheet S-3, Part I, column 5, line 2 for title XIX
ICF/ <i>IID</i>	Worksheet S-3, Part I, column 5, line 3 for title XIX

**EXCEPTION:** When the SNF is located in a State that certifies the provider as an SNF regardless of the level of care given for titles V and XIX patients, enter the program inpatient days from Worksheet S-3, column 3, lines 1 and 2 for title V and from Worksheet S-3, column 5, lines 1 and 2 for title XIX.

Line 4.--Enter the total medically necessary private room days applicable to each health care program and each provider component.



Line 5.--For a full cost report, enter the total general inpatient routine service costs from Worksheet B, Part I, column 18, SNF from line 30, NF from line 31, or ICF/**IID** from line 32.

**EXCEPTION:** When the SNF is located in a State that licenses the provider as an SNF regardless of the level of care given for Titles V and XIX patients enter the general inpatient routine service costs from lines 30 and 31.

Line 6.--Enter the total charges for general inpatient routine services for the SNF, the NF, or the ICF/**IID** as applicable. These charges should agree with the amounts on Worksheet G-2, column 1, lines 1, 2, and 3. See exception after line 5 above.

Line 7.--Enter the general inpatient routine cost/charge ratio (rounded to six decimal places, e.g., .102589241 is rounded to .102589) by dividing the total inpatient general routine service costs (line 5) by the total inpatient general routine service charges (line 6).

Line 8.--Enter the private room charges from your records.

Line 9.--Enter the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the total charges for private room accommodations (line 8) by the total number of days of care furnished in private room accommodations (line 2).

Line 10.--Enter the semi-private room charges from your records.

Line 11.--Enter the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the total charges for semi-private room accommodations (line 10) by the total number of days of care furnished in semi-private room accommodations (line 1 – line 2).

Line 12.--Subtract the average per diem charge for all semi-private accommodations (line 11) from the average per diem charge for all private room accommodations (line 9) to determine the average per diem private room charge differential. If a negative amount results from this computation, enter zero.

Line 13.--Multiply the average per diem private room charge differential (line 12) by the inpatient general routine cost/charge ratio (line 7) to determine the average per diem private room cost differential (rounded to two decimal places).

Line 14.--Multiply the average per diem private room cost differential (line 13) by the private room accommodation days (line 2) to determine the total private room accommodation cost differential adjustment.

Line 15.--Subtract the private room cost differential adjustment (line 14) from the general inpatient routine service cost (line 5) to determine the adjusted general inpatient routine service cost net of private room accommodation cost differential adjustment.

Line 16.--Determine the adjusted general inpatient routine service cost per diem by dividing the amount on line 15 by inpatient days (including private room days) shown on line 1.

Line 17.--Determine the routine service cost by multiplying the program inpatient days (including the private room days) shown on line 3 by the amount on line 16.

Line 18.--Determine the medically necessary private room cost applicable to the program by multiplying line 4 by the amount on line 13.

Line 19.--Add the amounts on lines 17 and 18 to determine the total program general inpatient routine service cost.

Line 20.--Enter the capital-related cost allocated to the general inpatient service cost center from Worksheet B, Part II, column 18, SNF from line 30, NF from line 31, or ICF/*IID* from line 32. See exception after line 5 above.

Line 21.--Determine the per diem capital-related cost by dividing line 20 by inpatient days on line 1.

Line 22.--Determine the program capital-related cost by multiplying line 21 by line 3.

Line 23.--Determine the inpatient routine service cost by subtracting the amount on line 22 from the amount on line 19.

Line 24.--Obtain the aggregate charges to beneficiaries for excess costs from your records.

Line 25.--Obtain the total program routine service cost for comparison to the cost limitation by subtracting the amount on line 24 from the amount on line 23.

Line 26.--This line is not applicable for title XVIII, but may be currently used for title V and or title XIX. Enter the per diem limitation applicable to the respective title.

Line 27.--This line is not applicable for title XVIII, but may be currently used for title V and or title XIX. Obtain the inpatient routine service cost limitation by multiplying the number of inpatient days shown on line 3 by the cost limit for inpatient routine service cost applicable to you for the period for which the cost report is being filed. This amount is provided by your contractor and is entered in the space provided in the line description.

Line 28.--This line is not applicable for title XVIII, but may be used for title V and or title XIX. Enter the amount of reimbursable inpatient routine service cost which is determined by adding line 22 to the lesser of lines 25 or 27. Transfer this amount to the appropriate Worksheet E, Part II, line 4.

#### 4125.2 Part II - Calculation of Inpatient Nursing & Allied Health Cost for PPS Pass Through.

Line 1.--Enter the total SNF inpatient days from Worksheet S-3, Part I, column 7, line 1.

Line 2.--Enter the SNF program inpatient days from Worksheet S-3, Part I, column 4, line 1.

Line 3.--Enter the program Nursing & Allied Health cost from Worksheet B, Part I, column 14, line 30 for SNF. Do not complete for titles V or XIX.

Line 4.--Calculate the ratio of program days to total days. Divide line 2 by line 1.

Line 5.--Calculate the Nursing & Allied Health pass through cost. Multiply the amount on line 3 times the amount on line 4. Transfer this amount to Worksheet E, Part I, line 2, for title XVIII.

## 4130. WORKSHEET E – Parts I and II

Worksheet E is used to calculate reimbursement settlement. Use the applicable part of Worksheet E as follows:

Part I - Calculation of Reimbursement Settlement *for* Title XVIII

Part II - Calculation of Reimbursement Settlement for Title V and Title XIX

4130.1 Part I – Calculation of Reimbursement Settlement for Title XVIII.--Use this part to calculate reimbursement settlement under SNF PPS for program services. SNFs are reimbursed by Medicare under SNF PPS for cost reporting periods beginning on or after July 1, 1998.

Part A - Inpatient Service PPS Provider Computation of Reimbursement

Line 1.--Enter the prospective payment amount from your PS&R.

Line 2.--Enter the sum of title XVIII Nursing & Allied Health costs, from Worksheet D, Part III, column 5, line 100 and Worksheet D-1, Part II, line 5.

Line 3.--Enter the sum of lines 1 and 2.

Line 4.--Enter the amounts paid or payable by workmen's compensation and other primary payers where 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 to be 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 days and charges. In this situation, no primary payer payment is entered on line 4.

However, if the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and any deductible and coinsurance. In situations 1, 2, and 3, primary payer payment is not credited toward the beneficiary's deductibles and coinsurance. In situations 4 and 5, 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. In situations 4 and 5, primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

If the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 4 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance (situations 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 4.

Line 5.--Enter the Part A coinsurance billed to Medicare beneficiaries. Include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payments do not fully satisfy the obligation of the beneficiary to the provider. Do not include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to the provider. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 6.--Enter program reimbursable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

Line 7.--Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 6.

Line 8. --Calculate this line as follows: ((line 6 - line 7) times .7) PLUS the amount on line 7. For cost reporting periods that begin on or after October 1, 2012, as amended by section 3201(b) of the Middle Class Tax Extension and Job Creation Act of 2012, calculate this line as follows: [(line 6 - line 7) times 65 percent] + (line 7 times 88 percent)]. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: [(line 6 - line 7) times 65 percent] + (line 7 times 76 percent)]. For cost reporting periods that begin on or after October 1, 2014, calculate this line as follows: line 6 times 65 percent.

Line 9.--Enter the amount of recovery of reimbursable bad debts. This amount is for statistical purposes only, and does not enter into any reimbursement calculation.

Line 10.--Enter the applicable program's share of the reasonable compensation paid to physicians for services in utilization review committees applicable to the SNF.

Line 11.--Enter the sum of line 3, plus line 8 and 10 for title XVIII, plus or minus the sum of lines 4, and line 5.

Line 12.--Enter interim payments from Worksheet E-1, column 2, line 4.

**NOTE:** Include amounts received from PPS (for inpatient routine services) as well as amounts received from ancillary services.

Line 13.--Your contractor will enter the Part A tentative adjustments from Worksheet E-1, column 2.

Line 14.--Enter OTHER adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

Line 14.99.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times the sum of (line 11 plus or minus lines 14 through 14.98)]. If the sum of line 11 plus or minus lines 14 through 14.98 is less than zero, do not calculate the sequestration adjustment.

Line 15.--Enter the sum of the amount on line 11 minus lines 12, 13 and 14.99, plus or minus line 14 and its subscripts not previously identified. Enter a negative amount in parentheses ( ). Transfer this amount to Worksheet S, Part III, column 2, line 1.

Line 16.--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.

*Part B – Ancillary Service Computation of Reimbursement Lessor of Cost of Charges – Title XVIII Only*

Use this part to calculate reimbursement settlement for Part B services for SNFs under title XVIII.

Line 17.--Enter the amount of Part B ancillary services furnished to Medicare patients. Obtain this amount from Worksheet D, Part I column 5, line 100.

Line 18.--Enter the vaccine cost from Worksheet D, Part II, line 3.

Line 19.--Enter the sum of the amounts on lines 17 and 18.

Line 20.--Report the charges applicable to the ancillary services from Worksheet D, Part I, column 3, line 100, plus Worksheet D, Part II, Line 2.

Line 21.--Enter the lesser of line 19 or 20.

Line 22.--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 22.

However, if the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and any applicable deductible and coinsurance. In situations 1, 2, and 3, primary payer payment is not credited toward the beneficiary's deductibles and coinsurance. In situations 4 and 5, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductibles 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. In situations 4 and 5, primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

If the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 22 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 22.

Line 23.--Enter the Part B deductible and coinsurance billed to Medicare beneficiaries. Include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payments do not fully satisfy the obligation of the beneficiary to you. Do not include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to you. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 24.--Enter program reimbursable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

Line 24.01.--For cost reporting periods that begin on or after October 1, 2012, enter the gross reimbursable bad debts for dually eligible beneficiaries. This amount must also be included in the amount on line 24.

Line 24.02.--For cost reporting periods that begin prior to October 1, 2012, enter the amount from line 24. For cost reporting periods that begin on or after October 1, 2012, calculate this line as follows:  $[(\text{line 24} - \text{line 24.01}) \text{ times } 65 \text{ percent}] + (\text{line 24.01} \text{ times } 88 \text{ percent})$ . For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows:  $[(\text{line 24} - \text{line 24.01}) \text{ times } 65 \text{ percent}] + (\text{line 24.01} \text{ times } 76 \text{ percent})$ . For cost reporting periods that begin on or after October 1, 2014, calculate this line as follows: line 24 times 65 percent.

Line 25.-- Enter the sum of the amounts on lines 21, and 24.02, minus the amounts on lines 22, and 23.

Line 26.--Enter interim payment from Worksheet E-1, column 4, line 4.

Line 27.--Your contractor will enter the Part B tentative adjustments from Worksheet E-1, column 4.

Line 28.--Enter OTHER adjustments

Line 28.99.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as  $[(2 \text{ percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)}) \text{ times the sum of (line 25 plus or minus lines 28 through 28.98)}]$ . If the sum of line 25 plus or minus lines 28 through 28.98 is less than zero, do not calculate the sequestration adjustment.

4130.2 Part II – Calculation of Reimbursement Settlement for Title V and Title XIX Only.--Use Worksheet E, Part II, to calculate reimbursement settlement for titles V, and XIX services furnished by SNFs, NFs, and ICF/~~IID~~/s reimbursed under cost principles.

Mark in the appropriate box at the top of each page of Worksheet E, Part II, to indicate the program and the provider component for which it is used.

### Line Descriptions

Line 1.--Enter the cost of ancillary services furnished to inpatients for titles V, and XIX. Transfer these amounts from Worksheet D, Part I, column 4, lines 40 through 52.

Line 2.--Enter Nursing & Allied Health costs for title V or title XIX from Worksheet D-1, part II, line 5 accordingly.

Line 3. -- For titles V and XIX, enter the cost of outpatient services. Obtain the amount from Worksheet D, Part I, column 4, lines 60 through 71.

Line 4.--Enter the inpatient operating costs from Worksheet D-1, line 28.

Line 5.--Enter the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees applicable to the SNF, from the provider records.

Line 7.--Enter the applicable charge differential between semi-private and less than semi-private accommodations. The amount of the differential is the difference between the customary charge for semi-private accommodations and the customary charge for the less than semi-private accommodations furnished for all program patient days when the accommodations provided were not medically necessary.

Line 8.--Enter the amount on line 6 minus the amount on line 7.

Line 9.--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 the provider accepts 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 9.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and applicable deductibles and coinsurance. In situations 4 and 5, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer

payment or deductibles 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 deductibles and coinsurance. In all situations for services rendered on or after November 13, 1989, the primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days 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 (situations 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 9.

Line 10.--Enter the amount on line 8 minus the amount on line 9.

Lines 11 through 15.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 10.

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, §2104.3).

If the charges on Worksheet C do include such professional component, eliminate the amount of the professional component from the charges to be entered on lines 11 and 13. Submit a schedule showing these computations with the cost report.

Line 11.--For titles V or XIX only; enter the total charges for inpatient ancillary services from Worksheet D, Part I, column 2, lines 40 through 52 net of professional component.

Line 12.--For titles V and XIX only, enter the total charges for outpatient services from Worksheet D, Part I, column 2, lines 60 through 71 net of professional component.

Line 13.--Enter the program inpatient routine service charges from your records for the applicable component.

The amount on this line includes covered late charges which have been billed to the program where the patient's medical condition is the cause of the extended stay. In addition, these charges include the charges for semi-private accommodations of inpatients which workmen's compensation and other primary payers paid. Adjust these charges on line 13 in determining final settlement.

Line 14.--If the amount entered on line 12 has not been adjusted to take into consideration the differential between semi-private room charges and charges for less than semi-private accommodations. Enter the amount from line 7.

Line 15.--Enter the sum of lines 11 through 13 minus line 14.

Lines 16 through 19.--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. 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 16 through 18 but instead enter on line 19 the amount from line 15. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 19 exceed the actual charge on line 15.



Computation of Reimbursement Settlement

Line 20.--Enter the lesser of reasonable cost (line 8 before the application of the primary payer amount) or customary charges (line 19), minus the primary payer amount on line 9.

Line 21.--Enter the deductibles billed to title V and title XIX beneficiaries.

Line 22.--Enter the amount on line 20 minus the amount on line 21.

Line 23.--Enter the coinsurance billed to beneficiaries. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 24.--Enter the amount on line 22 minus the amount on line 23.

Line 25.--Enter program reimbursable bad debts net of bad debt recoveries for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services.

Line 26.--Enter the sum of the amounts on lines 24 and 25.

Line 27.--If your cost limit is raised as a result of your request for review, amounts which were erroneously collected on the basis of the initial cost limit are required to be refunded to the beneficiary. Enter any amounts which are not refunded either because they are less than \$5.00 collected from a beneficiary or because the provider is unable to locate the beneficiary.

Line 28.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination from the program or a decrease in program utilization. (See CMS Pub. 15-1, §§136 - 136.16.)

Line 29.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from a cash basis to an accrual basis. (See CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

Include any portion of the amount of the State's bill for determining the validity of nurse aide training and testing under §1919(b)(5) of the Social Security Act. This adjustment includes the State's cost of deeming individuals to have completed training and testing requirements and the State's cost of determining the competency of individuals trained by or in a facility-based program.

Line 30.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss from the disposition of depreciable assets. (See CMS Pub. 15-1, §§132-132.4.) Enter in parentheses ( ) the amount of any excess depreciation taken

**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 31.--Enter the sum of the amounts on line 26, plus or minus lines 29 and 30, minus lines 27 and 28.

Line 32.--Enter the Title V or Title XIX interim payment from your records.

Line 33.--Enter a negative amount in parentheses ( ). Transfer titles V and XIX SNF amounts on this line to Worksheet S, Part III, line 1, columns 1 or 4, as applicable. Transfer titles V and XIX NF amounts to Worksheet S, Part III, line 2, columns 1 or 4, respectively. Transfer title XIX ICF/*IID* amounts to Worksheet S, Part III, line 3, column 4.

**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:

- SNF-based HHAs use Worksheet H-5;
- SNF-based RHC/FQHCs use Worksheet I-5; and
- 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 amount from column 2 Worksheet E, Part I, line 12 for inpatient Part A, and from column 4 to Worksheet E, Part I, Line 27 for Part B.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 8 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, line 11 plus *the sum of* line 14 and all subscripts of line 14. For Part B, the amount in column 4 must equal Worksheet E, Part I, line 25 plus *the sum of* line 28 and all subscript of line 28.

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

## 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. 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 represents 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--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 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 their respective columns on Worksheet G, line 41 (Due to Other Funds).

Line 12.--Land--This balance reflects the cost of land used in 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 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 items such as, but 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 operations. Enter this amount as a negative.

Line 29.--Investments--This field contains the cost of investments purchased with SNF funds and the fair market value (at date of donation) of securities donated to the SNF.

Line 30.--Deposits on Leases--Report the amount of deposits on leases. This includes security deposits.

Line 31.--Due from 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 42.

Line 44--Mortgage Payable--This amount 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 49.

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 31. 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 5 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 5 through 9.

Line 10--Total Additions--In columns 2, 4, 6 and 8, enter the sum of lines 5 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 13 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 13 through 17.

Line 18.--Total Deductions--In columns 2, 4, 6 and 8, enter the sum of lines 13 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 SNF-based facility separately.

Part I - Patient Revenues--Enter total patient revenues associated with the appropriate cost centers on lines 1 through 4, and 6 through 13.

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 3.--ICF/ID--Enter the ICF/ID revenue from your accounting books and/or records.

Line 4.--Other Long Term Care-- Enter the revenue generated from other long term care sub providers 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.--Clinic--Enter in the appropriate column revenue from clinic 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.--RHC/FQHC--Enter in column 2 only, the revenue generated from the SNF-based RHC/FQHC.

Line 11.--CMHC--Enter in column 2 only, the revenue generated from *the* CMHC.

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.--Other (specify).

Line 14.--Total Patient Revenues--Enter the sum of lines 5 through 13.

Column 3--Enter the sum of columns 1 and 2, lines 1 – 14 respectively in column 3.

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

Line 1.--Operating Expenses--This amount is transferred from Worksheet A, line 100, column 3.

Lines 2 through 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 through 7, column 1.

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

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

Line 15.--Total Operating Expenses--Enter in 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--This worksheet requires 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 14, 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,  
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 through 23.--Enter on the appropriate lines 6 through 23 all other revenue not reported on line 1. Obtain these amounts from your accounting books and/or records.

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

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

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

Line 27.--Other Expenses (Specify)--Enter all other expenses not reported on lines 6 through 25.

Line 30.--Total Other Expenses--Enter the sum of lines 27 through 29, including subscripts.

Line 31.--Net Income (or Loss) for the Period--Enter the result of line 26 minus line 30.

4141. WORKSHEET H - ANALYSIS OF *SNF-BASED* HOME HEALTH AGENCY COSTS

This worksheet provides for the recording of direct *SNF-based* 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 and enter in columns 1, 2 and 4. All of the cost centers listed may not apply to all agencies.

The *SNF-based* 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 *SNF-based* 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 *SNF-based* 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 *SNF-based* 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:

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

All other payroll-related benefits based on gross salaries by cost center

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

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

**4142. WORKSHEET H-1, PART I - COST ALLOCATION HHA GENERAL SERVICE COST AND WORKSHEET H-1, PART II - 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. See §4120 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number.

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

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

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

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

**NOTE:** A change in order of allocation and/or allocation statistics is appropriate for the current cost reporting period if received by the contractor, in writing, within 90 days prior to the end of the cost reporting period. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, should be changed due to simplification of maintaining the statistics. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If the request is denied, the provider must use the previously approved methodology. (See CMS Pub. 15-1, §2313)

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, total expenses of the cost center to be allocated. Obtain this amount from Worksheet H-1, Part I, from the same column and line number used to enter the statistical base on Worksheet H-1, Part I. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet H-1, Part I, column 1, line 1.

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 25, equals the total expenses entered in column 0, line 25.

### 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, 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 costs 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, are 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 24, add the amounts on each line in columns 4A and 5, and enter the result for each line in this column.

Line 25--The total costs entered in column 6, lines 6 through 24, must equal the total costs entered in column 0, lines 1 through 24.

Transfer the amounts on Worksheet H-1, Part I, 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, Part I, column 6, lines as indicated. The amounts on line 21, columns 0 through 15 and column 17 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 15 and column 17, line 70. Complete the amounts entered on lines 1 through 20, columns 1 through 15 and column 17.

Line 22.--Enter the unit cost multiplier (column 18, line 1, divided by the sum of column 18, line 21 minus column 18, line 1, rounded to 6 decimal places. Multiply each amount in column 18, lines 2 through 20, by the unit cost multiplier, and enter the result on the corresponding line of column 19.

**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:** A change in order of allocation and/or allocation statistics is appropriate for the current cost reporting period if received by the contractor, in writing, within 90 days prior to the end of the cost reporting period. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, should be changed due to simplification of maintaining the statistics. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If the request is denied, the provider must use the previously approved methodology. (See CMS Pub. 15-1, §2313)

If there is a change in ownership, the new owners may request that the 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 16, Part I, enter the total of columns 3A through 15.

In column 19, Part I, for lines 2 through 20, multiply the amount in column 18 by the unit cost multiplier in column 19, line 22, and enter the result in this column. On line 21, column 19, enter the total of the amounts on lines 2 through 20. The total on line 21 equals the amount in column 18 line 1.

In column 20, enter on lines 2 through 20 the sum of columns 18 and 19. The total on line 21 equals the total in column 18, 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 20, 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 16, in addition to statistics for services that are not part of a home health plan.

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

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



**NOTE:** The sum of visits reported in columns 6 and 7 must equal the corresponding amounts on Worksheet S-4, column 5, lines 24, 26, 28, 30, 32 and 34, respectively. These visits are reported for episodes completed during the fiscal year.

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

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

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

#### Column Descriptions

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

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

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

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

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

Column 1--Enter the facility costs in column 1, lines 15 and 16, from Worksheet H-2, Part I, column 20, lines 8 and 9, respectively.

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

Columns 3 through 5--In column 3, enter the sum total of columns 1 and 2 on lines 15 and 16, respectively. Enter in column 4, lines 15 and 16, respectively, the total charges for such services in accordance with the instructions in §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 15--Enter the program covered charges for medical supplies charged to patients for items not reimbursed on the basis of a fee schedule. Do not enter medical supply charges in columns 6, 7, and 8 subject to reimbursement on the basis of a fee schedule or OPPS as all medical supplies are covered under the HHA PPS benefit.

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

Columns 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 *SNF-BASED* HHA REIMBURSEMENT SETTLEMENT

This worksheet provides for the reimbursement calculation of titles V, XVIII Parts A and B, and XIX. 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 OPSS 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. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, line 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, line 16

The above table reflects the transfer of the cost of pneumococcal and influenza vaccines from Worksheet H-3, Part I, column 10, line 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 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 workmen's' 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:

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

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

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

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

#### 4145.2 Part II - Computation of *SNF-Based* 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 payer amounts.

Lines 11 through 20.--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.

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 30.-- Enter any other adjustments.

Line 30.99.--Enter the sequestration adjustment amount from the PS&R.

Line 31.--Enter the sum of the amount on line 29 minus lines 30.99, plus or minus line 30 and its subscripts not previously identified.

Line 32.--Enter the interim payment amount from Worksheet H-5, line 4. For titles V and XIX, enter the interim payments from your records

Line 33.--For contractor use only: Enter the amount from Worksheet H-5, line 5.99.

Line 34.--Enter the sum of the amount on line 31 minus lines 32 and 33. 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 *SNF-BASED* HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

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

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

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the *SNF-based* 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-4, Part II, line 32.

**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 the net settlement amount (balance due to 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 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 7-- The sum of lines 4, 5.99, and 6, column 2, for inpatient Part A must equal Worksheet H-4, Part II, column 1, line 31. For Part B, the amount in column 4 must equal Worksheet H-4, Part II, column 2, line 31.

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

4148. WORKSHEET I-1 - ANALYSIS OF SNF-BASED *RHC/FQHC* COSTS

Use this worksheet only if you operate a certified *SNF-based* RHC/ FQHC. If you have more than one SNF-based RHC/FQHC, complete a separate worksheet for each *RHC/FQHC*, *unless the clinic/center has received prior contractor approval to file a consolidated cost report (see CMS Pub. 100-04, chapter 9, §30)*. *Effective for cost reporting periods beginning on or after October 1, 2014, SNF-based FQHCs do not complete the I series worksheets, they must complete the free standing FQHC cost report Form CMS-224-14.*

This worksheet is for the recording of direct *SNF-based RHC/FQHC* costs from your accounting books and records to arrive at the identifiable *clinic/center* 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 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 *RHCs/FQHCs*, 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 413.9(c)(3), 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 *Public Health Service* personnel may be included in your *RHC/FQHC*'s costs. Obtain this amount from your 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 *RHC/FQHC* 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 21.--Enter the sum of the amounts on lines 15 through 19.

Line 22.--Enter the sum of the amounts on lines 10, 14, and 21. Transfer this amount to Worksheet I-2, Part II, line 12.

Lines 23 through 26.--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 27.--Reserved for future use.

Line 28.--Enter the sum of the amounts on lines 23 through 26. Transfer the total amount in column 7 to Worksheet I-2, line 13.

Line 29.--Enter the overhead expenses directly costed to the *RHC/FQHC*. 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 *RHC/FQHC* 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 *clinic/center*. 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 16.

Line 32.--Enter the sum of the amounts on lines 22, 28 and 31. This is the total *SNF-based RHC/FQHC* cost. *This cost should agree with the amount reported for the SNF-based RHC/FQHC on Worksheet A, column 7.*

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

**4149.1 Part I - Visits and Productivity.**--Worksheet I-2, Part I, summarizes the number of *SNF-based RHC/FQHC* visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 list the types of practitioners (positions) for whom *SNF-based RHC/FQHC* 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 *SNF-based RHCs/FQHC*. (See CMS Pub. 100-04, chapter 9, §40.3 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 cost 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 nonphysician 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 contractor in lines 1 through 3.

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 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 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 *SNF-based RHC/FQHC* 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 9 and 11, enter the actual number of visits for each type of position.

**Line Descriptions**

**Line 10.**--Enter the total of lines 4 through 9.

**Line 11.**--Enter the number of visits furnished to *SNF-based RHC/FQHC* 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 *SNF-based RHC/FQHC*, 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 *SNF-based 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 *SNF-Based RHC/FQHC Services*.--Worksheet I-2, Part II, determines the amount of the overhead costs incurred by both the *SNF* and the *SNF-based RHC/FQHC* which apply to *SNF-based RHC/FQHC* services.

Line 12.--Enter the cost of health care services from Worksheet I-1, column 7, line 22.

Line 13.--Enter the total nonreimbursable costs from Worksheet I-1, column 7, line 28.

Line 14.--Enter the sum of lines 12 and 13 for the cost of all services (excluding overhead).

Line 15.--Enter the percentage of *SNF-based* RHC/FQHC services. This percentage is determined by dividing the amount on line 12 (the cost of health care services) by the amount on line 14 (the cost of all services, excluding overhead).

Line 16.--Enter the total *RHC/FQHC* overhead costs incurred from Worksheet I-1, column 7, line 31.

Line 17.--Enter the overhead cost incurred by the SNF 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 15 (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 12 (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 *SNF-BASED* RHC/FQHC SERVICES

This worksheet provides for the reimbursement calculation *for a SNF-based RHC/FQHC*. Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due to or from the program for the cost reporting period.

4150.1 Part I - Determination of Rate For *SNF-based* RHC/FQHC Services.--Part I calculates the cost per visit for *SNF-based* 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 10.

Line 5.--Enter the visits made by physicians under agreement from Worksheet I-2, Part I, column 5, line 11.

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 period 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 contractor.

Line 9.--Enter the lesser of the amount on line 7 or line 8. For cost reporting periods beginning on 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 *for SNF-based RHC/FQHC*.--Part II calculates the total payment amount due to or from the Medicare program for covered *SNF-based* RHC/FQHC services furnished to program beneficiaries during the cost 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 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 contractor's records (PS&R).

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 *SNF-based* RHC/FQHC services during the cost reporting period).

Line 12.--Enter the number of program covered visits subject to the outpatient mental health services limitation from your contractor's records (PS&R).

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 program cost. Enter the sum of the amounts on lines 11 and 14, in columns 1 and 2 respectively. For cost reporting periods beginning on or after January 1, 2011 do not complete column 1 and enter the sum of the amounts on lines 11 and 14, columns 1 and 2 in column 2.

**NOTE:** Section 4104 of the Affordable Care Act (ACA) eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. RHCs/FQHCs must provide detailed HCPCS coding for preventive services to ensure coinsurance and deductible are not applied. *RHC/FQHC must* maintain this documentation in order to apply the appropriate reductions on lines 15.03 and 15.04.

Line 15.01.--Enter the total program charges from the contractor's records (PS&R). For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter total program charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in column 2.

Line 15.02.--Enter the total program preventive charges from the *RHC/FQHC*'s records. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter total program preventive charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in column 2.

Line 15.03.--Enter the total program preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter the total program preventive costs ((line 15.02 divided by line 15.01) times line 15)) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 15.02 divided by line 15.01) times line 15, columns 1 and 2)) in column 2.

Line 15.04.--Enter the total program non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter the total program non-preventive costs ((line 15 minus lines 15.03 and 17) times .80)) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program non-preventive costs ((line 15, columns 1 and 2 minus lines 15.03 and 17) times .80)) in column 2.

Line 15.05.--Enter the total program costs. For cost reporting periods that overlap January 1, 2011, enter the total program costs (line 15 times .80) for services rendered prior to January 1, 2011, in column 1, and enter total program costs (line 15.03 plus line 15.04) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program costs (line 15.03 plus line 15.04), in column 2.

Line 16.--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 16.

Line 17.--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 contactor from clinic bills processed during the cost reporting period. RHCs determine this amount from the interim payment lists provided by the contractor. FQHCs enter zero on this line as deductibles do not apply.

Line 18.--Enter the coinsurance amount applicable to the RHC/FQHC for program patients for visits on lines 10 and 12 as recorded by the contactor from clinic/*center* bills processed during the cost reporting period. Informational only.

Line 19.--Enter the net program cost, excluding vaccines. This is equal to the result of subtracting the amount on line 16 from the amounts on line 15.05, columns 1 and 2.

Line 20.--Enter the total reimbursable program cost of vaccines and their administration from Worksheet I-4, line 16.

Line 21.--Enter the total reimbursable program cost (line 19 plus line 20).

Line 22.--Enter the total reimbursable bad debts, net of recoveries, from your records.

Line 22.01.--Enter the total adjusted reimbursable bad debt for cost reporting periods that begin on or after October 1, 2012, calculate this line as follows: line 22 times 88 percent. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: line 22 times 76 percent. For cost reporting periods that begin on or after October 1, 2014, calculate this line as follows: line 22 times 65 percent.

Line 23.--Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 22.

Line 24.--Enter any other adjustment. Specify the adjustment in the space provided.

Line 25.--Enter the sum of line 21 plus line 22, plus or minus line 24. For cost reporting periods that begin on or after October 1, 2012, enter the sum of line 21 plus line 22.01, plus or minus line 24.

Line 25.01.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 25]. If line 25 is less than zero, do not calculate the sequestration adjustment.

Line 26.--Enter the total interim payments made to you for covered services furnished to program beneficiaries during the reporting period (from contractor records). Transfer amount from Worksheet I-5, line 4.

Line 27.--Your contractor will enter the tentative adjustment from Worksheet I-5, line 5.99.

Line 28.--Enter the total amount due to/from the program, line 25 minus lines 25.01, 26 and 27. Transfer this amount to Worksheet S, Part III, columns 1, 3, or 4 as applicable, line 5 or line 6 accordingly.

Line 29.--Enter the program reimbursement effect of protested items. The reimbursement effect of non-allowable 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 CMS Pub. 15-2 §115.2)

#### 4151. WORKSHEET I-4 - COMPUTATION OF *SNF-BASED RHC/FQHC* 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. 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 SNF. If a patient simultaneously received vaccine(s) with any Medicare covered services as an inpatient or outpatient, those vaccine costs are reimbursed through the SNF and cannot be claimed by the RHC/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.

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 the 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 *RHC/FQHC*.

Line 7.--Enter the amount from Worksheet I-2, line 19.

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 administered to Medicare beneficiaries 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 20.



**4152. WORKSHEET I-5 - ANALYSIS OF PAYMENTS TO SNF-BASED *RHC/FQHC*  
FOR SERVICES RENDERED**

Complete this worksheet for Medicare interim payments only. Complete a separate worksheet for each *SNF-based RHC/FQHC*. Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your 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 includes amounts withheld from the *RHC/FQHC's* interim payments due to an offset against overpayments to the *RHC/FQHC* 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 26.

**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 *RHC/FQHC* 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 *RHC/FQHC* to program, show the amount and date on which the *RHC/FQHC* 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, must equal the amount on Worksheet I-3, line 25 plus or minus line 25.01.

4153. ***WORKSHEET J-1, PARTS I & II***

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 Cost Centers for CMHC.--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 Cost Centers for *CMHC - Statistical Basis.*--Worksheet J-1, Part 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 cost reporting period if received by the contractor, in writing, within 90 days prior to the end of the cost reporting period. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, should be changed due to simplification of maintaining the statistics. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. If the request is denied, the provider must use to the previously approved methodology. (See CMS Pub. 15-1, §2313)

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, columns 1 through 18 as appropriate (e.g., capital-related cost buildings and fixtures, transfer the amount from Worksheet B, Part I, column 1, line 73 to Worksheet J-1, Part II, column 1).

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 Worksheet J-1, 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 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 column 17, Part I, if Worksheet B, Part I, column 17, excluded costs, column 17 on this worksheet must also exclude these costs.

In column 18, Part I, enter the sum of columns 16 and 17.

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.

In column 19, line 23, calculate the unit cost multiplier for component administrative and general costs. Divide column 18, line 1 by the result of column 18, line 22 minus line 1 and round to six decimal places.

In column 19, for lines 2 through 21, multiply the amount in column 18 by the unit cost multiplier in column 19, line 23, and enter the result in this column. On line 22, enter the total of the amounts on lines 2 through 21. The total on line 22 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 CMHC REHABILITATION COSTS

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

4154.1 Part I - Apportionment of CMHC Cost Centers.--

Column 1.--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, 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 CMHC charges from your records for title V in column 4, and title XIX in column 8. Do not complete column 6 for CMHC title XVIII charges as they are reimbursed under OPPS. 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 CMHC Services Furnished by Shared 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 CMHC facility.

Column 3.--For each of the cost centers listed; enter the ratio of cost to charges that are 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 CMHC charges from your records for title V, in column 4, and title XIX, in column 8. Do not complete column 6 for CMHC title XVIII charges as they are reimbursed under OPPS.

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 9.

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

4155. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT OF *SNF-BASED* COMMUNITY MENTAL HEALTH CENTER SERVICES

Line 1--Enter the cost of rehabilitation services from Worksheet J-2, Part II, line 31 from columns 5 or 9, respectively for Titles V and XIX.

Line 2--Enter the gross PPS payments received for title XVIII services rendered during the cost reporting period excluding outliers. Obtain this amount from the PS&R and/or your records.

Line 3--Enter the total outliers payments received. Obtain this amount from the PS&R and/or your records.

Line 4.--Enter the amounts paid and payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer (from your records).

Line 5.--Title XVIII CMHCs enter the result obtained by subtracting line 4 from the sum of lines 2 and 3. Titles V and XIX providers not reimbursed under PPS enter the total reasonable costs by subtracting line 4 from line 1.

Line 6.--Enter the charges for the applicable program services from Worksheet J-2, sum of Parts I and II, Columns 4, and 8 as appropriate, lines 22 and 30.

**NOTE:** Title XVIII CMHCs and providers not subject to reasonable cost reimbursement do not complete lines 7 and 8.

Lines 7 and 8.--Lines 7 and 8 provide for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in 42 CFR 413.13(e). DO NOT complete for Title XVIII.

Enter on line 7 the excess of total customary charges (line 6) over the total reasonable cost (line 5). In situations when in any column the total charges on line 6 are less than the total cost on line 5, enter zero (0) on line 7.

Enter on line 8 the excess of total reasonable cost (line 5) over total customary charges (line 6). In situations when in any column the total cost on line 5 is less than the customary charges on line 6, enter zero (0) on line 8.

Line 9.--Title XVIII providers enter the total reasonable costs from line 5. Titles V and XIX providers not reimbursed under PPS enter the lesser of line 5 or line 6.

Line 10.--Enter the Part B deductibles billed to program patients (from your records).

Line 11.--Enter the Part B coinsurance billed to program patients (from your records).

Line 12.--Enter the sum of line 9 minus lines 10 and 11.

Line 13.--Enter reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records).

Line 13.01.--Enter the adjusted reimbursable bad debt for cost reporting periods that begin on or after October 1, 2012, calculate this line as follows: line 13 times 88 percent. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: line 13 times 76 percent. For cost reporting periods that begin on or after October 1, 2014, calculate this line as follows: line 13 times 65 percent.

Line 14.--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount must also be included in the amount on line 13.

Line 15.--Enter the sum of lines 12 and 13. For cost reporting periods that begin on or after October 1, 2012 enter the sum of lines 12 and 13.01.

Line 16.--Enter the amount of other adjustments from your records.

Line 17.--Enter the amount on line 15 plus or minus line 16.

Line 17.01.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 17]. If line 17 is less than zero, do not calculate the sequestration adjustment.

Line 18.--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 19.--Your contractor will enter the tentative adjustment from Worksheet J-4, line 5.99.

Line 20.--Enter the balance due component/program (sum of lines 17 minus lines 17.01, 18 and 19) and transfer this amount to Worksheet S, Part III, columns as appropriate, line 7.

Line 21.--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 *SNF*-BASED CMHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. Complete a separate worksheet for each community mental health center.

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

**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 includes 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 18.

**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.--The sum of lines 4, 5.99, and 6, column 2, must equal the amount on Worksheet J-3, line 17 plus or minus line 17.01.

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## 4157. WORKSHEET K – ANALYSIS OF HOSPICE COSTS

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 *and* 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. *Effective for cost reporting periods beginning on or after October 1, 2015, do not complete these worksheets but complete the O series worksheets.*

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 *through* 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 *through* 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 413.9(c)(3), enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §4116.)

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 includes 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 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 are 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. Physical therapy 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.--*This* 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. Occupational therapy 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. 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 the terminally ill individual and family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided 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 the individual to adjust to their 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 services costs 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 other hospice services which have not been provided for in the previous lines.

Lines 35-38.--Non Reimbursable Costs.--Enter on the appropriate lines the applicable costs. Bereavement program costs consist 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 contractor, and the contractor 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 contractor 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 operations. 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)-- These services must be provided under the direction of a physician by a social worker who meets the requirements set forth in 42 CFR 418.114(b)(3).

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. 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 subscript 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. 15-1, §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 cost reporting period if received by the contractor in writing within 90 days prior to the end of that cost reporting period. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or, if the allocation is as accurate, should be changed due to simplification of maintaining the statistics. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If the request is denied, the provider must use the previously approved methodology. (See CMS Pub. 15-1, §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 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 39, 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 39 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 40. 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 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 39) 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. 15-1, §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. Contractor 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, Part I, column 5A, line 39 and the accumulated cost reported on Worksheet K-4, Part II, column 6, line 6. Enter any amounts reported on Worksheet K-4, Part I, column 5A for (1) any service provided under arrangements to program patients only 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, Part I, 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.

Obtain the total direct expenses (column 0, line 34) from Worksheet A, column 7, line 83. Obtain the cost center allocation (column 0, lines 1 through 33) from Worksheet K-4 part I column 7, lines as indicated. The amounts on line 34, 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 33, columns 1 through 16.

Line 35.--Enter the unit cost multiplier (column 16, line 1), divided by the sum of column 16, line 34 minus column 16, line 1, rounded to 6 decimal places. Multiply each amount in column 16, lines 2 through 33, by the unit cost multiplier, and enter the result on the corresponding line of column 17.

In column 16, Part I, enter the total of columns 4A through 15.

In column 17, Part I, for lines 2 through 33, multiply the amount in column 16 by the unit cost multiplier on line 35, column 17, and enter the result in this column. On line 34, enter the total of the amounts on lines 2 through 33. The total on line 34 equals the amount in column 16, line 1.

In column 18, Part I, enter on lines 2 through 33 the sum of columns 16 and 17. The total on line 34 equals the total in column 16, line 34.

4162.2 Part II - Allocation of General Service Costs to Hospice Cost Centers - Statistical Basis.--*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.*

**NOTE:** A change in order of allocation and/or allocation statistics is appropriate for the current cost reporting period if received by the contractor, in writing, within 90 days prior to the end of the cost reporting period. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, should be changed due to simplification of maintaining the statistics. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If the request is denied, the provider must use the previously approved methodology. (See CMS Pub. 15-1, §2313.)

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

Lines 1 through 33.--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 34.--Enter the total of lines 1 through 33 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 35.--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, columns as indicated, line 83.

Line 36.--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 35 by the total statistic entered in the same column on line 34. 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.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (Part I, line 34) must equal the total cost on line 34, Part II.

Perform the preceding procedures for each general service cost center.

4162.3 Part III- Computation of Total Hospice Shared Costs.--This worksheet provides for the shared therapy, drugs, or medical supplies from the SNF to the hospice.

Column Description

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 hospice, enter on the appropriate lines the charges from the provider's records, applicable to the SNF-based hospice.

Column 3.--Multiply the amount in column 2 by the ratios in column 1 and enter the result in column 3.

Line 9.--Sum of column 3 lines 1 through 8.

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

Worksheet K-6 calculates the average cost per day 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, column 18, line 34, less column 18, line 33, plus Worksheet K-5, Part III, column 3, 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 12 to arrive at the average other cost.



**4164. WORKSHEET O - ANALYSIS OF SNF-BASED HOSPICE COSTS**

*The O series of worksheets must be completed by all SNF-based hospices effective for cost reporting periods beginning on or after October 1, 2015. This worksheet is used to record the trial balance of expense accounts from the provider's 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.*

*Column Descriptions*

*For columns 1, 2, 4, and 6, direct patient care service costs (lines 25 through 46) are reported by LOC on Worksheets O-1, O-2, O-3 and O-4. For each cost center on Worksheet O, enter the sum of the amounts from Worksheets O-1, O-2, O-3, and O-4 for salaries, other costs, reclassifications, and adjustments, in columns 1, 2, 4, and 6, respectively.*

*Column 1* -- *Enter salaries from the provider's accounting books and records. Salaries for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 1 of Worksheets O-1, O-2, O-3, and O-4. The total salaries for column 1, line 100, must equal the salaries reported on Worksheet A, column 1, line 83.*

*Column 2* - *Enter all costs other than salaries from the provider's accounting books and records. Other costs for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 2 of Worksheets O-1, O-2, O-3, and O-4. The total other costs for column 2, line 100, must equal the other costs reported on Worksheet A, column 2, line 83.*

*Column 3* - *For each cost center, enter the total of columns 1 plus 2.*

*Column 4* - *Enter any reclassifications among cost center expenses 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 or reported on Worksheet A, line 83. Show reductions to expenses as negative amounts.*

*If reclassifications are needed for direct patient care service cost centers (lines 25 through 46), enter the reclassification amounts on the appropriate Worksheets O-1, O-2, O-3, and O-4, column 4, for each level of care.*

*Reclassifications for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 4 of Worksheets O-1, O-2, O-3, and O-4. The total reclassifications for column 4, line 100, must equal the reclassifications reported on Worksheet A, column 4, line 83.*

*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 - In accordance with 42 CFR 413.9(c)(3), enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §4016.) This column need not be completed by all providers, but is completed only to the extent adjustments are needed or reported on Worksheet A, column 6, line 83. Show reductions to expenses as negative amounts.*

*If adjustments are needed for direct patient care service cost centers (lines 25 through 46), enter the adjustment amounts on the appropriate Worksheets O-1, O-2, O-3, and O-4, column 6, for each level of care.*

*Adjustments for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 6 of Worksheets O-1, O-2, O-3, and O-4. The total adjustments for column 6, line 100, must equal the adjustments reported on Worksheet A, column 6, line 83.*

*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 O-5, as follows:*

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

Line Descriptions

The Worksheet O cost centers are segregated into general service, direct patient care service, and nonreimbursable categories to facilitate the transfer of costs to the various worksheets. The general service cost centers appear on Worksheet O-5, and Worksheets O-6, Parts I and Part II, using the same line numbers as Worksheet O. The direct patient care service cost centers appear on Worksheets O-1, O-2, O-3, and O-4 using the same line numbers as Worksheet O.

General service cost centers (lines 1 through 17) include expenses incurred in operating the facility as a whole that are not directly associated with furnishing patient care such as, mortgage, rent, plant operations, administrative salaries, utilities, telephone, and computer hardware and software costs. Except where descriptions are provided below, see §4113 for descriptions of general service cost centers.

Lines 1 and 2 - Cap Rel Costs-Bldg & Fixt and Cap Rel Costs-Mvble Equip.--Enter in column 2, the capital-related costs for buildings and fixtures and the capital-related costs for moveable equipment on lines 1 and 2, respectively.

Line 3 - Employee Benefits Department.--Enter in columns 1 and 2, the salary and other costs of the employee benefits department and fringe benefits paid (see CMS Pub. 15-1, chapter 21, §2144 and CMS Pub. 15-1, chapter 23, §2307).

Line 4 - Administrative & General.--Enter in columns 1 and 2, the salary and other costs of A&G.

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 & Maintenance.--This cost center includes expenses incurred in the operation and maintenance of the plant and equipment (see §4113, Maintenance and repairs, and Operation of plant). Enter in columns 1 and 2, the costs of plant operation and maintenance.

Line 6 - Laundry & Linen Service.--Enter in columns 1 and 2, the cost of routine laundry and linen services.

Line 7 - Housekeeping.--Enter in columns 1 and 2, the cost of routine housekeeping activities.

Line 8 - Dietary.--Enter in columns 1 and 2, 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.--Enter in columns 1 and 2, 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 your 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.--Enter in columns 1 and 2, 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.--Enter in columns 1 and 2, the 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.--Enter in columns 1 and 2, 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.--Enter in columns 1 and 2, the cost of the overall coordination of service volunteers including their recruitment and training costs of volunteers.

Line 14 - Pharmacy.--Enter in columns 1 and 2, the costs of drugs (both prescription and over-the-counter), pharmacy supplies, pharmacy personnel, and pharmacy 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.--Enter in columns 1 and 2, 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, conducting required face-to-face encounters for recertification, 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 O-6 to accumulate in-facility costs not separately identified as HIRC, HGIP, 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 HIRC, HGIP or residential care). The amounts allocated to this cost center on Worksheet O-6 are allocated to HIRC, HGIP 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 (such as hospice home care provided in a residential unit), costs are reported directly on line 66.

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

Direct patient care service costs (lines 25 through 46) are reported by level of care (LOC) on Worksheets O-1, O-2, O-3 and O-4. For each cost center on Worksheet O, enter the sum of the amounts from Worksheets O-1, O-2, O-3, and O-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 (HIRC or HGIP) 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. 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 Physician Administrative Services (line 15). 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 other than nurse practitioners.

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 37.

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 center 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 DME and oxygen, as defined in 42 CFR 410.38 and 42 CFR 418.202(f), furnished to individual HRHC or HCHC 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 HRHC and HCHC 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 new LOC, report the transportation cost to that LOC. For example, a patient in a HGIP LOC is transferred to HRHC LOC and transported to their home, the transportation cost associated with the transfer must be included in the HRHC 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 O-6, Parts I and II.

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

*Nonreimbursable cost centers include costs (lines 60 through 71) 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.--Enter in columns 1 and 2, the salary and other costs 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.--Enter in columns 1 and 2, the salary and other costs of volunteer programs. (See CMS Pub. 15-1, chapter 7.)

Line 62 - Fundraising.--Enter in columns 1 and 2, the salary and other costs of fundraising. (See CMS Pub. 15-1, chapter 21, §2136.)

Line 63 - Hospice/Palliative Medicine Fellows.--Enter in columns 1 and 2, the salary and other costs of hospice and palliative medicine fellows.

Line 64 - Palliative Care Program.--Enter in columns 1 and 2, the salary and other costs of palliative care provided to non-hospice patients. This includes physician services.

Line 65 - Other Physician Services.--Enter in columns 1 and 2, the salary and other costs of other physician services that are provided outside of a palliative care program to non-hospice patients.

Line 66 - Residential Care.--Enter in columns 1 and 2, the salary and other 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 HRHC and/or HCHC LOC worksheet.

Lines 67 - Advertising.--Enter in columns 1 and 2, the salary and other costs of nonallowable community education, business development, marketing and advertising (see CMS Pub. 15-1, chapter 21, §2136).

Lines 68 - Telehealth/Telemonitoring.--Enter in columns 1 and 2, the salary and other costs of telehealth/ telemonitoring services. These costs are nonreimbursable since a hospice is not an approved originating site (see 42 CFR 410.78(b)(3)).

Lines 69 - Thrift Store.--Enter in columns 1 and 2, the salary and other costs of thrift stores.

*Line 70 - Nursing Facility Room and Board.--Enter the 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.*

*Lines 72 through 99.--Reserved for future use.*

#### *4164.1. WORKSHEETS O-1, O-2, O-3, AND O-4 - ANALYSIS OF SNF-BASED HOSPICE COSTS*

*Worksheet O-1 - Analysis of SNF-Based Hospice Costs Continuous Home Care*

*Worksheet O-2 - Analysis of SNF-Based Hospice Costs Routine Home Care*

*Worksheet O-3 - Analysis of SNF-Based Hospice Costs Inpatient Respite Care*

*Worksheet O-4 - Analysis of SNF-Based Hospice Costs General Inpatient Care*

*Worksheets O-1, O-2, O-3, and O-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 O in order to facilitate the transfer of direct patient care costs to Worksheet O. 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 O.*

*Column 1--For each LOC worksheet, enter salaries from the provider's accounting books and records.*

*Column 2--For each LOC worksheet, enter all costs other than salaries from the provider's accounting books and records.*

*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 LOC worksheet enter any reclassification of direct patient care service costs needed to effect proper cost allocation. For each line, the sum of the reclassification entries on Worksheets O-1, O-2, O-3 and O-4, column 4, must equal the amount on the corresponding line on Worksheet O, column 4.*

*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 LOC worksheet, enter any adjustments for direct patient care service costs (lines 25 through 46) required under Medicare principles of reimbursements. (See §4116.) Show reductions to expenses as negative amounts. For each line, the sum of the adjustment entries on Worksheets O-1, O-2, O-3 and O-4, column 6, must equal the amount on the corresponding line of Worksheet O, column 6.*



Column 7--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. For each LOC worksheet, transfer the amount on line 100 to the corresponding LOC line on Worksheet O-5, column 1, as follows:

<u>From line 100 of:</u>	<u>To Worksheet O-5, column 1, line:</u>
Worksheet O-1	50
Worksheet O-2	51
Worksheet O-3	52
Worksheet O-4	53

#### 4164.2. WORKSHEET O-5 - COST ALLOCATION - DETERMINATION OF SNF-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Worksheet O-5 determines total expenses of each general service cost center for proper allocation of general service costs to each LOC and to nonreimbursable cost centers. This worksheet combines the direct general services costs reported on Worksheet O, lines 1 through 17 with the overhead allocation of the hospital general services costs reported on Worksheet B Part I, line 83, columns 1 through 15.

#### Column Descriptions

Column 1--For each general service and nonreimbursable cost center, transfer the amount from the corresponding cost center on Worksheet O, column 7. For each LOC line, transfer amounts as follows:

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

The total on line 100 of column 1 must equal the amount on Worksheet A, column 7, line 83.

Column 2--For each general service cost center, transfer the amount from the corresponding column on Worksheet B, Part I, line 83 as follows:

<u>Line:</u>	<u>From Worksheet B, line 83, column(s):</u>	<u>Line:</u>	<u>From Worksheet B, line 83, column(s):</u>
1	1	10	10
2	2	11	12
3	3	12	N/A
4	4	13	N/A
5	5	14	11
6	6	15	N/A
7	7	16	15
8	8	17	13
9	9		

Column 3--For each line, enter the sum of columns 1 and 2. The total on line 100 of column 3 must equal the amount on Worksheet B, Part I, column 18, line 83. Transfer the amount from each cost center to the corresponding line on Worksheet O-6, Part I, column 0.

**4164.3. WORKSHEET O-6 - PART I - COST ALLOCATION - SNF-BASED HOSPICE GENERAL SERVICE COSTS AND WORKSHEET O-6 - PART II - COST ALLOCATION - SNF-BASED HOSPICE GENERAL SERVICE COSTS 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.*

*Worksheet O-6, Parts I and II, facilitate the step-down method of cost finding. This method recognizes that general services of the hospice are utilized by other general service, LOC, and nonreimbursable cost centers. Worksheet O-6, Part I provides for the equitable allocation of general service costs based on statistical data reported on Worksheet O-6, Part II. To facilitate the allocation process, the general format of Worksheet O-6, Part I is identical to that of Worksheet O-6, Part II. 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 O) are reported by LOC on lines 50 through 53 of Worksheets O-6, Parts I and II. The line numbers for nonreimbursable cost centers are identical on Worksheet O and Worksheet O-6, Parts I and II.*

*When certain general services costs are related to in-facility days and are not separately identifiable by LOC or service, Worksheet O-6, Parts I and II, provide for the accumulation of these costs on line 17, Patient/Residential Care Services. The amounts accumulated in this cost center are allocated based on the in-facility days for HIRC, HGIP, 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 O-6, Part II 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 O-5, column 3, has a negative balance, show this amount as a negative balance on Worksheet O-6, Part I, 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 100 of the column, and do not allocate. This enables Worksheet O-6, Part I, column 18, line 101 to cross foot to Worksheet O-6, Part I, column 0, line 101. After receiving costs from overhead cost centers, LOC cost centers with negative balances on Worksheet O-6, Part I, column 18, are not transferred to Worksheet O-7.*

*On Worksheet O-6, Part II, enter on the first available line of each column, the total statistics applicable to the cost center being allocated (e.g., in column 1, Cap Rel Costs-Bldg & Fixt enter on line 1 the total square feet of the building 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 O-6, Part II, enter on line 101, the total expenses of the cost center to be allocated. Obtain the total expenses from the first line of the corresponding column on Worksheet O-6, Part I, which includes the direct expenses from Worksheet O-6, Part I, column 0 plus the allocated costs from previously closed cost centers. Divide the amount entered on Worksheet O-6, Part II, line 101 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 102.*

*For each column on Worksheet O-6, Part II, multiply the unit cost multiplier on line 102 by the 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 O-6, Part I. For each column on Worksheet O-6, Part I, the sum of the costs allocated (line 100) must equal the total cost on the first line.*

*After the costs of the general service cost centers have been allocated on Worksheet O-6, Part I, enter on each line of column 18, the sum of the costs in columns 3A through column 17 for lines 50 through 71. The total costs entered on Worksheet O-6 Part I, column 18, line 100 must equal the total costs entered in column 0, line 100.*

### Column Descriptions

*Column 0--For each line, enter the total direct costs from the corresponding line on Worksheet O-5, column 3.*

*Column 3A--For each line, enter the sum of columns 0 through 3. The sum for each line is the accumulated cost and, unless an adjustment is required, is the Worksheet O-6, Part II, column 4 statistic for allocating A&G costs.*

*If an adjustment to the accumulated cost statistic on Worksheet O-6, Part II, column 4, is required to properly allocate A&G costs, enter the adjustment amount on Worksheet O-6, Part II, column 4A for the applicable line. For example, when the hospice contracts for HIRC or HGIP services and the contractual costs include A&G costs, the contractual costs reported on Worksheet O-3, column 7, line 25, or Worksheet O-4, column 7, line 25, may be used to reduce the accumulated cost statistic on Worksheet O-6, Part II, column 4A, line 52 or line 53, respectively.*

*For each line, the accumulated cost statistic on Worksheet O-6, Part II, column 4, is the difference between the amount on Worksheet O-6, Part I, column 3A and the adjustment amount on Worksheet O-6, Part II, 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 O-6, Part I, column 3A, line 4, to Worksheet O-6, Part II, column 4A, line 4.*

*The total accumulated cost statistic for Worksheet O-6, Part II, column 4, line 4 is the difference between the total on Worksheet O-6, Part I, column 3A, line 101 and the amounts in column 4A of Worksheet O-6, Part II.*

*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 O-6, Part I,</u> <u>column 18:</u>	<u>To Worksheet O-8,</u> <u>column 3:</u>
line 50	line 1
line 51	line 6
line 52	line 11
line 53	line 16

#### 4164.4. WORKSHEET O-7 - APPORTIONMENT OF SNF-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

*This worksheet calculates the cost of ancillary services provided by SNF ancillary departments to SNF-based hospice patients.*

##### Column Description

Column 1--For each cost center, enter in column 1, the cost-to-charge ratio from Worksheet C, Part I, column 9, line as indicated in column 0.

Columns 2 through 5--For each cost center, enter the charges, from the provider's records, for ancillary services provided by SNF ancillary departments to SNF-based hospice patients. Enter the charges by LOC in the appropriate LOC column.

Columns 6 through 9--For each column, calculate cost of ancillary services provided by SNF ancillary departments to SNF-based hospice patients as follows:

<u>Column:</u>	<u>Calculation:</u>
6	col. 1 x col. 2
7	col. 1 x col. 3
8	col. 1 x col. 4
9	col. 1 x col. 5

*For each column 6 through 9, enter the sum of lines 1 through 10 on line 11.*

**4164.5 WORKSHEET O-8 - CALCULATION OF SNF-BASED HOSPICE PER DIEM COST**

*Worksheet O-8 calculates the average cost per diem by level of care and in total.*

Line 1.--Enter in column 3 the total HCHC cost from Worksheet O-6, Part I, column 18, line 50 plus Worksheet O-7, column 6, line 11.

Line 2.--Enter in column 3 the total HCHC days from Worksheet S-8, column 4, line 10.

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

Line 4.--Enter in column 1 the title XVIII - Medicare HCHC days from Worksheet S-8, column 1, line 10. Enter in column 2 the Title XIX - Medicaid HCHC days from Worksheet S-8, column 2, line 10.

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.

Line 6.--Enter in column 3 the total HRHC cost from Worksheet O-6, Part I, column 18, line 5 plus Worksheet O-7, column 7, line 11.

Line 7.--Enter in column 3 the total HRHC days from Worksheet S-8, column 4, line 11.

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

Line 9.--Enter in column 1 the Title XVIII - Medicare HRHC days from Worksheet S-8, column 1, line 11. Enter in column 2 the Title XIX - Medicaid HRHC days from Worksheet S-8, column 2, line 11.

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 HIRC cost from Worksheet O-6, Part I, column 18, line 52 plus Worksheet O-7, column 8, line 11.

Line 12.--Enter in column 3 the total HIRC days from Worksheet S-8, column 4, line 12.

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

Line 14.--Enter in column 1 the Title XVIII - Medicare HIRC days from Worksheet S-8, column 1, line 12. Enter in column 3 the Title XIX - Medicaid HIRC days from Worksheet S-8, column 2, line 12.

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 HGIP cost from Worksheet O-6, Part I, column 18, line 53 plus Worksheet O-7, column 9, line 11.

Line 17.--Enter in column 3 the total HGIP days from Worksheet S-8, column 4, line 13.

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

Line 19.--Enter in column 1, the Title XVIII - Medicare HGIP days from Worksheet S-8, column 1, line 13. Enter in column 3, the Title XIX - Medicaid HGIP days from Worksheet S-8, column 2, line 13.

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-8, column 4, line 14.

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

EXHIBIT 1 - Form CMS-2540-10 Worksheets

The following is a listing of the Form CMS-2540-10 worksheets and the page number location.

<u>WORKSHEETS</u>	<u>PAGE (S)</u>
Wkst. S, Parts I, II & III	41-303
Wkst. S-2 Parts I & II	41-304 - 41-306
Wkst. S-3, Parts I, II, <i>III, IV &amp; V</i>	41-307 - 41-309
Wkst. S-4	41-310
Wkst. S-5	41-311
Wkst. S-6	41-312
Wkst. S-7	41-313 - 41-314
Wkst. S-8	41-315
Wkst. A	41-316 - 41-317
Wkst. A-6	41-318
Wkst. A-7	41-319
Wkst. A-8	41-320
Wkst. A-8-1	41-321
Wkst. A-8-2	41-322
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